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The Institute applies psychological medicine principles to the human elements in the work place and combines the specialties of Psychological Medicine, Administration and Management
The paradigm shift in Human Capital Management and Potential Enhancement

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Professor Srikanth Nimmagadda
Professor of Psychological Medicine, IIOPM
Consultant Forensic Psychiatrist and Medical Director
Cheswold Park Hospital, Doncaster, UK
I am extremely delighted to bring out the third edition of the bulletin of the International Institute of Organisational Psychological Medicine (IIOPM). This bulletin is aimed to produce a globally contributed and globally relevant collection of articles, which comprehensively covers major themes comprising the field of organisational psychological medicine. The overall goal of this bulletin is to advance our understanding and knowledge of many different approaches to human capital management in organisations. Although this addition retains some of the features similar to the previous editions, it has been expanded to include new research findings, and expanded discussions of selected human capital potential themes including positive psychological capacities, leadership, fatigue, physician burnout, embitterment, post embitterment syndrome etc.

The role and value of human capital in successful organisations is highlighted in lists such as Fortune 500 companies best to work in the world. The modern-day organisations face various challenges including the emergence of artificial intelligence and automation in various sectors. Of course, the implications of artificial intelligence are not fully understood in terms of the work force issues. Human capital is also driven by various titanic forces including globalisation, the increase in pace of technological changes and also the massive worldwide demographic shifts in the management environment. Globally, with increasing retirements combined with shrinking labour pool, there will be a dramatic knowledge worker shortfall in the next few years. Similar trends will apply in some parts of the world including Western Europe and Japan, where the population growth has been declining. Increasingly, organisations are able to understand that knowledge equals profit and rather than relying on the critical interactions in technology, they are investing extensively in career education programmes and employee retaining programmes. Thereby, they are reaping both short term and long-term benefits and profits. This strategy will increase personal performance and also, enhance human capital return of investment (ROI) of the business. Therefore, more than ever, harnessing the human capital, i.e. the accumulated skills, experience, wisdom and capabilities of the people employed is fundamental to creating real value and the success of any organisation.

The psychological health of human capital in organisations can be impacted by the workplace and beyond. Poor psychological health results in poor outcomes in terms of the performance of both an organisation and its staff. Various studies on burn out and demoralisation of the human capital concluded that psychopathological sequelae resulted in the decreased efficiency and productivity of the workforce. Other studies have concluded that embitterment in the work place resulted in psychopathological embitterment post-traumatic stress disorder. This sets into motion a vicious cycle, i.e., workplace-related psychiatric pathology impacts on outcomes and also results in recruitment difficulties and poor retention of staff. This in turn negatively affects the need for good talent management for increased productivity in the organisations.

Most organisations are not the stable predictable structures of the past. The leaders face a difficult task at all levels today to keep people motivated and committed in an area of unrelenting and exhilarating change. Organisations need to be far more agile and flexible in how they operate, both internally and externally. This changing nature represents a new challenge for those in positions of leadership. There is need for emotional intelligent leaders who will be able to create organisational climates that fosters not
only performance but also a sense of pride and purpose in the workforce.

According to the Centre for Mental Health’s report ‘Mental health at work: developing the business case’ published in December 2007, stress-related illness is the leading cause of sickness absence, directly costing the UK economy roughly £26 billion per annum. This does not even take into account the costs attributed to the NHS for treating people who become ill. Research has highlighted that main stressors at work include a long-hours culture, lack of work life balance, lack of engagement, job insecurity, abusive and poor line management etc. There is strong research evidence coming from various parts of the world that presenteeism is double the cost of absenteeism, with people turning up to work ill for fear of job loss, and ultimately burning themselves out and contributing little added value to their job and organisation.

It is indeed encouraging that the results of the study ‘Employee Benefits/Health Shield Healthcare research 2017’ highlighted that organisations are recognising that workplace stress is a big issue, not only in terms of employee health but also productivity, with 67% of organisations identifying the reduction of workplace stress as a duty of care issue. Therefore, health and wellbeing at work should be on the top of the agenda if organisations want higher levels of productivity, lower absence and presenteeism, and talent retention.

In an article by Kotter, published in Harvard Business Review ‘What Leaders really do’, it is articulated that that an adaptive organisation is one where a genuine culture of leadership exists and that the emergence of leaders is encouraged at every level of organisation. He further explained that leadership is about the process of sharing the vision in a way that will facilitate the release of individual’s energies towards a common goal. High performance leaders consistently lead in a manner that inspires others to trust and follow them. They know how to connect with the workforce in such a manner that everyone in the organisation understands the mission at hand. They also encourage their teams to stretch and achieve, while holding them accountable for their performance and behaviour. They help the organisations to cope with ambiguity by crystallising their end objective and providing focus in terms of enhancing productivity.

The branch of Organisational Psychological Medicine’s scope of practice expands from the diagnosis and management of work place-related psychological disorders to the added sphere of preventive psychological medicine, resilience and positive psychological medicine applied to the human capital within organisations. These include population health initiatives of developing programs that will enhance the outcomes of human capital of organisations. Thus, the discipline benefits the bottom line of both the individual and the organisation. It also broadens its horizons to encompass corporate social responsibility in this area and leadership along with the enhancement of human capital.

The IIOPM has now expanded globally over the last four years. The main objective of the IIOPM is to enhance the potential of human capital in the organisations and to achieve this by preventing, identifying, and managing workplace related psychological pathologies in the human capital. The IIOPM bulletin aims to promote and exchange knowledge, ideas, and theories and to develop the discipline of organisational psychological medicine in diverse organisations across the globe. The Institute’s objective is also to raise the awareness of various aspects of the human capital management and productivity. It is our sincere wish that the field of organisational psychological medicine becomes a more embracing and internationally recognised field as it develops into a global arena for science and practice over the next few decades.

I am delighted to highlight some of the work and initiatives undertaken by the Institute and the future plans in the next few paragraphs.
The Institute has established active academic links with various renowned universities and organisations across the globe and continues to expand in various parts of the world. The Institute already has a memorandum of understanding (MoU) with a range of academic institutions and healthcare universities in USA, UK, India and Australia.

The IIOPM has been rapidly growing over the last few years and given that a full curriculum is in place, psychiatrists, other doctors and professionals with administration and organisational experience would be eligible for the membership examination commencing in the next 2 years. This would enable them to obtain a qualification and use of post nominals, i.e., MIIOPM or FIIOPM. The Institute has honoured various senior psychiatrists and management professionals in health care organisations with a fellowship after they met the necessary requirements of rules and bye laws of the Institute.

Over the past year, the Institute has held human capital management seminar meetings in Watford (UK) and Jaipur (India) and has received a tremendous response and interest from various psychiatrists, senior managers, and doctors from other specialities. The scientific presentations essentially focused on human capital management based on a psychological approach and were hugely successful. The events enabled the participants to gain insight and understanding into key issues relating to the human capital management practices in organisations and learn ways to promote resilience and productivity of the workforce.

A few of the highlights of these symposiums include the following: Professor D’Souza talked about ‘Presenteeism, and Work Place Psychological Health Promotion’ and has stressed that the most important issue for organisations is to design appropriate programmes and implement them to achieve the desired optimal results to reduce risks of presenteeism and enhance productivity. Mr Mazeau delivered a talk on ‘Wellbeing at Work: A Major Challenge for Socially Responsible Companies’ and highlighted that despite the challenging economic conditions, corporate responsibility continues to move up the agenda for organisations. He emphasised that a tailored approach to corporate responsibility, which bolsters and supports core business strategy, is much more likely to create real business and brand value. The other speakers talked about burn out and the essential role of emotional intelligence in enhancing productivity in organisations. These seminars enabled the delegates to gain more understanding into some of the critical issues related to the human capital management in organisations and ways of promoting resilience and productivity of the workforce.

The Institute is in the final stages of signing an agreement with Oxford University Press and is working towards publishing the first text book on Organisational Psychological Medicine. We are currently working with the contributing authors for relevant chapters and hoping that book will be published in the next 12-15 months. The text book will provide an overview of this evolving discipline and will bring together the expanding research base covering the study of psychiatric and psychological pathology in the workplace and its’ prevention.

Various articles relevant to human capital enhancement, including the framework of embitterment and post-traumatic embitterment syndrome, burn out, fatigue, stress and relaxation at workplace are considered in detail in this edition. The diagnostic criteria and symptoms of post-traumatic embitterment disorder and the factors leading to the embitterment are discussed. The article by Professor D’Souza et al offers a fascinating insight into the effects of embitterment and post-traumatic embitterment disorder on an individual’s effectiveness and organisational productivity. Various original research articles including evaluation of fatigue in nurses caring for people with cancer offers an in-depth understanding into the issues of fatigue. Physician burn out as a work related symptom and the gender and generation differences affecting the physician burn out is an excellent research article by Dr Amanullah and his Candaian team. Dr Seemann’s article on the role of Transcranial Magnetic Stimulation (rTMS) in boosting wellbeing
Professor Agis’s article in this bulletin covers the interplay of various themes of leader, leadership and management in the success of any organisation. This article analyses leadership theories and gives special attention to how each approach can be applied to individual situations. The article examines the nature of authentic leadership, its underpinnings and how it works. Research has shown that corporate culture can have important influence on the occurrence of stress in an organisation. Professor Zafiris highlighted in his article the importance of understanding workplace stress and how preventing and repairing the ill effects of stress will reduce both the financial as well as the human costs of workplace stress.

Finally, human capital potential enhancement has become a key issue for most organisations, leading more people to engage in high quality, lifelong learning. It is important for organisations to have a clear human capital strategy to address various obstacles, including recruiting and retaining good talent, valuing human capital and thereby improving personal effectiveness of individuals and organisational productivity. There is considerable research evidence which points out the importance that human part of the organisation continues to play a significant role, if not entire role, in terms of contributing to the success of an organisation. There are various critical forces that need to be considered in devising human capital strategy in any organisation including globalisation, changes in work force demographics, skills shortages, environmental factors and more. The IIOPM is working on not only on factors contributing to the psychological pathologies in the workforce but also trying to identify and offer solutions in terms of addressing them. The IIOPM will continue to work with various leaders and organisations beyond healthcare and try to establish links in terms of ensuring that some of the issues that are relevant to the human capital are identified for the benefit of both individuals and organisations.
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Melbourne, VIC, Australia
Can we afford the ‘Clean Slate’ approach in Organisational Reengineering?

Professor Umit Agis
Professor of Psychological Medicine, IIOPM

Introduction

In today’s highly competitive business environment survival is predicated on an organisation’s ability to remain responsive and relevant to customer needs with greater efficiency and cost-effectiveness. Many organisational theorists call for a radical rethinking of organisational functioning to strategically align themselves with this ethos (Hammer, 1990; Hammer 1995; Ross, 1995; Al-Mashari, Irani and Zairi, 2001). Business Process Reengineering (BPR) has been identified as the new organisational change paradigm that has been shown to deliver radical improvements in business outcomes (Grint, 1994; Hammer, 1995; Grey and Mitev, 1995; Stoddard and Jarvenpaa, 1995; Buchanan, 1998; Al-Mashari, Irani and Zairi, 2001). One of the central assumptions underlying the concept of BPR is that it must start with a ‘clean slate’ (Hammer, 1990). In explicating its theoretical underpinnings, the proponents of the ‘clean slate’ approach to BPR strongly advocate for the disregarding of the existing business processes so as not to be limited by, and in turn be freed from, the legacies of the past, and to focus solely on future processes that will ensure the desired business outcomes (Hammer 1990; Al-Mashari and Zairi, 2000). Boudreau and Robey (1996) argue, however, that such assumption is ‘fallacious’ in its application as they argue “even the most radically redesigned business processes need to be implemented in real organisations that have histories and memories. Re-engineering design teams cannot wipe clean the slates members of the organisation carry in their heads, nor can they obliterate the shared understandings and mental models that have accrued overtime (p45). Some have argued that such assumptions undermine and possibly contribute to the apparently high failure rates observed in reengineering efforts (Grey and Mitev, 1995; Maglittta, 1995; Boudreau and Robey (1996).

Accordingly, the focus of this paper is to expand on the postulation forwarded by Boudreau and Robey (1996). In doing so the author argues that the obliteration of the existing business processes does not inherently guarantee business success. In fact, it is suggested that the extent to which this occurs may undermine the very success BPR professes to its constituent practitioners. It is asserted that there are significant factors that inhibit the purist application of the ‘clean slate’ approach to BPR. Whilst there are several constraining factors, due to space limitations the writer will unavoidably limit the discussion to some of the more fundamental issues emerging from the literature review undertaken including the influence of the existing legacy systems, economic considerations and the paramount role of people and organisational memory in the espoused implementation of organisational change. Embedded within the latter is the ideological dimension located within the aggressive stance of the ‘clean slate’ approach to BPR by positioning itself with the mechanistic view of transformational change, located as it is within the scientific management paradigm (Grey and Mitev, 1995; Morgan, 1997). This ideological alignment, it is argued, represents an internal constraint within BPR and thereby undermines the principles embedded in transformational change to which it lays claim. Where necessary, case examples will be used to further illuminate the points being made. It must be stated; moreover, that given the complex nature of the constraints under scrutiny, a thorough discussion of each area and their theoretical origins is beyond the scope of this paper. Whilst this may pose a challenge to the reader, it is hoped that the detail given will be sufficient to elevate the necessary awareness to appreciate its central thesis. Furthermore, in order to establish the contextual premise for the unfolding discussion, a definition of BPR will be offered and the key theoretical underpinnings will be briefly reviewed.
Business Process Reengineering (BPR): A Brief Definition

There are various competing definitions of Business Process Reengineering (BPR). O’Neill and Sohail (1999) suggest that this is in part due to it being an evolving organisational theory and that the differences ostensibly lie “both in the interpretation and scope of the organisational change” (p574). Notwithstanding these variations, Davenport and Stoddard (1994) argue that most definitions rest on five key concepts which they summarise as: cross-functional business process orientation, information technology (IT) as a major enabler of reengineering oriented change, radical shift in thinking and performance outcomes; aligning human resource management practices with the goals of BPR which includes such factors as training, cultural change, new job descriptions and the accompanying principles of communication, and an aggressive approach to the new work design and change, which is enshrined in the ‘clean slate, or clean sheet’ approach to change. Closer examination of this definition partly unearths the central argument of this paper insofar as identifying the paradoxical nature of the relationships that exist amongst some of the key concepts, namely between the type of radicalism called for in the ‘clean slate’ approach and the concepts of role of IT, human resource and change management. Before going any further, the author will proceed firstly by expanding on the constituent elements of a clean sheet approach to BPR and secondly by extrapolating the barriers to achieving its purist stance in relation to implementing organisational change.

Clean Slate and BPR

In his seminal work Hammer (1990) utters his often-cited words in the PBR literature: “Don't automate, obliterate!” The naked assumption underlying this approach was that in order to be truly radical in creating new process-oriented outcomes organisations must start afresh, that the organisation must “throw away all existing processes, activities, systems, people, etc.” (Davenport and Stoddard, 1994:122). By doing this they would free themselves up in order to be able to adopt the “outside the box” thinking necessary to achieving the utopian organisational state of heightened efficiency and competitiveness. It is not concerned with the current workflow arrangement but is guided by the achievement of a preconceived organisational outcome or goal that is directly determined by the end-user of its product, the customer. A cross-functional process management team made up of senior executive and those managers who have a stake in its implementation are charged with the conception of the design which is guided by the broad organisational vision provided by the key organisational leaders. It assumes the total absence of barriers both in the design of new workflows and their implementation on the ground (Boudreau and Robey, 1996).

In their criticism of the ‘clean slate’ approach, Manganelli and Klein (1994) assert the view that “the possibility of starting with a clean sheet is an illusion” (p.46). Moreover, Davenport and Stoddard (1994) assert that it is rare to find change of such magnitude in scope and have found in their studies that to start from scratch meant overstretching resources for an outcome that is not guaranteed and that managers often are unwilling to take such risks. In another study conducted by Stoddard, Jarvenpaa and Littlejohn’s (1996) it is concluded that organisations seldom used the clean sheet approach due to implementational constraints. Their findings supported the use of a ‘clean sheet’ approach to designing radical and innovate new workflow solutions but implementation had to be incremental as it allowed strategic incorporation of the existing barriers so as to maximize its chances of success. This view has been echoed in the BPR literature (Patching, 1995). A case in point is the constraints relating to technology.

Technological Constraints

In their review of the international literature, Al-Mashari, Irani and Zairi (2001) found that clean slate is seldom used because of high risk of cost. This point is particularly salient in IT infrastructure and
software. Several writers have identified IT as one of the most crucial enablers of BPR as it facilitates cross-functional processes across the organisation (Markosian, Newcombe, Brand, Burson and Kitzmiller; 1994; Stoddard and Jarvenpaa, 1995; Alderson and Shah, 1999; Al-Maashari and Zairi, 2000:). However, the necessary IT changes required to complement the change in work design often lag in its development and thus implementation, thereby contributing to a significantly compromised outcome and induces cynism from staff which cumulatively put future change efforts at risk (Davenport and Stoddard, 1994). Changing information systems associated with IT, moreover, is a particularly difficult process (Alderson and Shah, 1999). This is in part due to the economic costs involved and secondly its influence over work practices it purports to engineer.

It has been argued that, paradoxically, today’s systems of information technology have the inherent tendency to become a barrier to implementing change as they represent a ‘legacy system’ ((Davenport and Stoddard, 1994). Legacy system is defined as incompatibility of the existing information systems (IS) with the current business strategy (Alderson and Shah, 1999). The significance of this statement is located in the assertion that the design of new work processes presupposes the availability of the required IT solutions (Bateman and Rich, 2003). As indicated earlier, invariably the economic cost of investing in a major IT change without any indications for success discourage management from undertaking a ‘clean slate approach (Grey and Mitev, 1995; Hill and Collins, 1997). The fact of the low rate of IS-oriented change internationally, 6% in U.S. and 4% in Europe (Maglitta, 1995) may underlie the fancifulness of the notion of the ‘blank cheque’ approach required to achieve ‘clean slate’ change. This assumptive approach to change, where the resources required to realising it are assumed to exist, also finds expression in the accompanying social changes required, which Hurst (1996) argues is the one of the major causes of high rate of BPR failures.

