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Social Support and Work Diseases in Working Population with Burnout Syndrome, Guadalajara, Mexico

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Abstract: Social support is closely related to the Burnout Syndrome, since it determines, in many cases, whether or not the person perceives their situation as stressful, manifesting in addition to the Burnout Syndrome any other alteration in their health.
Objective: to analyze the association that exists between social support and work-related illnesses in the working population that already manifests the burnout syndrome.
Method: the study was descriptive, cross-sectional and correlational in 1152 workers from different work activities. A questionnaire was applied with socio-demographic and labor themes, the Maslach Burnout Inventory scale and the modified Díaz Veiga Social Resources Inventory.
Results: the dimension of lack of personal fulfillment was the most affected, family social networks are low or bad. 47.6% reported, in addition to the syndrome, some discomfort or illness in the last six months such as upper respiratory diseases, gastrointestinal, metabolic, cardiovascular, musculoskeletal and psychological. The associations found between social support networks and the burnout syndrome show a significant negative association towards a low or poor support network, especially with the dimension of emotional exhaustion, with being sick and with some of the diseases such as gastrointestinal, metabolic, neurological, psychological and respiratory non-infectious diseases are also associated with a low or poor support network, with p values less than 0.05. Conclusion: Having the syndrome brings as a consequence, greater fatigue, bad or low support network and various occupational diseases. Intervening in positive psychosocial factors is an adequate strategy for the prevention of burnout.

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I. INTRODUCTION

According to the International Labor Organization (ILO), "work" is defined as a "set of human activities, paid or unpaid, that produce goods or servicesin an economy, or that meet the needs of a community or provide livelihoods necessary for individuals "(International Labor Organization, 2004). Work brings with it positive indicators towards the physical, mental and social health of the individual, but it can also get at negative consequences (Gutiérrez & Flores, 2015; Vera, Vélez & Córdoba, 2018) that were recognized by the appearance of the "Treaty of diseasesof artisans"by Bernardino Ramazzini in 1773 (Rodríguez & Menéndez, 2005), currently, his study acquires a growing importance.

In Mexico, the Federal Labor Law (LFT for its acronym in Spanish) conceptualizes occupational diseases as "any pathological state derived from the continued action of a cause that has its origin or motive at work or in the environment in which the worker is obliged to provide his services "(LFT, 2015; Franco, 2018), caused by one or multiple factors, which, in turn, can cause one or more diseases or injuries in people.

Within these occupational diseases is the Burnout Syndrome (psychological syndrome that implies a prolonged response to chronic interpersonal stressors at work), dividing it or grouping its signs and symptoms into three key dimensions: strenuous exhaustion, feeling of cynicism and detachment from work and a sense of ineffectiveness"(Maslach, 1993: 19-32). The syndrome is one of the health problems that has been the focus of attention by researchers in recent years (Ortiz, Gómez & García, 2015, Marecos& Moreno, 2018). It is important to remember that Gil Monte (2000) and Martos (2000) refer to burnout syndrome as a new pathology derived from chronic work stress.

What is relevant in this study is not only the knowledge of its prevalence, but the recognition of the repercussions that it entails on the physical, mental and social health of the subject who manifests it. Within some of these manifestations is labor dissatisfaction (Tipán, 2018), the increase of rotation of position or shift, absenteeism, resignations, low commitment to the company (Maslach, 2009, Flores &Ruíz, 2018), decrease in

the quality of life (Flores et al, 2013; Fabián & Smith, 2018); to cardiovascular diseases (Tovalin et al, 2012), other coronary diseases (Tamayo et al, 2018), musculoskeletal and psychological (Aranda et al, 2013), sleep disorders, gastrointestinal disorders and pain (Prado, Pérez &Saisó, 2015), neurosis, headaches, joint pains, menstrual alterations, anxiety and depression symptoms (Prado et al, 2014, Vera, Vélez &Córdova, 2018).

On the other hand, there is a variable known as "Social Support" that has a close relationship with the Burnout Syndrome and generally with work-related illnesses. This variable is defined as the interrelationships that occur between people, with behaviors that are also related to each other (Aranda, Pando &Rincón, 2009). As part of its history, already in the years 350 a. C., the social support was a necessity by its importance in the physical and psychological well-being of the people. Centuries later, scientific studies on the relationship of social support and social support networks with well-being are reported (Gracia, Herrero &Musitu, 1995, Vera, Vélez &Córdova, 2018); with suicide (Durkheim, 1897); with recovery in emotional balance at work (Gandarillas et al, 2014); depression, anxiety, sleep disorders, psychosomatic and mental disorders (Zamora & Cruz, 2012; Vera, Vélez &Córdova, 2018); well-being and self-esteem (Goncalves, Feldman & Guarino, 2013: Vera, Vélez &Córdova, 2018) and even, with affective and normative commitment towards the company in which they work (Calderón, Pedroza & Pando, 2015; Franco, 2018) ; however, studies have also been published that reveal the consequences of their deficiency: the perceived effects on health may be worse (Rocha et al, 2014), or more stressful (Gottlieb, 1983), or of greater riskfor the development of the syndrome (Burke et al, 2012, Fradelos et al, 2014, Galek et al, 2011, Gil-Monte, 2001, Jiménez, Jara&Celis, 2012, Rzeszutek&Schier, 2014, Sánchez et al, 2014: Marecos& Moreno, 2018).

Social support is intimately related to the Burnout Syndrome, since it determines, in many cases, that the person perceives or not their situation as stressful, also manifesting the burnout syndrome any other alteration in their health. The theoretical models focused on the framework of organizational theory are the ones that best support this (Gil-Monte &Peiró, 1997).

The objective of this work is to analyze the association that exists between social support and work-related illnesses in workers who already manifest the burnout syndrome.

II. MATERIAL AND METHODS

Type of study: The study was descriptive and transversal (García, 2004) because the phenomenon is analyzed in a short period of time and on a single occasion, and correlational (Abreu, 2012) because it is tried to measure the association and interaction between the variables of study.

Study population:A total of 1152 workers from different work centers were surveyed in Guadalajara, Mexico, among them family doctors from three public health institutions, representing 40.4% of the study population; workers of the state congress (18.6%) and electric train workers (39.6%) selected precisely for their economic and cultural diversity. Of these, 329 (28.7%) are women, the rest are men.

The minimum age reported was 17 years and the maximum age was 84, averaging 42.5 years. Most of the workers were married (71.9%), followed by singles (14.9%) and in free union (4.4%). The highest level of education, for some of the workers, was the specialty, master's or doctorate.

Evaluation instruments: Three instruments were applied for the evaluation. The first collected socio-demographic and labor data such as sex, age, marital status, level of education, shift, seniority in the institution and in the current position, workload, whether or not they had another job, as well as the items needed to evaluate whether or not you had any illness (s) and / or discomfort (s) in the past six months and what the illness (s) or discomfort (s) were. The second instrument, the Maslach Burnout Inventory-Human Services Survey scale (MBI-HSS), helped identify cases of burnout syndrome, and a third instrument, was used for the evaluation of social support networks, the Diaz Veiga scale modified by Aranda and Pando.

The scale of assessment of "Maslach Burnout Inventory (MBI-HSS) in its 22-item version (Maslach and Jackson SE, 1986) is conceptualized by three scales: 1. Emotional exhaustion (emotional variables), 2. Depersonalization (feelings of unreality), and 3. Low personal and work performance (demotivation) (Gil-Monte, 2002).

It is a likert scale, where 0 means never and 6 every day. The scores of the subjects for the MBI are rated based on the American norm and Catalan adaptation, where being at the low level is "no presence of burnout", while being at the medium and high level is "if presence of burnout", in each of the dimensions (Maslach and Jackson, 1986). The overall prevalence of burnout syndrome is obtained when the subject has at least one burned dimension (Aranda, Rendón and Ramos, 2011). With respect to the psychometric properties of the scale, it was validated by Aranda, Pando and Salazar (2016) in the Mexican population, in 1,958 subjects, obtaining Cronbach's alphas of .658 for the whole scale and 41.6% of variance explained; while, by dimensions, for Emotional Exhaustion the alpha was .835, in Depersonalization of .407 and in Lack of Realization of .733 (Aranda, Pando and Salazar, 2016). For the evaluation of social support networks outside work or family, as well as work, the Social Resources Inventory of Diaz Veiga modified by Aranda and Pando (2006) was used. The original inventory of Diaz Veiga (Barrón, 1996) only evaluates the family part, while in the modified labor

aspects are annexed. Finally, the modified inventory evaluates on the one hand the structural elements of social support, both family and work (frequency of contact with its support network, shaping the objective aspects of the network), as functional elements (satisfaction with its network of support, attending to the subjective aspects). To evaluate the family or extra-employment network, the scale is scored by adding the objective aspects of each of the interactions from which a score and a classification level (high, medium and low) are obtained, the subjective aspects are added, obtaining a score and a level. For the labor network, the same procedure is devaluating the interactions corresponding to the labor network. In addition, the instrument allows to make a total assessment, that is, to obtain a global prevalence. The scores of both non-labor and labor objective aspects are added and they are placed at a classification level. The same is done for the subjective aspects of both networks, extra-labor and labor. The purpose of this is to identify if the entire support network that the subject has is high or very good, medium or adequate and low or very bad. The internal consistency indices of the different subscales for said instrument reveal a reliability between 0.35 and 0.86 (Montorio, 1994).