‘The clean slate’ approach to implementing change minimises the important role the existing organisational memory plays in any change process, as embodied in the tacit knowledge of employees (Ahmed, 2002). These factors have been argued to have the capacity to enable as well as disable change (Argyris, 1994; Senge, 1993). Marjanovic (2000) adds weight to this assertion in her study where she concludes that most BPR efforts fail because leadership is unwilling or unable to tap into the considerable reserves of creativity and knowledge in their employees. Rather than being empowered, people are further disempowered by being excluded from design implementation (Boudreau and Robey, 1996). Employees embracing change and identifying with the change goals are said to be some of the basic constituent elements of transformational change (Kotter, 1995). BPR too claims to be transformational in its scope but is argued to be constrained in its efforts where it is closely aligned with the clean sheet methodology. By explicating the basic operant assumptions underlying transformational change, a framework will be developed to expand on Marjanovic’s (2000) central contention.

Transformational Change and the ‘Soft Side’ of BPR

Organisational management theory defines transformational change as a fundamental shift in the conceptualisation of the organisation from its current functioning to the one that promotes organisational excellence and growth (Senge, 1993; Kotter, 1995). Organisational leadership initiates it by creating a shared vision, which is communicated in a way that secures the trust of people and by establishing psychological contracts between leadership and employees that bind them into a relationship with reciprocal obligations based on a shared set of values (Kotter, 1995). These values are played out through organisational culture, which promotes set of behaviours consistent with these values. Schein (1985) defines culture as a collectively shared norms and values that dictate the way in which organisational members relate to one another. Most organisations have a culture (Schein, 1985) and most have organisational memories (Gavin, 1993; Senge, 1994) in the form of tacit knowledge (Ahmed, 2002). It is beyond the scope of this paper to discuss these concepts in detail. As indicated, these concepts will be
drawn upon insofar as they provide a platform for analysis, which implicate the shortfalls inherent in the ‘clean slate’ approach to work design implementation. It makes, for instance, several assumptions about the need for disregarding the existing processes in their totality.

**Current Work Processes: The Building Block of an Imagined Future**

Biazzo (2000) argues that ignoring the need for a careful ‘as is’ analysis of the current processes is fundamentally an erroneous approach. His premises his criticism on the view that it is imperative that we know what is not working. A redesign may inadvertently recreate past problems that we are trying to change to achieve a radical outcome. It also has the dual benefit of being able to map the constraints and opportunities within the system so that they can be factored in to any change design. Several case studies have shown that the ‘dirty slate’ approaches can often secure favourable outcomes with limited input (Lemons and Crom, 1995).

In their study of an organisation that used this methodology, Lemon and Crom (1995) observed that a BPR design team in mapping the ‘as is’ processes of an administrative procedure in a high-technology electronics research and development company, discovered that a critical step in the requisitioning of new pc’s took place at the end of a process. By simply moving this step to the beginning the company saved “months of time” (p17). The outcome was radical but not the design required to achieving it. The design team was drawn from senior management, middle management and shop floor supervisors. The supervisors had an intimate knowledge of the existing process and were able to identify the problematic steps and took active part in the implementation.

Incorporating the existing knowledge as a leverage and empowering employees to use their tacit knowledge achieved the change. The preceding example also highlights the context-specific nature of change, where the local operational issues were intimately known to the staff that was able to identify and incorporate them into the organisational BPR. Clean slate approach to design and implementation, however, erroneously assumes that change is context-free (Davenport and Stoddard, 1994; Grey and Mitev, 1995).

**The Importance of Context in BPR**

Arndt and Bigelow (1998) refute the contextlessness of change in their review of the application of BPR in a general hospital setting. They conclude that there are major industrial and legislative frameworks that prevent hospitals from using the clean slate approach to work design. Professional bodies have major industrial force and change to job descriptions in order to genericise certain functions so as to convert profession-specific tasks into cross-functional processes is untenable within the public health setting context.

In another study, Stoddard, Jarvenpaa and Littlejohn (1996) observed that in Pacific Bell’s Centrex Provisioning Process, the reengineering design was radical, but the implementation was more incremental and that whilst design had the capacity to assume a clean slate to change, implementation was limited by those constraints the management ‘couldn’t or will not remove’ (p61). For example, the redesign had as its centerpiece radical improvement in performance. The ‘clean slate’ approach to design was underscored by the assumption of “the availability of new roles, structures and information technology-based systems”. (Stoddard, Jarvenpaa and Littlejohn, 1996:61). The new roles and structures were primarily designed to achieve the necessary change in work culture, values and norms to support the change initiative. These were dispersed to all their plants across the U.S. A number of problems emerged during implementation, which ultimately undermined the scope of change envisioned in the design phase, and, predictably, returns were more modest then had been anticipated.
Stoddard, Jarvenpaa and Littlejohn, (1996) discovered that not only was IT not able to deliver the required technological tools in a timely manner, which effectively compromised the overall integrity of the change, but also the local managers were reluctant to adopt the full process change. Their concerns ultimately centered on the effects of the change on their good relationship with workers and the local union representatives. Their assessment was that the gains to be made from imposing an unworkable change did not match the potential loss of worker motivation and the induction of mistrust and disempowerment. It was concluded that the head office senior managers’ approach was characterised by an assumption of a change being a process devoid of context of human and practical dimensions. Valentine and Knights (1998) argue that any change designed to effect cultural change by definition has to be incremental and thus participative in order that the vision of the organisation shared amongst the employees. Hence, it can be argued that such a mechanistic view of change is impractical and will invariably minimise the impact of practical constraints on the change process.

Mechanistic View of Change

Mechanistic conception of organisational theory has its origins in the Taylorist tradition of scientific management theory which postulates the primacy of scientific planning of work flows, job design and change and that the quality processes being the responsibility of managers (Morgan, 1997). This approach found its critics in the transformational change management theorists who argued that responsiveness to customer need and quality of the work done required the utilisation of hitherto untapped skills and creativity of employees in critical change management and product innovation. Adapting to change, thus, became the determining competitive edge in the post-modern era of organisational management (Senge, 1994). Such responsiveness to external forces not only required focusing on flatter structures, team orientation but a focus on values and employee participation and the importance of culture as an enabler of change. In this paradigm quality becomes a shared responsibility. Control, as conceptualised in the Taylorist paradigm was external and suffocating of employee innovation, whereas in the new post industrial age of staff empowerment through participation and flatter organisational structures to embed responsiveness to customer demands, which BPR can be argued to be its by-product, control had to be internalised through staff subscribing to organisational values and culture (Willmott, 1993). Yet, it can be argued, that clean slate approach to design in general but implementation of change in particular highlights the potential clash of the two paradigms. One forces subjugation to detached scientific planning whilst the other encourages collective empowerment through participation and being one with the organisation.

Future Research

The centrality of radical approach to BPR is said to be critical to achieving quantum results. However, there is sufficient evidence to suggest that the theoretical purism inherent in the classical approaches to BPR is incongruent with the reality of the implementational constraints in adopting a clean sheet perspective on organisational change. There are major concerns exist as the plausibility of applying ‘the clean slate’ radicalism to design and implementation of new work processes. Stoddard and Jarvenpaa (1995) have observed that whilst it may be feasible to adopt the clean slate approach to work design, implementation must be incremental if it is to succeed. Many have argued the synergistic opportunities that may exist between BPR and the Total Quality Management (TQM) approach to change management (Valentine and Knights, 1998; O’Neill and Sohail, 1999; Love and Gunasekara, 1997; Gonzalez-Benito and Martinez-Lorente, 1999). Whilst a full discussion of TQM is beyond the scope of this paper suffice it to assert that it is characterised by an incrementalist approach to change through working with the existing constraints. Future research should consider exploring the potential learnings that may accrue from such interface so as to temper the inherent problems associated with ‘the clean slate’ approach to implementing change.
Further research should be also directed at the internal contradictions of BPR. The key concepts informing the BPR appear to create their own contradictions in the way they relate to one another. This is exemplified in the problems associated with minimising the impact of technological change and its capacity to undermine the existing strengths of the organisation. A review in this area may lead to a more enabling definition and methodology of BPR. Aligned with this is the need to further research the extent to which the clash between the ideological purism of the ‘clean slate’ with the transformational underpinnings of its aims account for the high failure rate in BPR.

Conclusion

It has been argued that in order to maintain their relevance to the market place organisations have been forced to come up with innovative ways of changing their work practices. Business Process Reengineering has been heralded as the next step in the evolution of management theory that is underpinned by a radical approach to changing the way work is conducted. Although returns on success, when achieved, have been exceptional, there are more companies fail in utilizing the BPR change paradigm (Hammer, 1995). It has been argued that one of its key defining concepts, namely ‘clean slate approach to work design and implementation of change, is problematic in its utility as it fails to acknowledge ‘the reality’ of the terrain within which it has to coexist. This terrain is characterised by opportunities and constraints to achieving radical outcomes vis-à-vis BPR. Future research directions have been identified to ascertain the conceptual factors such as the notion of ‘clean slate’ with its ideological purism as a barrier to BPR delivering on its promises. Failure to do so may result in casting more doubt on its ability to deliver what it promises.

References


Abstract

The following chapter introduces at the upcoming field of organisational psychological medicine and the value it holds for psychiatry in the coming years. The chapter also looks at the concept of embitterment and post traumatic embitterment disorder. The construct of embitterment and its implications are discussed. The diagnostic criteria and symptoms of post traumatic embitterment disorder are discussed. This is done in the light of the psychology of justice and equality. The factors leading to embitterment are elucidated. Various theories related to the same are discussed and treatment using psychotherapy called wisdom and competence therapy is outlined. The role of psychotherapy and competence in handling problems like embitterment is discussed and research needs for the future mentioned.

Key words: embitterment, post traumatic embitterment disorder, justice, wisdom, competence.

What is Organisational Psychological Medicine?

Psychological medicine has been involved in the diagnosis, treatment, and prevention of mental illness and emotional problems. Due to their medical training, the psychiatrist understands the body’s functions and the complex relationship between emotional illness and other medical illness. Thus the psychiatrist is the mental health professional and physician best qualified to distinguish between physical and psychological causes of both psychological and physical distress.

The medical specialty of psychological medicine utilises research in the field of neurosciences, psychology, medicine, biology, biochemistry and pharmacology. It has hence been considered a middle ground between neurology and psychology. Unlike other physicians and neurologists, specialists in psychological medicine have added expertise, to varying extents in the use of psychotherapy and other therapeutic communication techniques.

Psychological health of Human Capital in organisations can be impacted by the work place and beyond. Poor psychological health results in poor outcomes to the bottom line of both the human capital and the organisation. The studies on demoralisation on human capital of organisations found it resulted in psychopathological sequelae. Similarly, studies in embitterment in the work-place have found it resulted in psychopathological Embitterment post-traumatic stress disorder.

Work-place related psychiatric pathology impacts on organisational outcomes, and among other issues also results in poor retention and attraction of human capital. These affect negatively the important management need of good talent management for increased production of goods and or services. This lead to the initiation of the defined branch of Organisational Psychological Medicine, which includes psychiatrists with added qualifications and experience in management and administration, who are interested and involved in researching, studying the work-place related psychological and psychiatric pathology.

This branch of psychological medicine’s scope of practice expands from the diagnosis and management of work-place related psychological disorders to added forte of preventive psychological medicine and
resilience and positive psychological medicine applied to the human capital of organisations. These include population health initiatives of developing programs that will enhance the outcomes of human capital of organisations. Thus the discipline benefits the bottom line of both the individual and the organisation.

The discipline of **Organisational Psychological Medicine** offers neuro-scientific evidence based underpinnings and avenues for:

a) Enhancing Human Potential of an organisation with the principles of positive psychiatry – Resilience and Psychological medicine.

b) Preventing psychopathological sequel in the human capital of organisations resulting from the work-place - Preventive Psychological Medicine.

c) Recognising and managing the psychopathological sequelae resulting from the work-place and beyond in the human capital of organisations.

**Enhancing Human Capital’s Potential of an Organisation**

a) Developing and organising programs with neurosciences, positive psychiatry, dynamic psychological principles, management underpinnings, quantum physics and spiritual philosophy principles used in coordination for the dynamic outcomes:

b) Maximising employee potential and output impacting on organisational creativity and entrepreneurship.

c) Evidence based scientific programs to enhance the use of available discretionary effort and behaviour.

d) Offering programs for Total Human Capital Management and enhancing organisational citizenship behaviour.

e) Use of neuroscientific based programs to enhance human capital's sharpness in intellect, endurance and presence of mind, resulting in individual’s skills of perception, observation and expression being optimised.

**Preventing Psychological Pathologies in the Human Capital of an Organisation**

a) Programs that identify and offer prevention of the psychopathological sequelae that ensures from the work place practice in an organisation such as demoralisation, embitterment, occupation fatigue and burnout:

b) Preventing the psychopathological sequelae ensures the protection of the negative impact on the personal, physical, psychological and social outcome of human capital.

c) This ensures the bottom line of the organisation and the individual are protected.

d) Advisory and Advocacy to Organisations leadership on programs and education that will prevent psychopathological outcomes to the human capital in organisations.

e) Creating and organising programs that fulfil the Corporate Social Responsibility of an organisation.

**Managing the Psychopathological Sequelae**

a) Evidence based management Programs that identify, manage and resolve the psychopathology.
b) Psychopathology education programs for management that result in early identification and minimisation of negative outcomes.

c) Knowledge on the principles of rehabilitation programs – return to work place education and training programs.

d) Relapse prevention and resilience programs for human capital of organisations.

Post Traumatic Embitterment Disorder

In the last decade, post-traumatic embitterment disorder (PTED) has been internationally recognised as a specific form of adjustment disorder, which arises after severe and negative, but not life threatening, life events (conflicts at work, dismissal, retrenchment, demotion, unemployment, divorce, severe illness). More recent research on its specific feature’s symptomology suggests, it has a chronic course, and the difficulties of treatment, have lead to the definition of distinct diagnostic criteria for PTED Post-traumatic Disorder Embitterment Disorder (Linden, 2003).

Background

The German research team led by Professor Linden, Department of Psychosomatic Medicine of the University of Berlin has conducted, over nearly ten years, numerous studies in the clinical setting of a diagnostic category and specific alternative: Post-traumatic Embitterment Disorder (PTED). In the decade following the fall of the Berlin Wall (1989), the authors observed a significant increase of patients who, because of events that have led to considerable changes in their personal history, demonstrating intense negative psychological reactions. Millions of German citizens, who lived in the former German Democratic Republic, were forced to rearrange their lives completely. Immigration from East Germany to West Germany began immediately after the fall of the wall and many of these immigrants have long been unpopular and marginalized from the social context in which they were established, due to obvious differences socio-political, economic and cultural. Many German citizens have been facing important changes from the economic point of view: those who had previously held positions of prestige in society, found itself suddenly and without any recognition with a present to rebuild. In addition, citizens of East Germany were often considered “second class citizens” (Linden, 2003).

In a public poll conducted in 2002, 59% of respondents recognised that there are great differences between East and West. Only 20% reported perceiving citizen of the Federal Republic of Germany in all respects. 30% of respondents had met in a downgrading socioeconomic, about 10% had collided with serious adverse events and about 30% had a perception of bankruptcy itself. While immediately after the fall of the wall it had not been an increase of psychopathological disorders, in the following years there was an increase in serious and prolonged states of psychological distress, for which were increasingly being required treatment. The onset of the problem was often linked to a specific event perceived as frustrating, humiliating and derogatory after which the subject developed a persistent and exhausting sense of bitterness (Linden et al., 2003).

This specific reaction was subsequently observed in other subjects and other situations and not only in connection with German unification. The trigger for the occurrence of this particular event was a particularly negative symptoms like conflicts at work, dismissal, retrenchment, demotion, unemployment, divorce and severe illness that, although exceptional in people’s lives are part of the lives of individuals. The critical event, perceived by the subject as unfair and humiliating, could trigger a short time a deep state of bitterness, anger and hopelessness that involved a progressive impairment in all areas of life functioning (Linden et al., 2006). Not being the psychopathological picture of these subjects (for cause, symptoms and course) due to any of the diagnostic pictures proposed by the DSM-IV and ICD-10,
Linden et al. have proposed a new definition, that of Post Traumatic Embitterment Disorder (Linden et al., 2007).

The Concept of Embitterment

Figure 1 – The Concept of Embitterment

Justice is a critical issue for almost all individuals. Situations that include a feeling of injustice can lead to strong emotional reactions such as anger, hostility, guilt and shame. The embitterment (literally = “bitterness”) is an emotional state characterised by a persistent and exhausting feeling of having been wronged and the victim of a profound injustice followed by feelings of humiliation, helplessness and desire for revenge. This psychological condition develops as a result of events that the subject perceives and or believes it is particularly unjust, humiliating and derogatory. It is an emotional state that in many cases does not cease independently but continues unabated. It is distinguished by emotional states such as demoralisation, depression, despair or anger although it may share certain traits or develop simultaneously (Linden and Maercker, 2011).

A person may be angry with another person or to a situation without being bitter. Unlike anger, embitterment is accompanied by a strong experience of guilt and the feeling of having suffered a grave injustice. The psychological reaction is therefore a prolonged feeling of bitterness, characterised by feelings of defeat and injustice accompanied by the force to react but the inability to identify the appropriate targets to do so. It is a state of mind persistent and long-lasting, in which the person continually draws to mind the triggering event. This aspect is very similar to PTSD, because of frequent intrusive thoughts. The difference is noticeable that embitterment thoughts can be both painful and unpleasant is rewarding, especially when accompanied by the idea that it can be done in revenge for the wrong suffered (Znoj et al., 2016).
The embitterment is an emotional state that persistent intensifies over time and where you can create a vicious circle, in which the subject is constantly busy mulling event triggered. This could be due to the fact that the subject feels the need to convince others of the seriousness of this to their own life and to defend its cause and the reason for his anger. These people can quickly change mood and go from despair to smile at the thought that it can be avenged. The spectrum of psychopathology in which this emotion manifests itself is so vast and complex (Maercker, 2011).

The deep state of bitterness could also represent a subject’s emotional defense after difficulty expressing his real feelings regarding the incident. There is a relationship between embitterment and affective inhibition, a concept developed in the context of psychosomatic medicine, and responsibility in the development of many medical illnesses (Linden, 2003). The psychopathological impact of embitterment can result in impaired performance, commitment, motivation, enthusiasm, energy and positivity. This shall have a profound impact of the organisation.

**Psychology of Justice and Embitterment**

Embittered persons recall the insulting or humiliating event over and over again. In PTED there is initially an insult, humiliation, or injustice, which leaves the person helpless and causes embitterment. To understand why injustice can have such dire consequences, one has to understand the psychology of “belief in a just world” (Dalbert, 2011; Lerner, 1980).

From childhood on, we are given as firm belief that positive behaviour will be rewarded, and negative behaviour will be punished. That belief is the prerequisite for social behavior because it gives the security that one can influence others by what one does oneself. The wilful infliction of injustice means that the offender wants to be aggressive and at the same time believes that he can do so because the victim cannot defend himself or herself. In modern societies, where physical aggression is forbidden, injustice is a frequent substitute. A first reaction to injustice therefore is counter aggression (Willebrand et al., 2002).

This type of aggression has especially negative consequences when injustice puts into question important values in life, that is, when basic beliefs are violated. Basic beliefs of a person or personal theories of reality or internal world models are, similar to language, learned in childhood from 5 to 20 (Beck et al., 1979; Bolby, 1969; Epstein, 1991). They allow coherent behaviour across the life span of an individual (e.g., “money must be saved, not wasted,” which results in thriftiness in many situations over the life span), define large groups of persons (e.g., “belief in Mohamed” defines Muslims), and are passed on from generation to generation, they therefore also define what is correct or incorrect, just or unjust. Given this important role, it is evident that basic beliefs are by and large resistant to environmental changes. Persons will still feel that they are Greek, even after living most years of their lives in the Australia. Because basic beliefs are learned, different persons will react differently to the same event. Persons for whom the highest value in life is their professional career will react severely if they are not promoted, even though they had given everything to their company. At the same time, they will show no serious reaction when they are left by their wife but instead just look for another one who fits better with their present professional position. In the same situation, a person who has the basic belief that the most important thing in life is the family will react in an opposite way.

When life events at the work place challenge the basic beliefs of persons, they touch on the security of who one is and the assumption that the world is predictable and controllable (Rini et al., 2004). There must be intense feelings, if basic beliefs are put into question by events or persons (i.e. their social status, nation, religion, or assumptions about justice). Persons go to war, if basic beliefs are endangered, and the defence of basic beliefs makes martyrs.
Diagnostic Criteria of Post Traumatic Embritterment Disorder

(Linden et al., 2008)

A. Core criteria

1. A single exceptional negative life event precipitates the onset of the illness.

2. The individual knows about this life event and see their present negative state as a direct and lasting consequence of it.

3. The individual experience the negative life event as unjust and respond with embitterment and emotional arousal when reminded of the event.

4. No obvious mental disorder in the year before the critical event. The present state is not recurrence of a pre-existing mental disorder.

B. Additional signs and symptoms

1. The individual sees themselves as victims and as helpless to cope with the event or the cause at the workplace.

2. The individual blame themselves for the event, for not having prevented it, or for not being able to cope with it.

3. The individual. Reports of repeated intrusive memories of the work place critical event. They even think that for some part it is important not to forget.

4. The individual express thoughts that it no longer matters how they are doing and are even uncertain whether they want the wounds to heal.

5. Additional emotions are dysphoria, aggression, downheartedness, which can resemble melancholic depressive states with somatic syndromes.

6. Patients show a variety of unspecific somatic complaints such as loss of appetite, sleep disturbances, pain.

7. Patients can report phobic symptoms in respect to the work place or to persons at the work place related to the event.

8. Energy, motivation and drive is reduced and blocked. The individual experience themselves not as drive inhibited but rather as drive unwilling or negative.

9. Emotional modulation is not impaired, and patients can show normal affect when they are distracted or can even smile when engaged in thoughts of revenge. Consummatory pleasure

C. Duration: Longer than three months

D. Impairment: Reduction in performance in daily activities in the work place and might display impaired role in the work place.

Therapeutic Intervention as Devised by The IIOPM

The treatment of these individuals from organisations has been particularly difficult because the emotional picture, characterised by feelings of bitterness, coincides most of the time with the rejection of any form of aid and the perceived toxic workplace environment. In addition, the attitude, aggressive and fatalistic tendencies typical of these patients prevents them to develop alternative perspectives and to stimulate the desire to change, making the management quite expensive in terms of time and energy.
The International Institute of Organisational Psychological Medicine (IIOPM) have used the principles of preventive psychological medicine, resilience and positive psychological medicine in developing and applying interventions applied to human capital of organisations. IIOPM have developed a specific therapeutic approach aimed at preventing embitterment and treating an organisation's human capital that might have symptoms of post traumatic embitterment disorder. The prevention and resilience of the organisation's human capital to embitterment, demoralisation, burn out and compassion fatigue has been achieved by the IIOPM's Wisdom Competence Therapy (WCT) a group intervention at an organisation level (Linden et al., 2011).

**Wisdom Competence Therapy**

This intervention incorporates the underpinnings of neurosciences and the principles of cognitive behavioural sciences with specific tasks to foster the skills related to wisdom, transformation, inner growth and greater purpose. This Wisdom has been defined as the ability of people to manage and deal with situations of life particularly difficult and problematic and can be considered a “competence” that helps people better tolerate and overcome situations of life at the workplace that might be particularly difficult (Meeks and Jeste. 2009).

The WCT has been developed and tested by investigators of IIOPM on Healthcare professionals, Education professionals and Corporate Executives. Psychological health of human capital in organisations can be impacted at the workplace and beyond. But these psychopathological symptoms can result in poor outcomes to the bottom line of the organisation and the human capital. Evidence is available from embitterment, post traumatic embitterment disorder, demoralisation, and compassion fatigue, impacting negatively on productivity, creativity, poor attraction and retention of talent and good and effect management. The evidence suggests that these poor outcomes can be disastrous to the long-term success of an organisation.

The management protocol is based on the principles of wisdom, as proposed by the Wisdom Competence Therapy, in addition to strategies for the ‘increase of psychological well-being. These have been stratified into profession specific modulated programs, incorporating experiential learning and the use of dynamic tools in exercises related to specific tasks related to resilience, prevention and resulting in a therapeutic impact of organisation's human capital. The intervention ‘Valuing the human capital in health care’ and ‘Valuing the Human capital in education’ built of the principals of wisdom competency therapy, incorporates neuro scientific and cognitive behavioural sciences underpinnings, that enables enhancing the potential of the organisation's human capital by increasing resilience. This enables the ability of coping with stress and negative life events in the work place that might result from individual issues and or system issues (Linden et al., 2011).

The intervention was tested on samples of educational professionals and healthcare professionals in Australia and UK and compared with a protocol CPD training that was in place at organisations. The results confirmed an overall improvement in feelings of value, morale, interprofessional relationships and cooperation, absenteeism, stress and well-being to the group subjected to the protocol ‘Valuing the human capital in health care’ and ‘Valuing the human capital in education’ based on the Wisdom Competence Therapy. Further controlled studies to follow up on larger samples of population can confirm the specific role of Wisdom Competence Therapy for the prevention and treatment of post traumatic embitterment disorder or psychological distress related to negative life events in the work place (Sears, 2015).
Summary

The main features of embitterment and post traumatic embitterment disorder, such as anger, the bitterness, the constant dwelling on the wrong suffered, have been associated with an increased risk of adverse physical consequences and the intrusive nature of this disorder and chronicity aggravates the allostatic load – oxidative stress, an important concept of psychosomatic medicine (Danese and McEwen, 2012).

The presence of significant critical events as well as the cumulative effect of small daily events may in fact exceed the individual's ability to cope with the demands of adaptation to the workplace environment (homeostasis) and lead to an increase in physiological parameters related to stress. In this sense the embitterment could be understood as:

1. As a normal emotion limited in intensity and duration;
2. A predisposition to such reactions can be due to aspects of personality;
3. Embitterment a symptom that can be related to other psychological disorders;
4. Can result from a series of minor events that have accumulated rather than a single event

Implications for Organisational Psychological Medicine

Psychosocial studies show that the consequences of psychopathological embitterment may affect individual well-being, social and work place productivity. The chronic course can result in increased absence from work that often ensues and the general resistance to treatment make this disorder a very complex clinical picture and with high costs both in economic terms and in terms of individual well-being and the organisation. For this reason, it is necessary that the building of resilience and preventing embitterment is considered early at an organisational level.

Given the importance that this disorder may have especially after conflicts at work, redundancy, dismissal and unemployment, there must be an increased awareness to resilience prevention in the work place with interventions valuing the human capital in health care, education and in senior corporate executives, based on neuro sciences and cognitive behavioural sciences underpinnings in wisdom competency therapy and when identified to offer evidence-based solutions.

References

Introduction

Stress is the imbalance between environmental demands and adaptive capacity. There is a mismatch between the amount of challenge/pressure is that’s offered in a given situation and the capabilities necessary to deal appropriately with the challenge at hand. In the workplace stress is also described as the physical and emotional responses that occur when the requirements of the job do not match the capabilities, resources, or needs of the employee. Stress is the natural response of body and mind to demand and or threat and originates in our innate fight or flight reaction to real or perceived danger. Perceived is an important word because for our nervous system it is difficult to distinguish between real threat and perceived threats, both are experienced the same way.

The costs of chronic workplace stress are high, including the financial as well as the human costs. From a financial perspective, stress related problems are enormous for organisations, society as a whole and for the individual experiencing stress. One would imagine that most companies have stress prevention and/or repair programs in place for their employees; however this is still rarely the case. Many organisations do not know what to do and/or believe that the costs of such programs would be too high. But the contrary is true. Although there are not enough studies yet to verify the impact of prevention and repair programs empirical data shows that companies that do have programs in place report reduction in costs and sick leave, higher job satisfaction and overall increase in wellbeing.

Human Costs of Stress

The human costs are significant. From reports of more fights with loved ones, sleep disorders to serious ailments like anxiety, depression, burnout, cardiovascular disease and even diabetes.

The occurrence of workplace stress is closely related to the sense of control a person experiences. Many current interventions aim to reduce as much environmental stressors as possible. This is a good and necessary thing, however, as stress is a subjective experience and strongly influenced by our individual map of reality and the meaning we give our experiences we have to conclude that stress reduction interventions have to focus on regaining an internal sense of control. Especially when we understand that when stress happens the influence of external sensory based stimuli increases. Bringing our attention even more to the external constraints.

Core interventions for Prevention and Repair of Stress

The three core interventions for prevention and repair programmes include the following:

a) State Management

The ability to influence one's state and change a stressed state. This ultimately enables individuals to strengthen and optimise states that are effective for the job requirements.

b) Increase ownership of our meaning making capacity
Increasing awareness that experiences do not have meaning by themselves but have meaning because we give it our personal meaning. The meaning we attribute will trigger new meanings and so influence our state. Depending on the quality of our meaning making we can experience distress as well as eustress. Many people will only start with exploring their meaning making when they feel that the environmental constraints cannot be changed. As long as we believe that something still can be done about our circumstances we stubbornly cling to the desire to change our environment. Empirical research has shown that individuals can hold on to that idea for years without actually being able to change the external constrains. That same empirical research tells us that the sooner we embrace the fact that our ultimate freedom is in our meaning making the sooner we will master our stress response.

c) Increase Resilience

Resilience is our ability to effectively deal with change. In our current environment changes happen so frequent that individuals rely on a strong sense of resilience. When change changes into setback resilience is diminished. Resilience is complex. Setbacks can be experienced when we are setback by external factors as much internal standards we’re not able to meet. To regain resilience, we need to address all factors related to a faltering resilience. This means a combination of level 1 interventions (coping strategies) and level 2 interventions that aim for changes in self-worth; empowerment; owning meaning making, changing limiting beliefs and future perspective.

Conclusion

Working with these elements as highlighted in the above paragraphs can also be beneficial for the repair of anxiety, depression and burnout. Research has shown that corporate culture can have important influence on the occurrence of stress in an organisation. Working with both the corporate culture as well as the individual has shown to be most effective however not all organisations are keen to look at their corporate assumptions that create workplace stress. It goes beyond the scope of the chapter to discuss organisational interventions.

Understanding workplace stress and how to prevent and repair the ill effects of stress will reduce both the financial as well as the human costs of workplace stress. Understanding workplace stress and it effects as described above takes the problem out of the medical perspective to a workplace perspective that organisations can incorporate, leaving the taboos about stress behind.

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A Power Nap in the Afternoon Reduces Fatigue in Healthcare Professionals: A Preliminary Study

Manjeshwar Shrinath Baliga, Mangalore Institute of Oncology, India
Suresh Rao, Mangalore Institute of Oncology, India
Pratima Rao, Mangalore Institute of Oncology, India
Professor Russell D’Souza, Psychological Medicine, IIOPM Australia
Princy Louis Palatty, Department of Pharmacology, Father Muller Medical College, India

Abstract

Healthcare workers are exposed to myriad stress and the goal of management is to mitigate the ones possible. A power nap has been reported to be useful in mitigating stress and fatigue in people working a night shift, in aviation, and hospital care workers. In the present study we investigated the beneficial effects of a power nap in 13 healthcare workers. The study was a single arm and in the first stage a baseline was calculated by evaluating fatigue in the beginning of the week and at the end using the Fatigue Assessment Scale (FAS). A two week gap was kept, and the beneficial effects of a power nap were evaluated in the same individuals. The study showed that a power nap was more effective in reducing the mental fatigue (p < 0.05) than in the physical fatigue.

Key words: power nap, healthcare workers, mental fatigue, physical fatigue.

Introduction

Healthcare professionals working in busy hospitals are stressed and this affects their working efficiency, family and family health. Of all healthcare branches, providing care for people afflicted with cancer is one of the most stressful and affects the healthcare professional’s immensely (LeBaron et al., 2014). A considerable body of literature indicates that long-term exposure to stress may affect the health and increase risk of ailments like type II diabetes, hypertension and coronary heart disease (Sharma et al., 2011). Stress can consequentialy cause/aggravate psychological issues like anxiety, demoralisation, depression, fatigue and burnout and inevitably lead to premature retirement or discontinue services in the healthcare sector (Cocker and Joss, 2016; Peterson et al., 2008; Firth-Cozens and Greenhalgh 1997; Friganović et al., 2017). In the long run this causes loss to the establishment as training new recruits and graduates leads to a gap in the overall care patients, puts additional pressure on the existing staff, reduces the performance of the hospital and leads to a decrease in clientele respect and patronage (Cocker and Joss, 2016; Peterson et al., 2008; Firth-Cozens and Greenhalgh 1997; Friganović et al., 2017).

Recent reports from around the world indicate that a power nap, which is a short midday sleep session, is an efficient way to reduce stress to increase the endurance and mental acuity in professionals, and that this could be an important strategy to improve procedural motor memory, increase productivity and enhance quality of life (Backhaus and Junghanns, 2006; Luo et al., 2001; Santos-Silva et al., 2016). Studies suggest a power nap prevents cell damage and improves cardiac functioning, boosts testosterone, relieves stress and boosts immune system, elevates mood, boosts productivity and alertness, improves memory and learning, all of which are important in professionals (Backhaus and Junghanns, 2006; Lemos et al., 2014; Luo et al., 2001; Santos-Silva et al., 2016). Additionally, scientific studies with adolescent students have also shown that a power nap was useful in enhancing the duration of declarative memories (Lemos et al., 2014).

Studies with adults have also shown that a day time nap of 60–90 min enhance the perceptual learning and that this was the equivalent to that achieved when the individual has had an 8 hour period of night time sleep (Mednick et al., 2003). Reports also suggest that naps as short as 6 minutes improve the
declarative memory retention (Lahl et al., 2008). Additionally, seminal studies by Oriyama and co-workers (2014) have also shown that two 15 minute naps by night shift nurses reduced the tension and cardiac changes.

Depending on the biological body clock, in many people the post lunch period is characterised by slow and inattentive phase and this affects the work efficiency and productivity. Previous studies have shown that a short 15-20 minute nap is an easy way to maintain their level of energy, and to boost alertness after power nap (Backhaus and Junghanns, 2006; Lemos et al., 2014). In lieu of these observations the present study was conducted to ascertain the effect of power nap in reducing physical and mental fatigue in healthcare professionals.