Statistical analysis: We obtained frequencies, percentages, averages, prevalences, as well as tests of statistical significance taking into accounta risk factor (OR) greater than one, a Confidence Interval (CI) of 95% to know if it is true the difference and to detect the probability of observing differences, the value of p equal to or less than 0.05 (statistical significance). For the tabulation of data, the Statistical Package for Social Sciences (SPSS version 18) was used. The Spearman rank correlation test would be interpreted as a negative correlation if they occur within the values previously proposed.

Ethical aspects: The participants signed their participation voluntarily through the letter of informed consent, after informing them about the application of the instruments, but also explained that all information deposited as well as the dissemination of the results would be anonymous and that, at any time could be withdrawn of the study without causing any inconvenience. According to the regulation of the General Health Law on Health Research in its Article 17 (Official Gazette of the Federation, Mexico 1984), the present study is considered as risk-free, category one.

III. RESULTS

Of the 1152 workers surveyedwith burnout syndrome and in terms of work shift, the busiest was the morning (48.5%) followed by the shift varied (27.5%) and the evening (12.8%). The minimum working age and the seniority in the position was one month and the maximum of 42 (0.3%) and 36 (0.1%) years respectively. 46.1% of workers say they work 40 hours a week, followed by 30 hours (33.3%) and 35 hours (6%).

47.6% of workers with burnout syndrome had some other discomfort or disease different from the syndrome in the last six months, manifesting as flu, rhinitis, pharyngitis, tonsillitis, asthma, bronchitis, cough, colitis, enteritis, diarrhea, gastritis, ulcers, hyperlipidemia, obesity, diabetes, triglycerides, hypertension, hypotension, arrhythmias, angina, heart failure, back pain, sprains, tendinitis, fractures, muscle aches, rheumatism, headaches, migraines, parkinson, epilepsies, neurosis, sexual harassment (as annoyance) , stress, depression, exhaustion, insomnia, anxiety, fatigue, irritability, climacteric, mastopathies, menstrual disorders, prostatism, testicular pain, dengue, urinary tract discomfort, periodontal, kidney failure, kidney stones, cataracts, eyestrain, ear problems, buzzing, psoriasis.

To carry out the association analyzes, these discomforts and /or diseases were grouped into 16 groups of diseases (table 2). The groups of diseases with the highest prevalence or at least above 50% were: upper respiratory diseases, gastrointestinal, metabolic, cardiovascular, musculoskeletal and psychological diseases (table 2).

Of the workers with the syndrome, the dimension most affected was lack of realization (73.1%) followed by emotional exhaustion (27%) and finally depersonalization (23.5%), (table 3).

Regarding the variable of social support in workers with syndrome, it is observed that family social networks are low or bad, contrary to the support networks that workers receive and perceive at the labor level, where they tend to be high or medium, that is, from very good to adequate. However, by joining both networks, both family and work, these are not adequate, tending to low or bad support (table 4).

The associations found between social support networks and the burnout syndrome in workers who already have the syndrome show a significant negative association with a poor or low support network, especially with the emotional exhaustion dimension (OR 2.24, CI 1.70-2.92 and p = 0.00 (table 5) also, Table 5 shows that in people who already have the syndrome, being sick is significantly and negatively associated with a bad or low support network (OR = 1.66, CI = 1.27 -2-17 and p = 0.00) and that some of the gastrointestinal, metabolic, neurological, psychological and non-respiratory infectious diseases are also associated with low or poor support network (table 6) with p values lower than 0.05.

Table 1. Distribution of the population according to socio-demographic and labor data

Socio-demographic data		No.	%
Gender			
	Female	329	28.7
	Male	818	71.3
Age			
	Minimum 17 years	1	0.1
	Maximum 84 years	1	0.1
	Average 42.5 years		
Marital status			
	Married	823	71.9
	Single	171	14.9
	Widower	28	2.4
	Divorced	45	3.9
	Separate	27	2.4
	Free union	50	4.4
School level			
	Primary	115	10.3
Secundary		267	23.8
	High school or technical career	280	25.0
	Bachelor's degree	237	21.2
	Specialty, master's, doctorate	185	16.5
	Other	36	3.2
Turn			
	Morning	554	48.5
	Evening	146	12.8
	Night	74	6.5
	Accumulated work day	54	4.7
	Variate	314	27.5
Seniority in the institution			
Minumum 1 month		3	0.3
	Maximum 42 years	1	0.1
	Average 10.4 years		
Antiquity in the current position			
Minumum 1 month		1	0.1
	Maximum 36 years	1	0.1
	Average 14.5 years		
Workload			
	10 hours per week	2	0.4
	30 hours per week	162	33.3
	35 hours per week	29	6.0
	37 hours per week	22	4.6
	40 hours per week	222	46.1
	83 hours per week	1	0.2
	Average 36.2 hours		
Another Job			
	Yes	274	26.4
	No	762	73.6

Source: Author

Table 2. Prevalence obtained by disease groups in the 1152 workers with burnout syndrome

Diseasegroups	Frequency	%
Diseases of the upper respiratory tract	64	6.8
Diseases of the lower respiratory tract	3	0.3
Gastrointestinal	57	6.1
Metabolic	64	6.8
Cardiovascular	61	6.5
Muscular and skeletal	98	10.5
Neurological	35	3.7
Psychological	53	5.7
Gynecological	5	0.5
Andrological	1	0.1
Infectious non-respiratory	19	2.0
Dentistry	2	0.2
Unspecified	3	0.3
Renal	5	0.6
Organs of the senses	12	1.4
Dermatological	1	0.2

Source: Author

Table 3. Prevalence by dimensions according to the Maslach Burnout Inventory Scale (MBI-HS) in 1152 subjects with burnout syndrome

Rating level	Dimensions of the burnout syndrome					
	Emotionalexhaustion		Personal accomplishment		Depersonalization	
	Number	%	Number	%	Number	%
High	170	14.8	439	38.2	64	5.6
Medium	256	22.2	401	34.9	206	17.9
Low	726	63.0	309	26.9	881	76.5

Source: Author

Table 4. Prevalence according to the INAPOLF-AP Scale in 1152 subjects with burnout syndrome

Rating level	Social supportnetworks											
	Objectivefamilynetwork		Subjectivefamilynetwork		Objective labor network		Subjective labor network		Bothobjectivenetworks		Bothsubjectivenetworks	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
High	24	2.1	14	1.2	40	3.5	50	4.4	17	1.5	24	2.1
Medium	315	27.3	238	20.7	634	55.2	550	48.0	386	33.5	358	31.1
Low	813	70.6	900	78.1	475	41.3	546	47.6	749	65.0	770	66.8

Source: Author

Table 5. Only associations obtained according to dimensions of the syndrome and social support in the 1152 subjects with burnout

Dimensions of the burnout syndrome	Social support networks					
	Objective family network	Subjective family network	Objective labor network	Subjective labor network	Both objective networks	Both subjective networks
Emotional exhaustion	OR=2.23 CI=1.70-2.92 p= 0.00	OR=2.17 CI=1.62-2.92 p= 0.00	***	OR=2.41 CI=1.86-3.12 p= 0.00	OR=2.00 CI=1.5-2.60 p= 0.00	OR=3.03 CI=2.32-3.95 p= 0.00
Lack of	***	OR= 1.66	***	***	***	***

realization		CI= 1.20-2.30 p= 0.00				
Be sick	OR= 1.66 CI= 1.27-2.17 p= 0.00	OR= 1.91 CI= 1.42-2.58 p= 0.00		OR= 1.45 CI= 1.13-1.85 p= 0.00	OR= 1.51 CI= 1.17-1.96 p= 0.00	OR= 1.82 CI= 1.40-2.36 p= 0.00

Source: AuthorNote: *** non-significant results

Table 6. Associations obtained by Groups of diseases and Social Support in the 1152 subjects with burnout

	Social supportnetworks					
Groupsofdiseases	Objectivefamilynetwork	Subjectivefamilynetwork	Objective labor network	Subjective labor network	Bothobjectivenetworks	Bothsubjectivenetworks
Gastrointestinal	***	***	***	***	***	OR= 1.79 CI= 1.01-3.21 p= 0.0486
Metabolic	***	OR= 1.69 CI= 1.01-2.84 p= 0.0475	***	OR= 1.76 CI= 1.01-3.08 p= 0.0434	***	***
Neurological	OR= 2.50 CI= 1.20-5.22 p= 0.0110	***	***	OR= 2.52 CI= 1.16-5.58 p= 0.0163	OR= 2.08 CI= 1.01-4.34 p= 0.0471	***
Psychological	***	OR= 2.36 CI= 1.24-4.46 p= 0.0062	***	OR= 2.73 CI= 1.43-5.23 p= 0.0011	OR= 1.91 CI= 1.05-3.47 p= 0.0300	OR= 3.95 CI= 2.15-7.30 p= 0.0000
Infectious non-respiratory	***		OR= 6.11 CI= 1.44-54.8 p= 0.0120	***	***	OR= 2.69 CI= 1.06-6.92 p= 0.04