Material and Methods

a) Study area and population

The study is a Hospital based single arm, purposive, preliminary study and was conducted in willing healthcare workers (volunteers) at Mangalore Institute of Oncology, Mangalore, India. The inclusion criteria included healthcare professionals who were not used to napping, destressing activities like yoga or meditation after lunch and willing to be a part in the study. The study was approved by the institutional ethics committee of Mangalore Institute of Oncology and the study was carried out after obtaining the necessary permission from the hospital administration in October 2017.

b) Data collection instrument used to ascertain fatigue

The data was collected using the Fatigue Assessment Scale (FAS) (De Vries et al., 2004). The scale consists of 10 questions and addresses both physical fatigue (6 questions) and mental fatigue (4 questions) domains. The healthcare professionals were individually approached by the investigators and briefed about the study purpose. The willing volunteers were provided with an informed consent and the study questionnaire. The volunteers were requested to answer all the questions and requested to return back the filled sheets.

c) Effect of power nap on fatigue

The study was a single arm and was done with 13 willing healthcare professionals who did not practice a power nap. In the first week of October, the FAS questionnaire was administered in the beginning before commencement of their duty on Monday morning and end of the week on Saturday at the end of the duty. In the second and third week the volunteers were trained in power nap by one of the investigators during the one hour lunch break time. In the fourth week the volunteers who were now acquainted with a power nap were requested to perform it for 20 minutes after the lunch for six consecutive days from Monday to Saturday. The FAS questionnaire was administered as indicated above.

Statistical analysis

Data was entered in Microsoft excel and analysed on the online based Vassar Stats statistical program. All quantitative variables are illustrated through mean and standard deviation and the ANNOVA with Tukey’s test was applied. A p value of < 0.05 was considered significant.

Results

The results of the study are represented in Table 1 and Figure 1. In the control which served as the baseline, the mental (3.23±1.30), physical (6.85±3.21), and total (10.07±3.92) fatigue was less in the
beginning of the week when evaluated on Monday before start of work (Table 1; Figure 1). At the end of
the week the scores for mental was 5.31±0.95; physical 9.69±1.70 and total 15.00±1.35 (Table 1; Figure
1) and was statistically significant (p < 0.01 to 0.05). Calculation of fold increase showed that the highest
increase was seen for mental (1.64) followed by total (1.48) and physical (1.41) fatigue (Table 1). The
fatigue level at the start of the powernap intervention (mental = 3.14±0.65; physical =7.14±2.21 and
total = 9.36±2.72) was not very different from that when evaluated on the control time period and was
statistically insignificant. At the end of the week the fatigue increased by 1.34 for mental (4.21±0.88);
1.19 fold for physical (8.50±1.21) and 1.26 fold for total (11.78±1.31) and was significant (p < 0.01).
Comparison of the two week end points suggest that a power nap reduced the fatigue by 0.79 fold for
mental and 0.87 fold for physical fatigue. Statistical analysis showed that a power nap was more effective
in reducing mental fatigue (p < 0.05) than physical fatigue.

Discussion
In this study it was seen that a daytime power nap of 20 minutes has a beneficial effect in reducing
mental stress in healthcare workers. These observations are in agreement to earlier reports (Cocker and
Joss, 2016; Peterson et al., 2008; Firth-Cozens and Greenhalgh 1997; Friganović et al., 2017). From a
healthcare worker’s perspective, studies have clearly shown that caring for people with cancer have high
rates of frustration, anxiety, depression, fatigue and burnout (Cocker and Joss, 2016; Peterson et al.,
2008; Firth-Cozens and Greenhalgh 1997; Friganović et al., 2017).

Of all effects, fatigue is a very common observation and can be physical, psychological or a combination
(Cohen et al., 1983; Michielsen et al., 2004). Mental fatigue compromises decision making, reaction time
and critical thinking and lead to decrease in working efficiency (Drake et al 2012). Prolonged fatigue
affects general health and can subsequently be a huge public health burden with costs to the individual,
the employer and the economy (Drake et al 2012). Fatigue affects performance, enhances chances of
occupational injuries and sick leave and in worse cases can lead to job loss and premature retirement,
thereby affecting the individual, the healthcare system and country at large (Swaen et al., 2003; Janssen
et al., 2003; Van Amelsvoort et al., 2002; Reynolds et al, 2004).

With regard to the mechanism of action, studies aimed at understanding the “topographic changes in
electroencephalographic (EEG) spectral power during pre and post-nap wakefulness as well as stages 1
(S1) and 2 (S2) NREM sleep have shown that a daytime nap increased delta-, theta- and beta-band power
and decreased alpha-band power in wide scalp regions (Luo et al., 2001). The investigators observed that
the delta- and theta-band power significantly increased in the frontal and central regions during S1 and S2
with an increase in inter- and intra-hemispheric correlations while the beta-band power increased in the
frontal, central and parietal regions during S2 with an increase in interhemispheric correlation (Luo et al.,
2001). However, in contrast, alpha-band power significantly decreased in the parietal-occipital regions
during S1 and S2 with a decrease in interhemispheric correlation (Luo et al., 2001)”. Cumulatively, all
these observations indicate that the nap-associated changes in interhemispheric and intrahemispheric
EEG were similar to that of nocturnal sleep (Luo et al., 2001) and to be of use in modulating emotions
to improve post-nap mental states (Luo et al., 2000).

Conclusion
The challenges posed by fatigue in hospitals caring for the critically ill is well documented. The results
of the preliminary study indicate that a power nap of 20 minutes after lunch was useful in mitigating the
mental fatigue in healthcare workers. The biggest drawback of the study is that this study was done with
a small sample size (n = 13) and that it was not a two armed parallel comparison study. More studies and
involving EEG evaluations are warranted to ascertain the benefit. In spite of all these lacunae it can be
deduced that a power nap in the afternoon is beneficial and the fact that it is devoid of side effects is beneficial to the volunteer/practitioner.

Table 1: The mental, physical and total fatigue before and after administering 20 minute power nap in healthcare workers

<table>
<thead>
<tr>
<th>Time point</th>
<th>FAS scores</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mental</td>
<td>Physical</td>
<td>Total</td>
<td></td>
</tr>
<tr>
<td>Control (No power nap)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Start of week</td>
<td>3.23±1.30</td>
<td>6.85±3.21</td>
<td>10.07±3.92</td>
<td></td>
</tr>
<tr>
<td>End of week</td>
<td>5.31±0.95</td>
<td>9.69±1.70</td>
<td>15.00±1.35a</td>
<td></td>
</tr>
<tr>
<td>Fold increase</td>
<td>1.64</td>
<td>1.41</td>
<td>1.48</td>
<td></td>
</tr>
<tr>
<td>Test (Power Nap)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Start of week</td>
<td>3.14±0.65</td>
<td>7.14±2.21</td>
<td>9.36±2.72</td>
<td></td>
</tr>
<tr>
<td>End of week</td>
<td>4.21±0.88a</td>
<td>8.50±1.21</td>
<td>11.78±1.31a</td>
<td>#</td>
</tr>
<tr>
<td>Fold increase</td>
<td>1.34</td>
<td>1.19</td>
<td>1.26</td>
<td></td>
</tr>
<tr>
<td>Test power nap end of week/Control (No power nap) end of week</td>
<td>0.79</td>
<td>0.87</td>
<td>0.78</td>
<td></td>
</tr>
</tbody>
</table>

Comparison within the group (star and end of control and test) \( p = a < 0.01; b < 0.05 \)
Comparison of end of the week in control vs end of the week in test: \( p = # < 0.05 \)

Figure 1: Fatigue in healthcare workers before and after power nap (# \( p <0.05 \) comparison with control)
References


**Introduction**

Over the years, the rates of physician suicides have caused much concern to the medical community. Physicians work hard and often in challenging circumstances with limited resources. The passion for delivering quality care often overrides their fears, worries and anxieties. However, this dedication often comes at a price and poor self-care has arisen as a cause for concern and potentially a contributing reason for suicides and suboptimal patient care.

Although there have been a number of studies conducted over the years, a recent paper summaries the definition of burnout well. West et al. (2018) define the concept of physician burnout as a work‐related syndrome that involves emotional exhaustion, depersonalisation and a sense of reduced individual accomplishment. These three domains have been measured using the Maslach Burnout Inventory (MBI).

Physician burnout has become an important subject since its prevalence has been growing recently and affects individuals differently. In a study of 7,288 physicians by Shanafelt et al. (2012) 45.8% of physicians reported burnout. What is more alarming, is that recent statistics show that 400 US physicians commit suicide each year (Ariely et al. 2015). It is important to understand who is affected by burnout and address the issues that lead to burnout in order to improve physician job satisfaction and optimize patient care. Interventions using mindfulness techniques in a hospital have been tried and showed successful results Amanullah et al (2017). Few studies however have focused on specific gender disturbances in a manner that will help in shaping delivery of care to different groups.

**Conceptual Issues Gender Differences**

Traditionally in society, women have been expected to fulfill multiple roles in addition to their occupation. Some of these roles include; home management and cooking and cleaning, on top of being seen as the primary caregivers to their children. Due to the added stressors of serving multiple roles one would think that women would naturally experience greater burnout than men who had previously only had the expectation to provide for the family financially. It was found by Amoafo and McMurray that women did indeed experience a greater extent of burnout than men. Both sets of authors note that women who are not supported by other individuals such as colleagues and significant others, experience a greater sense of burnout. In the Physician Work Life Study involving 2,326 respondents, McMurray et al. (2000), found that women reported 1.6 times the odds of feeling burnout compared to men. However, when supported by a colleague or significant other, burnout was decreased by 40% in those women with young children. Amoafo et al. (2015), agreed with McMurray et al. that females who were not married and worked longer hours experienced more burnout. Amoafo et al. (2015) also addressed hours worked and work/home conflicts as another factor for gender differences in experienced burnout. It has been discovered that women who worked longer hours and had less workplace control experienced a greater rate of burnout (McMurray et al. 2000). Dyrbye et al. (2011) found that 43% of 7858 female surgeons experienced burnout compared to 39% of males (p=0.01). The authors found that women surgeons were more likely than men to have conflicts with their partner’s career, experience work home conflicts and exhibit more depressive symptoms. These results exemplify how women who embody multiple roles...
both at home and in the workplace experience a greater degree of being pulled in different directions. In a study of female physicians in Hungary women scored higher on emotional exhaustion (30.6% compared to males 19.4%). Women also reported a higher level of work/family conflict and lack of job control. Lower levels of burnout were seen in men, and those not working in general practice. In a study of physicians in the United States, Linzer et al. (2002) found that more work hours led to greater burnout in female physicians.

One would think that studies would be unequivocal in revealing that women experience burnout at a greater rate than men. However, this has not always held true. In fact, Keeton et al. (2007) who used the MBI in their cross sectional study of 2,000 physicians with a 48% response rate found that a reduced experience of burnout was correlated with a greater satisfaction with one’s career. In fact, the study authors found that women were generally satisfied with their careers (79%) compared to 76% of men. Linzer et al. (2002) conducted a study comparing 2,326 American Physicians with 1,426 physicians in the Netherlands. The authors found that 28% of American female physicians reported burnout compared to 21% of American men. These gender differences were not found in physicians from the Netherlands despite the fact that in both study populations women worked fewer hours than males (54 hours versus 59 hours, P<0.05). The authors concluded that the lack of gender differences in the Netherlands were likely due to fewer hours worked by women per week in the Netherlands (44 hours/week compared to 48 hours/week by US women physicians) and greater sense of work control by women in the Netherlands compared to those women physicians from the United States. From a cross-cultural perspective, a Taiwanese study by Chen et al (2013) supported the findings of Keeton and Leigh in finding no differences between gender in burnout prevalence. This viewpoint was also supported by Leigh et al. (2002) who also found no difference in gender in terms of satisfaction by subspecialty choices.

Overall, it is unclear whether women and men experience burnout at different rates. It is however clear that in certain settings female physicians experience greater burnout and emotional exhaustion than men. Contributing factors include work family conflict, hours worked, lack of social support, age, experience of harassment and lack of control over their job. We can hypothesise that women may feel the pressure to offer responses to questions that are ‘socially correct’. It is also possible that physicians in general want to overstate their satisfaction with their careers as they have invested many years into their profession. Women are more likely to have to juggle various role responsibilities such as being a physician, mother, wife and care giver to elder parents and as such may feel pressured to not voice their concerns of role conflict (Dyrbye, 2013). Women also have the societal pressures of putting their family before their careers and tend to have husbands with equally demanding jobs (Jovic et al. .2006). Increased ‘pressures’ like these on women to embody multiple roles may put them at greater risk of burnout.

**Factors Influencing the Development of Burnout**

Figure 1.

Determinants of burnout from a female perspective

- Single or unsupported by colleagues
- Working longer hours
- Multiple perceived roles
- Perceived control of work environment

Factors of burnout experienced by both genders

- Total hours worked
Experience with malpractice
• Dissatisfaction with patient relationships
• Lack of support by colleagues
• Having young children

Multiple factors have been found to lead to physician burnout, these include hours worked, experience of malpractice, lack of support, age and having children at home. One factor strongly related to burnout was control over scheduling and hours worked (Keeton et al., 2007). Linzer et al. (2000), also agreed that women experienced burnout due to greater hours worked and lack of workplace control. It was established that for each additional five hours a women had to work the risk of burnout increased by 12-15%. However, this was not true for men. Chen et al. (2013) found that those who worked 13-17 hours in a row had higher levels of emotional exhaustion. From the above studies we can make a clear association between greater work hours a week and increased burnout. Chen et al. (2013) also found that those who had a history of medical malpractice experienced burnout in emotional exhaustion, depersonalisation and decreased personal accomplishment. This is an understandable fact as malpractice threatens the wellbeing and medical licence of physicians. Burnout was also found in physicians who were unsatisfied with their relationships with their patients. Lack of support at work could also lead to burnout. According to Richter et al. (2014), men placed higher value on being supported by their colleagues and superiors. The authors found that women are noted to suffer from greater emotional exhaustion as they move from being junior physicians to senior physicians.

In terms of having children, West et al. (2018) found that having a child who is younger than 21 increases burnout by 54% and having a partner who is not a physician increases burnout risk by 23%. Having young children leads to multiple responsibilities as a caretaker and a parent. Physicians have multiple roles and meeting these responsibilities can lead to role conflict which leads to burnout (McMurray et al., 2000). In a study by Richter et al. (2014), there were no gender differences of experienced emotional exhaustion when comparing junior physicians who had children and those that did not. However, amongst senior physicians, men without children experienced a higher rate of burnout than women.

Current Concepts: Physician Burnout by Specialty

Figure 2.

Specialty Choice and Burnout

Lowest Rates of Burnout by Leigh et al. 2002

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Odds ratio</th>
<th>Lower 95% CI</th>
<th>Upper 95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric internal medicine</td>
<td>2.04</td>
<td>1.19</td>
<td>3.49</td>
</tr>
<tr>
<td>Neonatal and perinatal medicine</td>
<td>1.89</td>
<td>1.04</td>
<td>3.42</td>
</tr>
<tr>
<td>Infectious disease</td>
<td>1.49</td>
<td>0.79</td>
<td>2.81</td>
</tr>
<tr>
<td>Dermatology</td>
<td>1.48</td>
<td>1.01</td>
<td>2.15</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>1.36</td>
<td>1.21</td>
<td>1.53</td>
</tr>
</tbody>
</table>
Studies show that specialty fields such as dermatology and pediatrics have lower burnout rates than those physicians providing frontline care such as in family medicine, internal medicine and emergency medicine. A survey of 12,474 physicians with a response rate of 65% in the late 1990's revealed that higher job satisfaction was found in geriatric internal medicine, dermatology and pediatrics. (Leigh et al., 2002). Shanafelt et al. (2012), found the lowest rates of burnout in pathology, dermatology, general pediatrics, occupational health and environmental medicine. In terms of work life balance, the greatest satisfaction was in dermatology, pediatrics and preventative medicine. Frank et al. (1999) conducted the Women Physicians' Health study surveying 4,501 women physicians. They found that 84% of females were content with their career. It was interesting to note that 31% would opt out of a career as a physician and 38% would change their specialty. These results were related to age, a feeling of control over their environment and perceived workplace harassment. This is an important statistic as it does seem that specialty choice is a contributing factor to burnout. It seems that when combining the results from Shanafelt et al. and Leigh et al. there was a consensus that dermatology and pediatrics had less burnout as a specialty choice than other specialties.

Figure 3.

Lowest Rates of Burnout by Shanafelt et al. (2012) odds ratios not given

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Odds Ratio</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dermatology</td>
<td>0.65</td>
<td>P=0.02</td>
</tr>
<tr>
<td>General Pediatrics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventative medicine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(occupational health and environmental medicine)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Highest Rates of Burnout by Shanafelt et al. (2012)

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Odds Ratio</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency medicine</td>
<td>3.18</td>
<td>P &lt;0.001</td>
</tr>
<tr>
<td>General internal medicine</td>
<td>1.64</td>
<td>P&lt;0.001</td>
</tr>
<tr>
<td>Family Medicine</td>
<td>1.41</td>
<td>P= 0.001</td>
</tr>
<tr>
<td>Neurology</td>
<td>1.47</td>
<td>P=0.01</td>
</tr>
<tr>
<td>Radiology</td>
<td>1.46</td>
<td>P=0.2</td>
</tr>
</tbody>
</table>
Shanafelt et al (2012) determined that the highest rates of burnout were in frontline care. These specialties included, family medicine, emergency medicine, internal medicine and neurology. Dissatisfaction with career choice was found in otolaryngology, obstetrics and gynecology, ophthalmology and orthopedics. (Leigh et al., 2002). Specialties with low work life balance included general surgery and its subspecialties, Obstetrics and Gynecology. Frontline care physicians face many barriers to patient care. In a study by Lee et al. (2008) it was found that 123 family physicians surveyed 42.5% had high stress levels. These stressors were around paperwork, long wait for tests, and feeling undervalued and unsupported. These physicians coped by spending time with family and eating well.

However, job satisfaction is not always correlated with work life balance. Although neurologists had a high level of overall burnout and work longer hours, they were generally satisfied with their specialty choice. Surgeons who had poor work life balance were still found to have overall had lower burnout rates (Shanafelt et al., 2012). In a study of neurosurgeons by McAbee et al. (2015), 80% of the 783 physicians surveyed were satisfied with their career and 70% would choose this profession again. Their reported burnout rate was 56.7%. Burnout in this group was related to work life balance and anxiety over future earnings and health care reform.

Career stage is another factor that determines experienced burnout. At different points in one’s career burnout may be experienced differently. Dyrbye et al. (2013) discovered that by specialty, early career physicians were more dissatisfied if in primary care, private practice or surgery. However, in mid-career stage physicians in internal medicine and pediatrics were the most dissatisfied with specialty choice and work life balance. These individuals were the least likely to recommend medicine to their children. Satisfaction with career choice was lowest in all middle career physicians, except for primary care.

Figure 4.
Olkinuora et. Al (1990) Burnout in Men by Specialty

<table>
<thead>
<tr>
<th>Specialties</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pediatrics</td>
<td>30</td>
<td>24.60</td>
<td>4.09</td>
</tr>
<tr>
<td>Obstetrics and gynecology</td>
<td>62</td>
<td>24.63</td>
<td>4.45</td>
</tr>
<tr>
<td>Clinical laboratory specialties</td>
<td>35</td>
<td>24.71</td>
<td>4.54</td>
</tr>
<tr>
<td>Otolaryngology and ophthalmology</td>
<td>62</td>
<td>25.02</td>
<td>3.84</td>
</tr>
<tr>
<td>Anesthesiology</td>
<td>42</td>
<td>25.43</td>
<td>3.95</td>
</tr>
<tr>
<td>Neurology</td>
<td>24</td>
<td>25.54</td>
<td>4.37</td>
</tr>
<tr>
<td>Surgery, neurosurgery, physiotherapy</td>
<td>145</td>
<td>25.60</td>
<td>4.60</td>
</tr>
</tbody>
</table>
Olkinuora et al. (1990) Burnout in Females by Specialty

<table>
<thead>
<tr>
<th>Specialties</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obstetrics and Gynecology</td>
<td>30</td>
<td>24.33</td>
<td>3.19</td>
</tr>
<tr>
<td>Otolaryngology and ophthalmology</td>
<td>26</td>
<td>24.81</td>
<td>4.18</td>
</tr>
<tr>
<td>Surgery, anesthesiology</td>
<td>38</td>
<td>24.87</td>
<td>3.61</td>
</tr>
<tr>
<td>Psychiatry, child psychiatry</td>
<td>50</td>
<td>26.48</td>
<td>4.11</td>
</tr>
<tr>
<td>Pediatrics, child neurology</td>
<td>56</td>
<td>26.68</td>
<td>3.72</td>
</tr>
<tr>
<td>Internal medicine, neurology, pulmonary disease, dermatology and venereology</td>
<td>76</td>
<td>26.75</td>
<td>5.00</td>
</tr>
<tr>
<td>Radiology</td>
<td>21</td>
<td>27.00</td>
<td>4.57</td>
</tr>
</tbody>
</table>

In a Finnish study by Olkinuora et al. (1990), males had higher burnout rates in general practice, psychiatry, internal medicine, pulmonary medicine and dermatology to have higher burnout rates. Where else, in female physicians’ higher burnout was in general practice, radiology, internal medicine, neurology, pulmonology and dermatology. Those in private practice, research institutes and public offices were more likely to be unsatisfied. It was the authors assumption that there are higher rates of burnout in those physicians taking care of patients that are chronically ill or dying compared to patients who have curable diseases and a more favourable prognosis (such as in obstetrics and gynecology, otorhinolaryngology and ophthalmology). In the Taiwanese study by Chen et al. (2013) it was found that those who worked in a metropolitan area were more stressed in the personal accomplishment field while specialty trained doctors had higher levels on the emotional exhaustion and depersonalisation scale but lower burnout level in personal accomplishment. It is clear that specialty choice influences the timing and intensity of burnout. Overall frontline care physicians involved in emergency medicine, internal medicine and family medicine experienced greater levels of burnout.

Current Concepts: Generational Differences in Experienced Burnout by Age

Leigh et al. (2002) found in their study that younger physicians and older physicians (>65) tend to be more satisfied. West et al. (2018) found that individuals younger than 55 experience greater burnout symptoms than those older than 55. In a Taiwanese study of physicians, they found that visiting staff and residents had a higher likelihood of burnout in terms of all aspects of burnout including emotional exhaustion, depersonalisation and personal accomplishment. It was found that those who were 20-30 years old had more emotional exhaustion and those 31-40 were higher on depersonalisation and felt less personal accomplishment.

In terms of age, Keeton et al. (2007) found that older physicians and those with fewer children had a greater emotional resilience. They found that older individuals felt a greater sense of personal accomplishment. This resulted in a greater work life balance. Leigh et al. (2002) hypothesises that perhaps older physicians were more satisfied because if they did not like their career choice they would already be retired by the age of 65. Shanafelt et al. (2012) agree that being older is associated with a lower risk of burnout with OR for each year older, 0.99.

According to Brown et al. (2013) physicians of Generation X (those born from 1965 to 1981) were perceived by the Baby Boomer generation (those born between 1946 to 1964) as working fewer hours.
Generation X perceive themselves as working hard but will not sacrifice their home life. These individuals are seen to desire autonomy and flexibility in their careers. Baby Boomers were seen to view a more balanced life as a lack of commitment to work. Boomers felt that there has been a decline in the value of work since the next generation of physicians entered the workforce. However, a Generation X physician remarked that the Baby Boomer physicians tend to believe that working long hours defines their work ethic. However, it was found that physicians of both generations work about 61 hours a week. It seems that risk of burnout is reduced as a physician grows older. There are not significant generational differences in hours worked.

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7. The role of life histories in the retirement adjustment process. The


For about 25 years rTMS has been investigated for psychiatric treatment, primarily used to treat depressed patients. The principle is, that an electromagnetic field induces various changes in the brain, which is an electromagnetic organ by itself. Through effects like induction of a current flow, activation of resting neurons and inhibition of active neurons, the plasticity of the brain is augmented by facilitation of neuronal networking and functional connectivity. It has been seen, that it comes to a synchronisation of electric waves and other kinds of modelling the frequency distribution. In general one can say, that the self-organisation is activated. Besides, there are effects like hippocampal neurogenesis, augmentation of regional blood flow and hormone secretion in blood and brain (e.g. Dopamine release in Nuclei caudati and accumbens).

Meanwhile indications are extended to a broad field of mental, psychosomatic, psychiatric and neurologic diseases and even for healthy clients to enhance well-being and mental fitness. Side-effects are rare, and efficacy is high, depending on the stimulation protocol and procedure of application, which requires quite a lot of experience. But once understood the principles and pragmatic application of rTMS, it can be easily applied in any outpatient clinic and complement psychiatry in a most satisfactory way to help numerous patients with various disturbances (Depression, Burn-out, Sleep, Anxiety, Stress, Dementia, Psychosis, OCD, Bulimia, PTSD, ADHD, Autism, Addiction, Tinnitus, Pain, MS, Post-Stroke-Rehab).

Since 2002, Dr Seemann has been a pioneer and “First mover” in German outpatient treatment with rTMS. As a consequence of his research he developed the hitherto only totally mobile, clinically tested applicator with proven efficacy, called GLAD-X.

As the treatment is somehow “organic”, because we stimulate with pulsed frequencies in the range of 1 to 14 Hertz, which the brain by itself uses, it is conclusive to use this treatment also for healthy clients to influence emotional states and cognitive functions.

In an observational study over 3 years it has been shown, that even with the weak magnetic fields of the mobile device, cognitive functions like concentration can be improved easily (Neuro-Enhancement) as well as wellbeing. Depending on the stimulation protocol relaxation, sleep or mental empowerment can be chosen.

Thus by using even the mobile device, during daytime productivity at work may rise, and better sleep at night can improve mood and concentration at work.

One more pragmatic and intriguing option is the so called “Power napping”. Please check for the sleep stages for a better understanding:
We usually sleep 7 to 9 hours a day. After about 90 minutes the REM sleep begins, within that we have most of our dreams. This cycle happens 4 to 5 times per night.

- 10 - 20 minutes of sleep (“power nap”) one reaches Non-REM sleep stage I and II. The return to being awake is very easy, just passing back through sleep stage I. This refreshes, raises physical and mental productivity, creativity, alertness, intelligence and problem solving capacity. Content of short term memory is converted to long term memory. As you feel gladder and more balanced you will be much more popular in the team. A nap in the afternoon is physiological and the effect is longer lasting than that of caffeine/taurine and has the benefit of having no crash in the end.

- Heart attack risk is reduced within 5 years by 37% and through activation of the glymphatic system the risk of Alzheimer’s also seems to be reduced.

- 30 minutes of sleep has the same effect like 10-20 minutes, but one feels groggy. This is called sleep inertia.

- 60 minutes of sleep, one reaches the deep sleep stage without REM phases. The effect is better memory of fact knowledge – “declarative or explicit memory”. The disadvantage is drowsiness because one passes the sleep stage III to I to return to being awake.

- 90 minutes of sleep reaches REM phase. By this memorising of new motory capabilities and creativity is raised – “procedural or implicit memory”. For easy reaching the awake stage, there is no feeling of drowsiness. This is the best protocol for football players like Ronaldo: 5 times a day 90 minutes of sleep.

We suggest that with the mobile GLAD-X applicator an easier and faster way of achieving sleep stage I and II is possible within 10-20 minutes. By this, one can easier fall asleep and also time is won.

During the lecture an optimised setting for Power Napping in companies is presented. Studies are encouraged to measure the positive effects. Parameters of success can be tests of concentration, less days of disability and raised satisfaction at work.

**Conclusion**

Transcranial magnetic stimulation is a safe, effective and a well-tolerated method of treatment for many psychiatric and neurological diseases and also for improving productivity, health and satisfaction at work.
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Introduction

Organisational survival is often predicated on the capacity of the leadership to unleash the creative energies of the organisation on the vision it communicates. A conclusive definition of or an operational manual on what constitutes effective leadership remains an elusive goal for organisational theorists. The challenge for the budding leader is to build on the threads hitherto created and develop the insight to know what works for you. This paper explores the personal and professional experiences of the author in one of his earlier leadership roles from the vantage point offered by Kotter’s (1990 and 1990b) definition of transformational leadership and the implications for the writer’s own learning and development both as a leader and a manager and being able to appreciate both.

The paper reaches the conclusion that leadership is neither inherently good nor bad. What separates the two surely are the humility and the integrity with which one accepts the idiom that the path to effective leadership is the outcome of a heightened state of self-awareness and commitment to continuous self-development. Our success alas does not rest in whether we get there, but in having dared to take on the journey.

“The problem with leadership is that, despite 2,000 years of trying, we still don’t understand it.” (Onsman, 2002:23). Such a proposition adds weight to Stogdill’s (1974) claim that “There are almost as many definitions of leadership as those who have attempted to define the concept” (Cited in Seters and Fields, 1990; 29). However, such claims have paradoxically instilled greater academic vigor in search of the most plausible model of leadership as a reference point in the development of successful leaders. The importance of this task is predicated on the universal view that corporate success in part is determined by the capacity of its leadership to anticipate market opportunities and to position the organisation in a way that exploits them to its advantage (Thompson and Strickland, 2003). This positioning, moreover, rests in the role-defining duality of the leadership’s tasks: to set the strategic direction for the organisation, and to align the interests of its employees with that of the organisational goals (Kotter, 1990a).

Given the vital role leadership is afforded in the success of an organisation, and the competing definitions of an effective leader, the aim of this paper is to explore the notion of leadership as it relates to the writer’s own professional experiences with reference to the broader leadership narrative. This task, moreover, will be undertaken within the definitional and theoretical framework offered by Kotter (1990a). The author will briefly outline his work context before integrating it into Kotter’s (1990a, 1990b) conceptual construct of leadership. Given the depth of the construct, the paper by necessity will limit discussion to the aspects of the model that are seen to be critical to the theme of the dialogue to be developed. This theme will ultimately be captured in the proposition that Kotter’s (1990a) definition provides constructive insights into the constituent elements of good leadership in general, and to the author’s understanding of his own leadership style in particular. Moreover, Kotter’s (1990a) claim that management is different to leadership but that management skills are an integral part of an effective leader provides the necessary platform from which to analyse the critical role of leadership culture in the creation of an adaptive organisation. Equally critical to the development of the central premise of this essay is a brief clarification of the following questions: What is leadership? Is it synonymous with being a leader?
In what ways is management different to these concepts?

**Leadership**

Kotter (1990a) argues that “Leadership... is about coping with change” as “major changes are more and more necessary to survive and compete effectively in this new (organisational) environment (p104), that is characterised by constant market volatility and the concomitant demand for adaptive organisational structures and practices. Hence leadership is underscored by an inherent capacity to create grand visions and to achieve through the alignment of the interests of all the major stakeholders. This is chiefly secured by motivating and inspiring people, “by satisfying basic human needs for achievement, a sense of belonging, recognition, self-esteem, a feeling of control over one’s life and the ability to live up to one’s ideals. Such feelings touch us deeply and elicit a powerful response” (Kotter, 1990a: 107). By exhibiting such qualities as honesty, consistency in approach, or credibility, produces the preconditions for leadership integrity that is vital for creating employee trust that binds the leader and follower relationship. Kotter (1990b) argues that together these traits, or qualities, define the most effective change-management oriented leadership style, that of the transformational leadership. Whilst it is beyond the scope of this paper to offer a full explication of whether leadership traits are inherited or developed, for the purposes of the ongoing discussion the writer adopts the view offered by Kotter (1990a, 1190b) that they can be learned, but that it is possible to have these predispositions such that it gives the person possessing them a distinct starting advantage. Several authors support this proposition (Bass, 1990 & 1999; Rost and Barker, 2000: Yukl, 1989).

**Leader or Leadership: Is it just a case of semantics?**

Moreover, the writer asserts the view that leadership and leader are not interchangeable concepts (Kotter, 1990a and 1990b). “Leadership is a socially constructed reality” (Rost and Barker, 2000). It is a powerful worldview that offers an explanation about the process by which groups, organisations, or social systems are activated to embrace change. It is arguably premised on a set of assumptions about human nature and an ability to generate a concordance between its needs and that of the prevailing social structure (Willmott, 1993).

Leader, on the other hand, is the individualised expression of leadership. This expression varies from leader to leader. It is argued that leaders emerge in response to particular social and historical factors and as such the forces that elevate them are immutably different in their specificity. (Yukl, 1989).

**Management**

Management, on the other hand, is about imposing order on complexity to achieve the leadership vision (Kotter, 1990a). This is done typically through budgeting, quality control, and by instituting predictable work practices. Hence Kotter (1990a) expounds, “The whole purpose of systems and structures is to help normal people who behave in normal ways to compete routine jobs successfully, day after day. It's not exciting or glamorous. But that's management” (p107). Kotter (1990b) argues further, however, that “effective leaders manage and lead and that the mix of the two produce the best results”(p104). Organisations best positioned are those that not only heed this proposition but also are those whose recruitment and training practices reflect a culture of leadership across the organisational continuum. Kotter, (1990b), in fact, argues that “institutionalising a leadership-centered culture is the ultimate act of leadership”(p. 111).

**Leadership Culture**

The exact definition of the anthropological construct of culture at first glance appears as contentious as
the one applies to leadership (Keesing, 1990; Palmer and Hardy, 2000; Smircich, 1983). Morgan (1997) defines culture as “referring to the pattern of development reflected in society’s system of knowledge, ideology, values, laws and day to day ritual” (p120). They support a certain construction of the self in relation to the broader social structure (Munro, 1999). Organisational theorists argue that the functioning of an organisation can be conceptualised in the same way (Morgan, 1997; Wilson, 2000). The position adopted by Kotter (1990b) implies that the leadership can construct a desired culture, a view supported by Willmott (1993). These cultures are ritualised into certain behaviors and actions. Kotter (1990a) contends that the human resource practices of the organisation must adopt carefully embedded training ideology for new leaders, from recruitment through to carefully conceived ‘development opportunities’, such as mentoring, new job assignments, formal training or being selected for special projects, to name but a few. Kotter’s (1990a) argument that leadership culture is integral to the success of the overall success of the organisation resonates with the author’s own style which is at odds with that of the enacted, rather than the stated, ethos of the organisation. The writer argues that his particular experience of leadership confirms and expands upon the one offered by Kotter (1990b).

In order for people to feel empowered through having some level of control over their work, employees must be given the opportunity to be part of the leadership. Consequently, in a deliberate attempt to achieve a high degree of mutuality of interests between employee and employer in, the writer expanded the idea of leadership to include the formation of an outpatient leadership team. The author also needed to reconsider and recast his role as a leader so that it reflected genuineness of intent as opposed to merely enacting managerial salesmanship skills to secure conformity to organisational changes. It is the writer’s contention that leadership needs to cascade throughout the organisational structure, with each sphere having its own set of formal and informal leaders, together combining to reflect the totality of the leadership required in a modern organisation that needs to readily adapt to change. Before going any further, however, the writer will briefly describe his organisational context.

**Case Study**

The writer was employed as a middle manager within one of the Health Networks. He had line management responsibility for two Adult outpatient clinics based in the community. Hierarchical governance characterises the overall Network organisational structure. The outpatient clinics were managed for day to day functioning by the two team leaders who directly reported to the writer. It had a multidisciplinary staffing profile, with each discipline having a senior clinician who too reported to the writer via the team leaders. The writer’s line manager was the Adult Program Manager (APM) who in turn reported to the General Manager (GM). This position in turn was accountable to the Network CEO who was answerable to the Board of Directors. The writer’s division was restructured to include additional programs accountable to the General Manager. At this time an outside consultant was engaged to promote leadership, management teamwork and a shared divisional purpose for the fledgling new structure. A measure of this unity would be the development of a new mission statement and a statement of organisational values. Another major challenge facing the organisation has been its severe resource limitations with demand outstripping capacity.