Source: AuthorNote: *** non-significantresults

IV. DISCUSSION

Authors such as De Vente et al (2003) state that more than 80 percent of the population reported complaints of chronic burnout (for more than six months) while similar figures reveal Avendaño et al (2009), however more current studies they reveal less worrisome results that range from 39% (Navarro, Ayechu&Huarte, 2014) to 17% (Vilà et al, 2015) and to almost the presence of 43% of the syndrome (Cadena et al, 2017).In the dimensions of the syndrome, Flores & Olivia (2018) appreciate a low level of emotional exhaustion and moderate in depersonalization and lack of personal fulfillment, indicating then that a moderate level in any of the three components of the burnout syndrome means that the workers manifest some behavioral, emotional, social or cognitive affectations. Similar data were reported in our study for the dimension of emotional exhaustion, but not for the lack of personal fulfillment and even less for depersonalization.

Marecos-Bogado& Moreno (2018) mention that only 19 percent of its population has levels of mild family dysfunction significantly related to Burnout syndrome; contrary to what Avendaño et al (2009) mention, where they state that 71.5% of their participants maintain levels of medium and high social support, and that "the perception of support received in general from co-workers and superiors, it has an influence on scoring differently in the dimensions of burnout", specifically depersonalization, where greater support less depersonalization. Comparing Jiménez, Jara& Miranda (2012), they report in their study high levels of social support, as well as a higher presence of burnout (in the group of teachers with burnout) lower level of support, whether it comes from the family, friends and others. Grossi et al. (2003), also show that in people who already have the syndrome or any of its dimensions, perceived social support is low,

However, the associations found between the diseases with the Burnout Syndrome, Lerman et al (1999) already mentioned that somatic diseases had a positive correlation with burnout; while Grossi et al (2003) showed that people with burnout syndrome maintain high rates of depression and anxiety, as well as sleep disturbances. Similar results are reported by Ahola et al (2005), where in addition to depression it also refers to association with dysthymia, and that, the probability of having a depressive disorder rises with the level of

burnout. Likewise, Ríos, Godoy & Sánchez (2011) find that the emotional exhaustion dimension is the one that significantly predicts the global presence of psychic discomfort, and particularly towards psychosomatic symptoms, anxiety and insomnia, while the symptoms depressives do it with the dimension of depersonalization. Caballero-Domínguez & González (2015) reveal a relationship between the syndrome with depression and anxiety, while García (2017) also finds a significant association between the syndrome with depression, anxiety and neuroticism. Marenco, Suárez & Palacio (2017)resolve that the emotional exhaustion dimension is related to depression, anxiety and psychoticism.

Another manifestation in the health of workers that has also been shown in people with burnout, is the elevation of heart rate, high systolic blood pressure at rest and high cortisol (De Vente et al, 2003), data that coincide with the study, since within the symptoms and /or illnesses that the workers reported were these same manifestations, but contrary to the exposed by Santana et al (2015) where the psychic wear was not associated with arterial hypertension.

Consequently, just as there is talk of psychosocial factors "negative for health", there are also around us and in any work area, a series of positive psychosocial factors "protective of health" important in the prevention of the syndrome. Zuluaga& Moreno (2012) make reference to "adequate coping strategies focused on the problem, important levels of self-efficacy, emotional control, locus of internal control and a mental state of engagement", decrease the development of burnout, likewise, the authors they emphasize the importance of "generating cognitive, emotional and behavioral tools from clinical practice for the generation of protective factors that reduce the risk in the face of highly debilitating work contexts". Teamwork and a good assessment by the bosses (Falgueras et al, 2015) would protect the worker from burnout.

According to Frögéli et al (2015) an adequate strategy to prevent burnout is acceptance and commitment therapy, which consists of avoiding stressful or negative thoughts that prevent problems from being resolved. Just as the study of psychosocial factors can be studied and analyzed from the point of view generated, they must also be seen from the positive psychosocial side, that is, those that do not harm health. Adopting this alternative can be a suitable strategy for both the prevention of burnout and mediate intervention. In addition, occupational health helps, by improving working conditions, in the promotion and prevention of occupational diseases and accidents, as well as in the quality of life of the worker.

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