**Integration of Theory and Practice - A Personal Reflection**

The consultancy agency named the two years of consultation as an opportunity for all to identify themselves as managers or leaders to take on the challenge of organisational change. The importance of clarifying roles is located in the fact that most of the managers have professional training in one of the five health disciplines of psychiatry, nursing psychology, social work or occupational therapy. Very few have had formal management qualifications or training. For the writer this odyssey coincided with his enrolment in the first year of a Masters of Management course. The ensuing training can best be
characterised by an immense confusion as to the role of management as opposed to the importance of leadership in organisations and our responsibilities. The underlying message was that we were expected to be managers and that management was responsible for the organisational culture. The Executive comprised of chief manager and the divisional heads were termed ‘the leadership group’. This group acknowledged that leadership is a shared responsibility but the subsequent behaviour of the GM betrayed a lesser approach.

The GM’s leadership style was purported to be transformational and yet lacked its essential ingredients: the presence of a broad statement of vision on being a team and service innovation but no map as to how we are to get there. Thompson and Strickland (2003) argue that one without the other is rendered ineffectual. There was tight control exercised over the divisional heads with risk-taking not being encouraged. GM role-models’ financial restraint by setting personal examples, including driving a base model car and using a very outmoded mobile phone even compared with the upgrades that the middle managers can easily access. However, such factors as credibility, integrity, and honesty were questionable at best as no one is given full access to budgetary information, including the divisional heads that have the ultimate responsibility for budgetary accountability for their programs. The middle management group were aware of these political factors and as a result questioned the leadership credibility. There was a pervasive lack of trust, which manifested itself in staff second-guessing the motivation of the leadership rather than connecting with them. This has the ultimate effect on morale and on the effectiveness of the organisation, which are decidedly not the building blocks of a transformational organisation or leadership.

The writer’s divisional manager’s behaviour paralleled that of the GM’s. However, her sense of integrity impelled her towards her eventual resignation, as her ability to lead her program was undermined by the strict control exercised over her division by the GM and the lack of transparency in their communication. The cumulative effect of this type of leadership was disempowerment, which is the antithesis of good leadership. The writer’s approach, on the other hand, has been underlined by his ambiguity towards his role as a manager. Imposing the ‘vision’ of financial leanness and service innovation within this context were meaningless and promulgated a reductionist managerial role of policing a value without believing. The sobering reality for my service still remained however, that we had limited resources, irrespective of its causal origin. We also had a commitment to our client group who relied on us for service delivery. Consequently, our clinics shared the common value that we would provide the best service that we could within the constraints of existing resources. Staff’s commitment was predicated on the matching of professional, personal and service values and the constant discussion of these as a precursor to initiating change. The outcome of this is that we were constantly on the lookout for innovative ways of delivering services. This cultural shift has been possible by the intersection of our values, that is the primacy of our responsibility in providing acceptable level of care to our clients, and the staff need to be heard and their need to be respected and to have a legitimate ownership claim on the process. Individuals are recognised for their contribution and those who command respect and show initiative are given distinct leadership responsibilities in their spheres of influence. These individuals had attended the recently erected strategic planning group to implement a major service overview, which was expected to change the nature of the service delivery. It was part of the writer’s succession planning strategy to carefully expose these individuals to further opportunities to develop their leadership and, management potential by being given specific portfolios that are both internal and external to the service, a strategy supported by Kotter (1990a, 1990b).

Staff saw the writer as credible and consistent with the requisite integrity to be seen as trustworthy. This trust was enshrined in our transparent communication style and people feeling safe to question motives and seek clarity. This interactional process clarified for the writer his leadership and management responsibilities and to appreciate and celebrate their differences and complementarity.
Conclusion

If one accepts the prevailing expert opinion, then one can conclude that leadership will become more and more critical not only to organisational but also to societal survival (Goldsworthy, 2002). We exist in a rapidly changing environment that presumes readiness to adapt, for the alternative is surely to achieve ignominy. We need the vision and the enabling capacity inherent in Kotter’s (1990a) definition of leadership to meet this challenge. An adaptive organisation is one where a genuine culture of leadership exists and that the emergence of leaders is encouraged at every level of the organisation. As Kotter (1990b) further argues that leadership is about the process of sharing the vision in a way that will facilitate the release of individuals’ energies towards a common goal. It has been argued by some that leadership is neither inherently good nor bad (Onsman, 2002). What separates the two surely are the humility and the integrity with which one accepts the idiom that the path to effective leadership is the outcome of a heightened state of self-awareness and commitment to continuous self-development. Our success alas does not rest in whether we get there, but in having dared to take on the journey.

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Human Development – Key Critical Aspects

Dr Avinash De Sousa
Consultant Psychiatrist & Founder Trustee, Desousa Foundation, Mumbai

Introduction

The following article provides a comprehensive overview of human development as seen by developmental psychologists. It aims to provide the reader with the conceptual understanding of human development and how it unfolds. It provides the reader with a detailed understanding of the different processes that underlie human development. Human development is a continuous process that occurs over a period of time and there are developmental tasks that need to be carried out at every level and must be accomplished fully before one can move ahead to further developmental tasks. The concepts of maturation and learning with respect to human development are also discussed. This paper serves as a primer for those hoping to have a fundamental understanding into the basic processes of human development and growth.

What is Human Development?

Developmental psychologists realise that an accurate picture of the developmental pattern is fundamental to an understanding of children. They also recognise that knowledge of what causes variations in development is essential to an understanding of each individual child.

Knowing what the developmental pattern is like has scientific as well as practical value. These values are: First, knowledge of the pattern of human development helps developmental psychologists to know what to expect of children, at approximately what ages to expect different patterns of behavior to appear, and when these patterns will normally be replaced by more mature patterns. This is important because if too much is expected at a given age, children are likely to develop feelings of inadequacy if they do not live up to the standards their parents and teachers set for them. If, on the other hand, too little is expected of them, they are deprived of incentives to develop their potentials. Equally serious, they often build up resentments toward those who underestimate their capacities.

Second, knowing what to expect enables developmental psychologists to set up guidelines in the form of height-weight scales, age-weight scales, age-height scales, mental-age scales, and social- or emotional-development scales. Since the pattern of development for all normal children is approximately the same, it is then possible to evaluate each child in terms of the norm for that child's age. If development is typical, it means that the child is making normal adjustments to social expectations. Should, on the other hand, there be deviations from the normal pattern, this may be regarded as a danger signal of poor personal, emotional, or social adjustments. Steps can then be taken to discover the cause of the deviation and to remedy it. Should the deviation be the result of lack of opportunities to learn, for example, the child can then be given learning opportunities and encouragement to use these opportunities.

Third, since successful development requires guidance, knowing the developmental pattern enables parents and teachers to guide the child's learning at appropriate times. A baby who is ready to learn to walk must be given opportunities to practice walking and encouragement to keep on trying until the walking skill has been mastered. Lack of opportunity and encouragement may delay normal development.

Fourth, knowing what the normal developmental pattern is makes it possible for parents and teachers to prepare children ahead of time for the changes that will take place in their bodies their interests, or
their behavior. For example, children can be prepared for what will be expected of them when they enter school. While this psychological preparation will not eliminate all tensions that come from such a radical adjustment, it will go a long way toward minimising them.

**Development Involves Change**

Many people use the terms “growth” and “development” interchangeably. In reality they are different, though they are inseparable; neither takes place alone. Growth refers to quantitative changes - increases in size and structure. Not only does the child become larger physically, but the size and structure of the internal organs and the brain increase. As a result of the growth of the brain, the child has a greater capacity for learning, for remembering, and for reasoning. The child grows mentally as well as physically.

Development, by contrast, refers to qualitative and quantitative changes. It may be defined as a progressive series of orderly, coherent changes. “Progressive” signifies that the changes are directional, that they lead forward rather than backward. “Orderly” and “coherent” suggest that there is a definite relationship between the changes taking place and those that preceded or will follow them. Neugarten has explained how changes in development affect people as they grow older.

“People change, whether for good or for bad, as a result of the accumulation of experience. As events are registered in the organism, individuals invariably abstract from the traces of those experiences and they create more encompassing as well as more refined categories for the interpretation of new events. The mental filing system not only grows larger, but it is reorganized over time, with infinitely more cross references. Adults are not only much more complex than children, but they are more different one from the other, and increasingly different as they move from youth to extreme old age.”

**The Goal of Developmental Changes**

The goal of developmental changes is self-realisation or the achievement of genetic potentials. This Maslow has labeled “self-actualisation” - the striving to be the best person possible, both physically and mentally. It is the urge to do what one is fitted to do. To be happy and well-adjusted, a person must be given an opportunity to fulfill this urge.

However, whether the person will achieve this goal will depend on what obstacles are encountered and how successful the person is in overcoming these obstacles. Obstacles may be environmental, such as growing up in an environment where children are deprived of educational and cultural opportunities; or they may be from within the person, such as a fear of attempting to do what they are capable of doing because of social criticism. Many potentially creative children, for example, fail to achieve the creativity they are capable of because of early social criticism of their creative endeavors.

**Types of Change**

a) Changes in Size

These include physical changes in height, weight, circumference, and internal organs, and mental changes in memory, reasoning, perception, and creative imagination.

b) Changes in proportions

Children are not miniature adults in their physical proportions. Nor are they mentally miniature adults. Their imaginative capacity is better developed than their reasoning capacity, while the reverse is true of adult.
c) Disappearance of old features

When certain physical features, such as the thymus gland after puberty and baby hair and teeth, lose their usefulness, they gradually atrophy, as do some psychological and behavioral traits - babyish locomotion and speech and fantastic extensions of the imagination.

d) Appearance of new features

Some new physical and mental features develop from maturation and some develop from learning and experience. New physical features include second teeth and primary and secondary sex characteristics; new mental features include interest in sex, moral standards, and religious beliefs.

e) Attitudes Towards Change

Whether the individual child’s attitudes toward “change are generally favorable or unfavorable depends upon many factors. First, children's awareness of the change. As babies become more autonomous, they begin to resent being waited on. Pubescent children, aware of the awkwardness that normally accompanies rapid growth, feel self-conscious and embarrassed instead of self-confident as they were earlier when slow growth enabled them to have better control over bodily movements.

Second, how the change affects their behavior. If the change enables children to be more independent of adult help or if it gives them added strength and speed so that they can take part in the play activities they associate with older children, they will welcome the change.

Third, social attitudes toward the change affect children just as they do adults. Most parents, for example, encourage their children to “grow up” as soon as possible. When children live up to parental expectations, they are praised; when they fall below these expectations, they are reproved for not “acting their age.”

Fourth, social attitudes are influenced, to some extent at least, by how the change affects the child’s appearance. As a cuddly baby becomes a spindly pre-adolescent and as teeth fall out, giving the face a comical, if not homely look, the child may be less appealing to adults. If so, they are likely to show it in their treatment of the child.

Fifth, cultural attitudes affect the way people treat children as a result of changes in their appearance and behavior. Attitudes are, for the most part, more favorable toward babies and young children than toward older children. Just as “everyone loves a baby,” so many people dread the prepubescent stage when children tend to become glum, moody, surly, and difficult to live or work with. Even peers may regard the prepubescent as a “pest” and old friendships often break as a result. Under such conditions, it is unlikely that children will have favorable attitudes toward many of the changes that puberty brings.

Early Development is More Critical

Long before scientific studies of children were made, it was an accepted fact that the early years are critical in the child’s development. This was expressed in the old Chinese proverb, “As the twig is bent, so the tree’s inclined.” In a more poetic way, Milton expressed the same fact when he wrote, “The childhood shows the man, as morning shows the day.”

The first important scientific clue of the significance of the early years came from Freud’s studies of personality maladjustment. Such maladjustments, Freud found, could be traced to unfavorable childhood experiences. More recent studies have substantiated Freud. From clinical studies of children from birth to maturity, Erikson has concluded that “childhood is the scene of man's beginning as man, the place
where our particular virtues and vices slowly but clearly develop and make themselves felt.” He has further explained that babyhood is a time of “basic trust”- the individual learns to view the world as safe, reliable, and nurturing; or a time of “basic distrust”- the individual learns to view the world as full of threat, unpredictability, and treachery.

What the child will learn, Erikson explained, will depend on how parents gratify the child’s needs for food, attention, and love. Once learned, these attitudes will color the individual’s perceptions of people and situations throughout life.

The histories of maladjusted children from preschool years into high school or college have revealed that most of them were so poorly adjusted as young children that they never belonged to any group or had many friends. In addition, many suffered from speech, academic, and enuretic difficulties and were regarded by their families as “problem” children. From studies of the life histories of delinquents, Glueck concluded that potential delinquents could be identified as early as two or three years of age by their antisocial behavior.

**Why Early Foundations are Important**

As evidence piles up to show that early foundations tend to be persistent and to influence the child’s attitudes and behavior throughout life, it becomes increasingly apparent why early foundations are important. There are four lines of evidence to substantiate this claim.

First, since learning and experience play increasingly dominant roles in development as children grow older, they can be directed into channels that will lead to good adjustment. Basically, this task must be handled by the family, though the larger social group can provide a culture in which children can fulfill their potentials.

Allowing children to grow up, doing what they want when they want, is obviously unfair to them. Children are too inexperienced to know what the social group expects of them. How, for example, can children know that mispronunciations and grammatical mistakes will create the impression that they are ignorant? How can they know that aggressive attacks on playmates will create more enemies than friends?

Guidance is most needed in the early stages of learning when the foundations are being laid. If children are put on the right track at first and encouraged to remain there until they become accustomed to it or realise why it is best, they will be less likely to get on the wrong track later.

Second, because early foundations quickly develop into habitual patterns, they will have a lifelong influence on children’s personal and social adjustments. Many years ago, James warned of this habituation when he said, “Could the young but realise how quickly they will become mere walking bundles of habits, they would give more heed to their conduct while still in the plastic stage”.

Third, contrary to popular belief, children do not outgrow undesirable traits as they grow older. Instead, as was stressed earlier, patterns of attitudes and behavior, established early in life, tend to persist regardless of whether they are good or bad, beneficial or harmful to the child’s adjustments.

Fourth, because it is sometimes desirable to make changes in what has been learned, the sooner the changes are made, the easier it is for children and, consequently, the more cooperative they are in making the changes.

In spite of the fact that early foundations are difficult to change, they can be, and often are, changed.
There are three conditions that facilitate such change. First, when children receive guidance and help in making the changes, second, when the significant people in their lives treat them in a different way, and third, when the children themselves have a strong motivation to make the changes.

**Meaning of “Maturation”**

Intrinsic maturing/maturation is the unfolding of characteristics potentially present in the individual that come from the individual's genetic endowment. In phylogenetic functions common to the race - such as creeping, crawling, sitting, and walking, development comes from maturation. Training, per se, is of little advantage. Controlling the environment in such a way as to reduce opportunities to practice may, on the other hand, retard development.

By contrast, in ontogenetic functions, functions specific to the individual, such as swimming, ball throwing, riding bicycles or writing, training is essential. Without such training, development will not take place. No hereditary tendency can mature fully, however, without environmental support.

**Meaning of Learning**

Learning is development that comes from exercise and effort. Through learning, children acquire competence in using their hereditary resources. They must, however, have opportunities to learn. A child with superior neuromuscular organisation, for example, may have a high aptitude for musical performance. But, if deprived of opportunities for practice and systematic training, the child will not develop this hereditary potential.

Some learning comes from practice or the mere repetition of an act. This, in time, brings about a change in the person's behavior. Such learning may consist of imitation, in which the person consciously copies what others do. Or it may consist of identification, in which the person attempts to adopt the attitudes, values, motives, and behavior of admired and loved persons.

Learning may come from training - selected, directed, and purposive activity. In training, children are directed in their behavior by adults or older children who attempt to mold their behavior into patterns that will contribute to their welfare and be acceptable to the social group.

The different environmental influences children experience affecting the pattern of their development. Were human development due to maturation alone, as in some animal species, individuality would be reduced to a minimum.

**Some Predictable Patterns of Development**

From the many evidences of an orderly, predictable pattern in physical development, in both prenatal and postnatal life, have come two laws of the directional sequence of development: the cephalocaudal law and the proximodistal law. According to the cephalocaudal law, development spreads over the body from head to foot. This means that improvements in structure and function come first in the head region, then in the trunk, and last in the leg region. According to the proximodistal law, development proceeds from near to far—outward from the central axis of the body toward the extremities. In the fetus, the head and trunk are fairly well developed before the rudimentary limb buds appear. Gradually, the arm buds lengthen and then develop into the hands and fingers. Functionally, babies can use their arms before their hands and can use their hands as a unit before they can control the movements of the fingers.

Longitudinal studies of intelligence have revealed that the pattern of mental development is as predictable as the pattern of physical development. The results of several longitudinal studies covering different
segments of the life-span from birth to 50 years show that the major part of mental growth comes when the body is developing most rapidly, during the first 16 to 18 years. There is also a predictable pattern for development of the different intellectual functions, such as memory and reasoning, that constitute general intelligence.

**Development is Continuous**

Development is continuous from the moment of conception to death, but it occurs at different rates, sometimes slowly and sometimes rapidly. As Piechowski has emphasised, “Development does not occur at an even pace. There are periods of great intensity and disequilibrium and there are periods of equilibrium. Development achieves a plateau, and this may occur at any level or between levels”.

Furthermore, developmental changes do not always go forward in a straight line. They sometimes go backward, as when a jealous child regresses to babyish ways of doing things in the hopes of winning the parental attention enjoyed earlier. However, in the end, these changes lead forward.

Since development is continuous, what happens at one stage influences the following stage. Unhealthy attitudes about self or about relationships with others during the early years, for example, are rarely eliminated completely. They are reflected in the individual’s outlook on life even in middle and old age. “Basic trust” or “basic distrust,” developed during the babyhood years, Erikson found, persist throughout life and color the persons reactions to people and to life situations.

**There are Individual Differences in Development**

Although the pattern of development is similar for all children, all children follow the predictable pattern in their own way and at their own rate. Some children develop in a smooth, gradual, step-by-step fashion, while others move in spurts. Some show slight swings, while others show wide ones. All children do not, therefore, reach the same point of development at the same age.

**Causes of Differences**

Dobzhansky has said, “Every person is indeed biologically and genetically different from every other”. In addition, no two people have identical environmental influences, even identical twins. This means that individual differences are caused by both internal and external conditions. As a result, the pattern of development will be different for every child, even though it is similar in its major aspects to the pattern followed by other children.

Physical development, for example, depends partly on hereditary potentials and partly on such environmental factors as food, general health, sunlight, fresh air, climate, emotions, and physical exertion.

Intellectual development is affected by such factors as inherent capacity, the emotional climate, whether one is encouraged to pursue intellectual activities, whether one has a strong intellectual drive, and whether one has opportunities for experiences and learning. Personality development is influenced by genetic factors as well as by attitudes and social relationships, both in the home and outside.

There is evidence that physical and mental differences exist between the sexes and in children of different racial backgrounds. These differences are due in part to hereditary factors and, in part, to environmental factors. Of the two, there is evidence that the environmental factors play a more dominant role in producing the differences that do the hereditary factors.
Developmental Tasks

People of all ages are well aware of these “social expectations.” Even young children know, from what people say to them and ask them to do, that certain things are expected of them. They soon realise, from the approval or disapproval of their behavior, that these social expectations largely determine the pattern of their learning.

Social expectations are known as “developmental tasks”. Havighurst has defined a developmental task as a “task which arises at or about a certain period in the life of an individual, successful achievement of which leads to his happiness and success with later tasks, while failure leads to unhappiness in the individual, disapproval by society, and difficulty with later tasks.” Some developmental tasks arise mainly as a result of physical maturation (learning to walk); others are developed mainly from the cultural pressures of society (learning to read or learning appropriate sex roles); still others grow out of the personal values and aspirations of the individual (choosing and preparing for a vocation). Most developmental tasks arise from all three of these forces working together.

In a culture that is relatively static, developmental tasks remain much the same one generation after another. In a changing culture, however, the new generation must perform new developmental tasks, while some of the old tasks will become less important or be eliminated. In a culture that changes from hand labor to machine labor, for example, learning hand skills becomes less important than learning to operate machines.

Developmental tasks serve three very useful purposes. First, they act as guidelines to help parents and teachers to know what children should learn at a given age. If, for example, children are to make good adjustments to school, they must have mastered the tasks needed to be independent of teacher help, such as putting on or taking off outer garments, and they must know how to play the games other children in the neighborhood play.

Second, developmental tasks serve as motivating forces for children to learn what the social group expects them to learn at that age. Children quickly learn that social acceptance depends on their being able to do what their age-mates do. The stronger their desire for social acceptance, the greater will be their motivation to learn to do what their age-mates do.

Third, developmental tasks tell parents and teachers what will be expected of children in the immediate and remote future. As such, they alert them to the necessity of preparing children to meet these new expectations. When children begin to play with their age-mates, it alerts parents, for example, to the importance of teaching them how to play the games and sports that are popular among the older children of the neighborhood so that their children will be ready to play them when playing with age-mates becomes an important play activity for their children.

Summary

- Knowledge of the developmental pattern is important for scientific reasons because it helps developmental psychologists to know at approximately what ages to expect different patterns of behavior and to use these to set up guidelines. For practical reasons it is important because it emphasizes the necessity for guidance and stimulation if the child’s full potentials are to be reached and it enables parents and teachers to prepare children ahead for what will be expected of them at given ages.
- Research studies have provided evidence for 10 fundamental facts about principles of development during the childhood years. As research continues, more principles may emerge.
• Children’s attitudes toward change are influenced by their awareness of these changes, how they affect children’s behavior, social attitudes toward these changes, how they affect children’s appearance, and how the social group reacts to children when these changes occur.

• The second principle of development is that early development is more critical than later development. Because early foundations are greatly influenced by learning and experience, if they are harmful to a child’s personal and social adjustments, they can be changed before they settle into habitual patterns.

• The third principle of development emphasizes the fact that development comes from the interaction of maturation and learning, with maturation setting limits to the development.

• The fourth principle of development is that the pattern of development is predictable, though this predictable pattern can be delayed or accelerated by conditions within the prenatal and postnatal environments.

• The fifth principle of development is that the developmental pattern has certain predictable characteristics, the most important of which are that there is similarity in the developmental pattern for all children; development proceeds from general to specific responses; development is continuous; different areas develop at different rates; and there is correlation in development.

• The sixth principle of development is that there are individual differences in development due partly to hereditary influences and partly to environmental conditions. This is true both for physical and psychological development.

• The practical significance of knowing that there are individual differences in development is that it emphasizes the importance of training children according to their individual needs and of not expecting the same behavior in all children.

• The seventh principle of development is that there are periods in the developmental pattern which are labeled the prenatal period, infancy, babyhood, early childhood, late childhood, and puberty. Within these periods there are times of equilibrium and disequilibrium and behavior patterns that are normal and those that are carry-overs from an earlier period, usually called “problem” behavior.

• The eighth principle of development is that there are social expectations for every developmental period. These social expectations are in the form of developmental tasks which enable parents and teachers to know at what ages children are capable of mastering the different patterns of behavior necessary to make good adjustments.

• The ninth principle of development is that every area of development has potential hazards, physical and psychological, which may alter the pattern of development.

• The tenth principle of development is that happiness varies at different periods in the developmental pattern. The first year of life is usually the happiest and puberty is usually worrisome.

References


Abstract

Nurses working in the oncology units are reported to be subjected to extreme stress and incur severe fatigue. The present cross-sectional study was conducted to understand fatigue with nurses caring for people with cancer in Mangalore, India. As a parallel comparative cohort nurses working in the non-oncology setup and taking care of patients with other health issues were also recruited. The willing volunteers were provided with Fatigue Assessment Scale (FAS) and requested to deposit them in a collection box. The data indicated that the nurses taking care of cancer patients had more physical (7.56±3.22 vs 9.35±2.15; p < 0.0002), mental (3.94±2.26 vs 6.02±2.24; p <0.0001) and total fatigue (15.37±2.89 vs 11.49±4.67; P < 0.0001). The findings from this study support the fact that nursing professionals working in the oncology units endure more fatigue and that suitable ameliorative modalities need to be developed.

Key words: Oncology nurses, Fatigue Assessment Scale (FAS)

Introduction

Study of occupational stress is an important aspect and the results accrued from a systematic research endeavor helps the individual, the employer and country at large. Providing nursing care especially to people with cancer is recognised to be an important occupational stress in the health care industry (LeBaron et al., 2014). Oncology nurses work in acute care setups, in ambulatory care sections, office, radiation and chemotherapy and surgical therapy sections (Lupo et al., 2013). In an ideal setup the onco-nurses are expected to be well versed in assessing patient’s general physical and emotional status, take down the past medical history and treatment details, review treatment plan with the treating doctor and be aware of the outcomes and possible complications, be aware of the results and general implications of all relevant laboratory, pathology, and radiological imaging, to provide knowledge of the disease and its treatment to the patients and their family (Lupo et al., 2013; LeBaron et al., 2014; Huang et al., 2014; Wu et al., 2016; Ghazavi et al., 2016). However, the difficult aspect is that onco-nurses care for critically ill and dying patients, this is the most disturbing fact of the nursing profession (Wu et al., 2016; Ghazavi et al., 2016). In this study we have attempted to understand fatigue in nurses caring for cancer patients and compared the stress with their peers working in non-oncological setup.

Material and Methods

a) Study Area and Population:

The study is a Hospital based cross-sectional study and was conducted in January 2015. The study was conducted in Mangalore Institute of Oncology, Indiana Hospital, Colaco Hospital and Minsa Hospital in the city of Mangalore, Karnataka, India. Of these four hospitals Mangalore Institute of Oncology is a referral centre and treats cancer patients, while the remaining three treat people with all health conditions. The inclusion criteria included nurses working in the four hospitals and were available at
work during the data collection period. The exclusion criteria included doctors and other hospital staff in the hospital. The study was approved by the Institutional Ethics Committee of Mangalore Institute of Oncology and the study was carried out after obtaining the necessary permission from the hospital administration.

b) Data Collection Instrument:

The data was collected using an English version of structured self-administered questionnaire consisting of the demographic and subject specific questions. The demographic details included age, gender, years in nursing practice and years in oncological services. The investigators made a conscious attempt at having the questionnaire brief to avoid interference in the nursing care. Fatigue was assessed using the Fatigue Assessment Scale (FAS) (De Vries et al., 2004). The scale consists of 10 questions and address both physical fatigue (6 questions) and mental fatigue (4 questions) domains.

The nurses were individually approached by the investigators and briefed about the study purpose. The willing volunteers were provided with an informed consent and the study questionnaire. The volunteers were requested to answer all the questions and to not write their names or leave any identification mark on the study questionnaire and requested to return back the filled sheets enclosed in an envelope and drop it in to a collection box placed in the reception counters of the four hospitals.

c) Statistical Analysis:

Data was entered in Microsoft Excel and analysed on the online based Vassar Stats statistical program. All quantitative variables are illustrated through mean and standard deviation and the “t” test was applied. A p value of < 0.05 was considered significant.

Results:

The study consisted of 82 nurses working in non-oncological set up, while 34 were working in oncological care. It was observed that there was no significant difference in the demographic details like in age (23.25±12.41 vs 22.92±7.6) and years of nursing (6.28±5.6 vs 6.14±3.6). It was also observed that the nurses working in oncological setup was 4.35±3.86. With respect to fatigue it was observed that the nurses working in the oncological care had greater physical (7.56±3.22 vs 9.35±2.15; p < 0.0002) and mental (3.94±2.26 vs 6.02±2.24; p <0.0001) fatigue domains (Figure 1). Accordingly, the cumulative fatigue was seen to be more in nurses working in oncological care (15.37±2.89) than in the other sections (11.49±4.67) and was highly significant (P < 0.0001) (Figure 1).

Discussion:

In the present study it was observed that when compared to nurses working in the general setup fatigue was more in ones working in oncological setup. Our observation validates earlier reports that caring for people with cancer is very stressful for nurses. From a nurse’s perspective, irrespective of their effectiveness in taking care, training, skills, beliefs and attitude death of patients affects onco-nurse immensely. Previous studies have unequivocally shown that nurses caring for people with cancer have high rates of frustration, anxiety, depression and burnout and this leads to absenteeism, reduced patient satisfaction, and diagnosis and treatment errors. Seminal studies by Kash and Coworkers (2000) have shown that nurses experienced more physical symptoms than did house staff and medical oncologists. Additionally, studies with nurses caring for people with cancer vs people with the acquired immunodeficiency syndrome (AIDS) have also shown that the nurses caring for cancer patients had greater emotional exhaustion, depersonalisation, had a sense of failure, poor management, and difficult staff relationships (Schraub and Marx,2004).
Fatigue can be physical or psychological or a combination and can lead to compromised decision making reaction time and critical thinking which will cumulatively lead to compromised work efficiency (Drake et al 2012). Additionally, fatigue can negatively influence the general health of an individual and can subsequently be a huge public health burden with costs to the individual, the employer and the economy (Drake et al 2012). Fatigue is known to impair performance, both physical and cognitive, enhance chances of occupational injuries and sick leave (Swaan et al., 2003; Janssen et al., 2003; Van Amelsvoort et al., 2002). In worse cases an immense fatigue for an extended period of time can lead to job loss and livelihood (Reynolds et al, 2004). Future studies are being planned to investigate whether incorporation of yoga and laughing therapy will be efficacious in reducing stress in the nurses improving overall well-being.

References


Figure 1: Fatigue (physical, mental and total) in the nurses working in non-oncology (mottled) and oncology (solid black) units.
It has been said that Workplace Misery is a choice. However, in the field of psychiatry such a statement would seem callous, unless, it is a conclusion based upon a thorough understanding of a person’s underlying psychodynamics.

A total understanding of the “true” environment in the workplace is necessary. Compromised environmental factors can significantly impair the realisation of the True Value of Human Capital at hand.

In addition to structural environmental factors a more significant component is the Dynamic Incongruence of the occupational environment. Management related Compathic Implosion, Empathetic Anhedonia and an Entitlement to Misery attitude is extremely counterproductive. A supportive dynamic environment is one that will not invoke past negative experiences (real or perceived) and therefore will not trigger an existential crisis state in the associate.

**Role of Hierarchical Self Placement in Workplace Misery**

There is a tendency to cognitively rank oneself amongst work associates. This tendency compromises the statistical central tendency of the group.

Top of the chain syndrome: Associates in this group have an “I am better than you” attitude. Bottom of the chain syndrome: Associates in this group have an “I will never be as good as the others” attitude.

These Cost Basis Risk Personalities result in a significant loss of human capital in the workplace.

Therapeutic measures with specialised interventions will result in a profound reduction in loss of human capital.

**Tail Elimination therapy (Tailimation technique )**

This Group Oriented Reality therapy essentially focuses on the elimination of positive and negative skewed tails of the group while at the same time encouraging a common movement towards the center.
While in group therapy the associate is encouraged to verbalise his/her self-perception relative to associates seated on either side in the group setting. With this approach, interactional tendencies are also reflected, with the goal of enhancing a more profound understanding of the self. It is believed that understanding one’s “skewed” perception of the self may facilitate movement towards the median. This movement, results in restoration of one’s Cost Basis (Dynamic Modulation of Cost Basis).
Introduction

Procrastination most simply understood is the prolonged avoidance of a variety of tasks which need to be accomplished – often leading to feelings of guilt, inadequacy and self-doubt. Often encountered, procrastination is a prevalent phenomenon across ages. Most widely seen in students (as much as 50%), procrastination is also a prevalent phenomenon among the adult (15%-20%) working professionals. Self-report measures report that these students and adults engage in procrastination to an extent that it causes personal distress [Day, et al 2000]. The term procrastination is usually negatively connotated. People most strongly characterise it as being bad, harmful, and foolish and over 95% of procrastinators wish to reduce it. However, there has been research that documents the positive aspects and outcomes of procrastination as well [Rozental, A, et al, 2014]. Though, the debate ensues whether procrastination is negative or positive, where the negative connotation of the phenomenon has an upper hand.

Though postponing tasks once in a while is okay, procrastination is a form of self-regulatory failure, where we ‘voluntarily delay an intended course of action despite expecting to be worse off for the delay’ [Nguyen, B et al, 2013]. A typical definition that comes across for procrastination due to its prolonged nature is that as a trait or behavioural disposition to postpone or delay performing a task or making decisions, making procrastination a personality disposition rather than an externalised phenomenon.

Procrastination at Work

Procrastination in the workplace is a commonly seen phenomenon among adults. It can range from being mild, moderate or severe. Mild procrastination may be almost normative and may not directly impact work productivity and output. Whereas, moderate and severe procrastination have varying impacts on work output.

Procrastination may manifest in variation at the workplace:

- Promising what you can’t deliver
- Being unrealistic
- Lacking planning
- No follow through or follow up
- Over promising and under delivering
- Little or no motivation
- Listening to the wrong people
- Getting caught up in a mob mentality
- Slowness to respond
- Lacking engagement
Procrastination, in a way is a disengagement. Disengagement occurs because of micro-management, insecurity on the job, lack of leadership, poor communications, boredom, lack of challenging work, lack of differentiation between poor performers and outstanding performers.

**Four Types of Procrastinators:**

1. The first type is those who wait until the last minute to finish a project. When asked why that is, many say they are either better workers under an adrenaline rush or they are more creative when under pressure.

2. The second are the highly organised perfectionists. Their procrastination is motivated by not wanting to begin a project until they feel it can be done to perfection, which entails gathering all the necessary data to proceed as well as never wanting to complete a project that doesn't hit their personal bar.

3. Thirdly, there are those who are so easily distracted that is difficult to stay on task because of easy distractibility.

4. Lastly, there are those who struggle with using the word “no.” These are the people-pleasers who are pulled in several directions at the same time, which take them away from their own priorities and projects.

There are also planned procrastinators where procrastinators are with purpose and they do their work with fine ability at the last minute.

**Why People Procrastinate?**

Procrastination brings negative outcome to the individual and the organisation. Though, it may not affect the individual as much as it does to the organisation. There are various reasons for procrastination, including:

1. Work may be unpleasant and uninteresting
2. Work may not optimally challenge the skill set of the employee
3. Lack of willingness to perform a task
4. Laziness
5. Work may be inconveniencing
6. There may be external stressors present that may hinder task performance
7. There may be lack of motivation
8. Slack in personal discipline
9. Inappropriately conducive work culture and work environment
10. Lack of organisational commitment
11. Fear of failure in employees who want are perfectionists
12. Subconsciously or even consciously, be a way of rebelling against a boss’ instructions, a schedule, or even expectations of employees' role

**Procrastination as a Personality Trait**

Is people's level of procrastination consistent temporally and situationally? Research shows that procrastination has a genetic and biological component [Bhatt, P, et al, 2017]. Research further shows
that procrastination can also be traced back to have a link with the five factor model, with the factor of conscientiousness [Roberts, BW, et al, 2005]. However, it is a further subset of 6 components of conscientiousness along with various other personality factors and different dimensions of the five factor model as well, with which procrastination has direct and indirect links.

Consequences of Procrastination

Higher levels of procrastination have been linked to income of employee, employment status and employment duration [Nguyen B, et al 2013]. There are several other consequences of procrastination seen on the employee and the organisation. Looking at how procrastination affects the employee, there are various associated variables like higher stress levels, ill effects on physical health, reduced cognitive and meta-cognitive abilities, increased disinterestedness, empty labour (the time that employees spend at work doing anything that is not what is needed in their job), consistent poor time management and work output, lowered levels of income and increased risk to unemployment. Whereas, in the workplace, lowered organisational productivity, attrition of employees and low turnover rates are negative outcomes of procrastination.

Overall, there is loss of productive time, lowered capacity to meet goals (personal and professional), important opportunities may be lost, there are negative impacts on the individual’s career, decision making is marred and there comes a divide between employee-organisational goals. Procrastination has been repeatedly found to vary with task characteristics, ‘most strongly associated with the aversive task components of frustration, resentment, and, in particular, boredom’ [Steel, P, 2007]. The variation of procrastination among jobs can also be accounted for by the gravitational hypothesis, where people gravitate or move to jobs commensurate with their abilities (Wilk, Desmarais, & Sackett, 1995). Alternatively, we can think of this in terms of person-job or person-organisational fit, in that our ability to refrain from procrastinating is necessary for us to be well matched to specific occupations. Consequently, certain jobs require us not to procrastinate while other occupations are more forgiving [DeArmond, S, et al, 2014].

Does Procrastination Have a Link with Creativity?

This is association of procrastination with creativity is that of debate. Where there is one school of research that supports the hypothesis, there is another school that does not support the same. Researchers reported on a preliminary investigation where they interviewed self-identified as chronic problematic procrastinators and found negative and positive beliefs about procrastination [Fernie, BA, et al, 2008].

Self-reported positive metacognitive beliefs:

• Procrastination helps creative thinking.
• You might come back to it with a fresher approach if you procrastinate.
• I would be better off leaving the task till later when I was in a better frame of mind to do it.
• Procrastination gives you preparation time.
• By procrastinating I don’t have to take that particular anxiety-provoking decision there and then.

Self-reported negative metacognitive beliefs:

• Mentally, procrastination is a tiring process.
• Procrastinating gives you negative feelings about the whole thing.
Procrastination could get out of control.
Procrastination is the product of an unordered uncontrolled mind.
When procrastinating, you waste a lot of time and energy thinking about a task that you wouldn’t have to think about if you had completed it already.
Procrastination can make me more anxious.
I think procrastination can be harmful.
Procrastination makes me frustrated and that gets me really annoyed at myself.
Procrastination increases your stress.
Procrastination is uncomfortable.
Procrastination can be difficult to control.
Procrastination can make me panic.

However, conclusive findings are not in place but what can be tentatively is agreed is that all delay is not procrastination, and it’s important to know the difference. It is also important to know that there is a degree and amount of delay that may lead to creativity but not necessarily that delay (or procrastination) may always lead to creativity.

**Procrastination and Psychopathology**

It is crucial to know that there is a reciprocal relationship between procrastination and psychopathological states. In psychopathology such as depression, anxiety, chronic stress, chronic pain, thought disturbances and other psychopathological conditions, procrastination may invariably result due to disturbed affective and cognitive states. Procrastination has been linked to personality factors that are predictive of psychopathology. Despite this, the association between procrastination and internalizing and externalizing psychopathology is not well understood. A twin study showed that fear of failure and neuroticism accounted for the relationship between procrastination and internalising psychopathology, whereas impulsiveness accounted for the relationship between procrastination and externalising psychopathology. These associations were due primarily to genetic influences [Gustavson, DE, et al, 2017].

**Steps to Reduce Procrastination**

It is quintessential to realise that procrastination is not a time management problem but an emotional management problem. There is mis-regulation of emotions to try to feel good in the present moment. Some fruitful ways to manage the level of procrastination can be [Day, V et al 2000, Howell, AJ, et al 2007]:

1. Emotion coping responses in order to reduce the reactivity to stressors and rather respond healthily
2. Reward employee behaviour after task performances and achievements in order to boost the level of motivation and confidence
3. Motivate employees enough and make them aware of the importance of a task by producing some concrete evidence of its value
4. A strategy based working schedule may sometimes help carry out the task better
5. It is not necessary to produce perfect work. Reducing the pressure of perfection helps. Reassure employees that they can relax, and mistakes are expected
6. Having breaks to refresh may be useful
7. Have group assisted or technology assisted working system for rechecking work and also to share the burden of workload.

References
What is Schizophrenia

Schizophrenia is a severe mental illness characterised by classic symptoms of loss in touch with reality, experiencing hallucinations and delusions and formal thought disorder (disorganised speech and behaviour). The individual suffering from schizophrenia may also experience loss of motivation (avolition), loss of interest in earlier pleasurable activities (anhedonia), blunted affect and ambivalence in attitudes and emotions expressed. At a global level, the prevalence of schizophrenia is up to 1% (1 out of 100 people). Schizophrenia is a complex condition that involves the contribution of various risk factors in its development. Genetic vulnerability, imbalance in biochemical matrix, environmental factors and dysfunctional brain anatomy are implicated risk factors in the development of schizophrenia. Schizophrenia is one of the most debilitating mental disorders that is not just crippling for the individual but also for the family and larger society. The illness most frequently becomes manifest in early adulthood, and often follows a chronic course. It is associated with high morbidity and mortality, and is a leading contributor to disease burden, health and social care costs throughout the world.

Socio-Occupational Deterioration on Schizophrenia

Cognitive functioning is one of the prime areas marred in schizophrenia which are also central to the development of the psychotic symptoms of the illness. The areas of cognition that get affected are attention, learning, memory (working memory and semantic memory), reasoning, processing speed and overall executive functioning. In consequence, the intellectual quotient of the individual is also reduced in patients of schizophrenia [Cowen, P, et al 2012]. The deterioration in cognitive functioning is relative to the severity of illness and consequently affects the social, occupational and daily functioning of the individual. Therefore, relationships with people, working and performing daily functions such as maintaining hygiene is deteriorated.

Schizophrenia and its Effects on the Workplace

The ability of an individual to be functional at the workplace is inversely proportionate to the severity of the illness. Research establishes that it is negative symptoms (loss of interest in activities, loss of motivation and flattened affect) and along with the cognitive deterioration (bizarre thoughts, any formal thought disorder and disorganised behaviour / speech) that affects an individual's functional ability at work. Cognitive deficits lead to problems with planning and organizing work, remembering tasks, socialising with colleagues and paying attention to targets. Though the positive symptoms (hallucinations and delusions) may not actively interfere with work. However, psychosis, one of the cardinal features in schizophrenia, is shown to defeat productivity and participation [Arciniegas DB, 2015].

An essential aspect of understanding the effect of schizophrenia at workplace depends on who is affected the workplace. When the employees at the lower rung are diagnosed with schizophrenia, it does not impact the overall organisation as much as they either lose the job or their work may get covered by other co-employees. Whereas, if someone from the managerial level is affected by schizophrenia, the entire team bears the brunt of mismanagement and lowered work output; as a result of which the team
suffers without any anchor out of the situation.

The following are different areas of workplace compromised as a result of schizophrenia at workplace, that affect the individual, co-employees, employer and the organisation as a whole. This also translates to impacting the overall national economic output and productivity level.

1. **Challenges Related to Screening & Recruitment**

There is no particular type of job that is well suited for an individual with schizophrenia. The severity of the illness (which consequently determines the socio-occupational functioning of the individual) along with the interest levels and skill set of the individual determine if an individual will be capable of doing that job. The extent of disability differs from individual to individual and is positively correlated with the severity of illness [Al-Yahya, AH et al, 2011]. Some of the general accommodations made for people with mental health problems include providing them the comfort of workplace, allowing them to leave early the days they may feel a trigger, flexible working hours and allowance to do a job that may not push them too much in a zone of discomfort. Though there is no universal insurance for schizophrenia, there are some financial independent countries that do provide the same. Though there is an appeal for a global insurance coverage for schizophrenia, it awaits to come to implementation [Patel, V, 2015]. There are several countries, like India, that do not provide for formalised accommodations at the workplace for those starting their career.

2. **Impact of Absenteeism**

As the disability increases due to schizophrenia, it eventually culminates in absenteeism at the workplace. This threatens the job security of an individual and affects the overall productivity for an organisation. Hospitalisations and relapse of an illness are also major contributors for absenteeism. Absenteeism is also a challenge when retraining and social / occupational training is to be provided with those with schizophrenia in order to be able to maintain at the workplace. It is also crucial to consider that sometimes it may not be the illness itself but a comorbid condition that may lead to absenteeism. Alcoholism or substance dependence (47%), depression (50%), obsessive compulsive disorder (23%) and panic attacks (15%) are the commonly co-occurring mental conditions that may lead to absenteeism [Buckley, PF et al, 2008, Glozier N, 2002].

3. **Presenteeism and Related Troubles**

Contrary to the concept of absenteeism, presenteeism is when the employee suffering from schizophrenia maintains to come to work, however, the quality of work dwindles down severely, and productivity suffers. The work output of the employee drastically reduces nullifying his / her presence in office. Presenteeism may also involve troubles for the co-workers where the employee with schizophrenia may hamper work of the employees, disrupt working environment and have interpersonal disturbances at the workplace at all rungs of employment.

4. **Delusion Related to Co-Workers**

Though hallucinations and delusions may not interfere as much with the individual’s work, there are two instances when it severely hampers the occupational functioning of an individual at work. One, is when the severity if illness is high enough to impair work and two, if delusions are based with relation to their co-employees. Many individuals keep their idiosyncratic thoughts/beliefs to themselves, act fairly normally, and perform their job adequately. It is when their “issue” comes to the fore that the frank irrationality of their beliefs is apparent. Since delusions are irrational beliefs that are deeply entrenched, it is better to have the individual work in independent positions as far as possible and have minimal team
interaction as possible (in the case that it may irk them in any way). The managers and organisation may sometimes face problems in the case that accommodation may be difficult to be made.

5. Violence at The Workplace

Though the depiction of violence is stigmatic in association with mental illnesses, it is in evidence that people with mental illnesses may indulge in some bizarre and arbitrary acts of violence. There are controlled studies in arrested offenders, inpatients, outpatients, and families with a mentally ill member, epidemiological surveys, and longitudinal cohort studies all report a relationship between violence and schizophrenia [Arango, C, 2000]. One of the most common and predictable factors for violence in schizophrenia is a previous act of violent behaviour. Psychosis, apart from that, is another factor that may predispose to violence. Family history of violence, comorbid substance dependence and antisocial personality increase the susceptibility to unpredictable violent behaviour.

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<tr>
<th>Clinical predictors of violence in schizophrenic patients with exacerbation of psychotic symptoms [Arango, C, 2000]:</th>
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<tr>
<td>• Type and characteristics of delusions</td>
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<td>• Delusions causing fear and anguish</td>
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<td>• Persecutory delusions</td>
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<td>• Active seeking of information to confirm or refute the delusional belief</td>
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<td>• Systematization and conviction of the delusion</td>
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<td>• Quality of the hallucinations</td>
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<td>• Previous violence</td>
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<td>• Less insight into symptoms</td>
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<td>• Higher Positive And Negative Syndrome Scale (PANSS) general psychopathology scores</td>
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Another aspect of violence at the workplace involves- the employee with schizophrenia may disrupt the work of others in the phase of his positive symptoms, the employee may send emails in anguish or may even engage in unrequired conversations and outbursts of unpredicted anger.

Assessing violence risk in an individual case – its nature, severity, and likelihood – should always consider an analysis of the risk factors for workplace violence too.

6. Reintegration at the Workplace

Reintegrating individuals who have had psychoses, into the workforce, a number of factors are considered to be associated with good occupational outcomes. The fitness to work of someone after a first episode of illness remains unanswered in most cases. Studies of patients admitted for schizophrenia, evidences that those with predominantly negative symptoms are less likely to be employed [Glozier, N, 2002]. These symptoms undermine many of the attributes required to function in the workplace and can be
present even after the positive symptoms have responded to treatment.

7. Assessment of Schizophrenia and the Role of Human Resource Management Team

When an employee suffers from schizophrenia, the organisation and its team are also implicated in the process of screening and recruiting, accommodating at the workplace and reintegrating them back to work. Various tools of assessing the risk and severity of negative symptoms in schizophrenia can be used at the workplace, and some of them include:

- Clinical Global Impression scale (CGI)
- Brief Psychiatric Rating Scale (BPRS)
- Positive and Negative Syndrome Scale (PANSS)
- Scale for the Assessment of Negative Symptoms (SANS)
- 16-item Negative Symptoms Assessment (NSA-16)
- Schedule for Deficit Syndrome (SDS)

Additionally, newer instruments are in development—the Clinical Assessment Interview for Negative Symptoms (CAINS) and the Brief Negative Symptoms Scale (BNSS) [Kane, JM, 2013].

It must be the responsibility of the HR in the organisation to keep a tap of assessment and making sure that the individual/employee suffering from schizophrenia is provided with adequate on the job training, extra supportive training (if required) and that the individual receives sufficient accommodation to carry out work adequately. However, this scenario is ideal and not all organisations may be able to make available the aforementioned accommodations. Making therapeutic sessions available on the job if required or otherwise for cognitive remediation and social skills training also is a part of HR responsibility when there is knowledge about an employee suffering from schizophrenia.

Another aspect of the HR that must circumscribe within their realm of duty is that of having a mental health professional on board in order to assist professionally in times of crisis. Having the HR team trained in mental health is equally important for employee well being and larger organisational well-being as well. A panel of psychotherapists and psychiatrists is a crucial aspect of the HR that may play focal role to not just manage employees with schizophrenia but also assist them at the work, psycho-educate co-workers and keep the best of interest for employees and the organisation.

It is important to recognise that having seniors who support mental health problems at work makes a huge difference about making workplace more inclusive for people with mental illnesses.

8. Gender and Disparity of Stigma

Though there is no gender difference in the prevalence of schizophrenia, it is a documented fact that women’s mental health is associated with status in society [World Health Organisation, 2000], which puts women with mental illnesses, at a risk of greater stigma [Thara, R, et al, 2015]. There are interpersonal and social ramifications on their lives. Working women with schizophrenia face greater troubles because their burden of workplace gets added with burden at home. Their inability to deal with fundamental responsibilities at home and at work, puts them at greater risk of stigma not just for themselves but for the house as a whole (the children and family get affected). Separation and breakdown is reported to be higher for married women as compared to married men which impacts their overall life [Thara, R, et al, 2015].

There are few people who suffer from schizophrenia, but their work is not compromised. They continue to be productive at workplace with no complaints at the occupational front. However, it often goes unnoticed then but the family and closer interpersonal relationships including caregivers are the receiving end of the brunt of the illnesses. Schizophrenia is one of the severe mental illnesses that does have a loading on caregiver burden. Thus, though the workplace escapes the burden of the illnesses, caregiver burden at home becomes lopsided.

Role of Organisations Towards People with Schizophrenia

Every organisation has provisions for employee well-being. Employment provides five categories of psychological experience that promote mental well-being [Harnois, G et al]:

- time structure (an absence of time structure can be a major psychological burden)
- social contact
- collective effort and purpose (employment offers a social context outside the family)
- social identity (employment is an important element in defining oneself)
- regular activity (organising one’s daily life).

With regards to mental health, there may not be specifically laid out rules and provisions however, there are some organisations that do provide for accommodation for people with mental illnesses. Most accommodations in the workplace can be established with minimal or no cost. Accommodations call for some flexibility and creativity, and quick to place in the system.

Accommodations may include:

- Creating a supportive environment – It is critical for individuals with mental health conditions to work with colleagues and leadership who are positive, open, and welcoming.
- Removing workplace stressors – Working in an office or workspace that is quiet may be more comfortable and manageable.
- Adjusting the approach to supervising – It could be as simple as scheduling recurring one-on-one meetings to see how things are going.
- Flexible schedules – Flexible arrival and departure times also allow individuals to perform duties when they can be most productive.
- Providing opportunity to telework – Telework may be an option in circumstances where the physical presence may not be necessary.
- Counselling and Psychotherapeutic help should be made available as part of the HR in order to manage employees with schizophrenia when the time arises

Apart from accommodations, making a provision for insurance to cover the treatment of mental illnesses is one of the most crucial responsibilities of the stakeholders. Though available in some countries, insurance for treatment of mental illnesses stands back to receive the implementation it needs considering the growing burden of mental illnesses. India has been one of the countries who has never had formal insurance coverage though there are sections of various cultural societies that do provide partial coverage of insurance for mental illnesses. Most recently, the insurance Regulatory and Development Authority of India has rolled out a request act to all insurers to cover the treatment of mental illnesses equally to
physical illnesses.

**Mental Health Leave: To Grant or No?**

Paid leave for medical illnesses, maternity and paternity leave are a norm of every company/organisation. Considering the rampantly growing burden of mental illnesses, it is a dutiful consideration to raise the question if organisations should pass a bill for paid leaves for mental illness. Though, there are some organisations in the West that do allow ‘mental health days’ however, it is not a gazetted norm. It may be wise to consider mental health leaves as they may aid in retaining talent as more employees can successfully return to work after mental health-related leaves of absence. The millennial generation (generation Y) is an active proponent for the same and though many organisations have made mental health leaves as part of their legislation, it remains to be as uniform as leaves for medical illnesses / paternity or maternity leaves.

*Work is at the very core of contemporary life for most people, providing financial security, personal identity, and an opportunity to make a meaningful contribution to community life. It is important to make the workplace more comfortable and inclusive for people with mental ill health.*

**References**

Registered Offices

**Australia**
71 Cleeeland Street
Melbourne, Victoria, 3175
Australia

**UK**
Cheswold Park Hospital, Cheswold Lane, Doncaster, South Yorkshire, DN5 8AR

**USA**
545 N Wickham Road, Suite 110, Melbourne, Florida 32940
USA