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Humor styles and psychosocial working conditions in relation to occupational burnout among doctors

Medical professionals are an occupational group at a particularly high risk for job burnout. The aim of the study was to determine relationships between humor styles and psychosocial working conditions on the one hand and occupational burnout in the medical profession on the other. Participants in the study were 82 professionally active doctors, interviewed and examined using questionnaire methods: the Maslach Burnout Inventory, Humor Styles Questionnaire, and the Psychosocial Working Conditions instrument. The results show that occupational burnout is a serious problem among medical doctors, even those with a short work history. Difficult psychosocial working conditions enhance the occupational burnout symptoms. Moreover, higher severity of burnout symptoms correlates with lower support from superiors and with less frequent utilization of adaptive humor styles: self-enhancing and affiliative. Therefore, it is worthwhile to develop programs of burnout prevention for medical professionals, with an emphasis on social skills training, and to enlarge such resources as support at workplace and humor utilization skills.

Keywords: *sense of humor, humor style, occupational burnout, psychosocial working conditions, doctors*

Introduction

Occupational burnout is defined as a cluster of psychological symptoms in response to long-term stress resulting from professional contacts with other people (Maslach, 2004). This syndrome particularly affects occupational groups characterized by highly emotional relationships and a high professionalism of services provided (Rutter, Herzberg & Paice, 2002). Undoubtedly then, the occupational group of doctors meets the two essential criteria in the relation with the patient, i.e. consumer of the health care services.

Psychosocial working conditions seem to be especially difficult in the medical profession. Doctors often feel overburdened with the amount of work, and with the number of contacts with their patients. High professional requirements, responsibility for human life and health, as well as patients' behaviors, often destructive, are detrimental to job satisfaction and became the cause of occupational stress. In consequence, the risk of job burnout is increased in this group (cf. Anczewska, 2006; Van Dierendonck, Schaufeli & Sixma, 2004). However, studies conducted in Poland rather seldom deal with doctors, but are focused rather on the auxiliary medical staff (cf. Anczewska, 2006; Cieślak & Widerszal-Bazyl, 2000).

Prolonged stress (resulting from e.g. overworking, shift system, night duties) seems to be particularly dangerous, since such stressors gradually and systematically exhaust the individual's resilience resources, and are perceived as the most oppressive ones. In the context of the phenomenon under study it is not unimportant that social perception of the medical profession has changed in recent years – it is associated above all with doctors' acting in self-interest, occupational prestige devaluation, and a popular belief that hospitalization is a luxury that should be additionally paid for (cf. Ogińska-Bulik & Kaflik-Pieróg, 2006). In the light of these considerations it is interesting that doctors tend to underrate the risk of job burnout and to overrate their own skills. Moreover, their characteristic coping skills include support seeking, escaping into professional development, passive leisure, and frequent use of psychoactive substances (Anczewska, 2006; Maslach, Schaufeli & Leiter, 2001).

Three key dimensions of occupational burnout are distinguished: emotional exhaustion, depersonalization

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and diminished personal accomplishment (Maslach et al., 2001). Emotional exhaustion denotes a sense of being overburdened that is accompanied by a considerable depletion of the individual's emotional and physical resources. This component is most strongly related to such workplace stressors as overworking, lack of social support or difficulties in the occupational role fulfillment (Van Dierendonck et al., 2004).

Depersonalization (or cynicism) pertains to negative, callous or overly indifferent attitudes towards various aspects of work. This includes keeping the patient at a distance, e.g. by active neglect for such values as treating patients with kindness and concern. Depersonalization is a kind of defense mechanism protecting the doctor against a sense of loss and a disproportion (detrimental to him) between efforts invested and actual outcomes. However, it is this keeping-at-a-distance and callous attitude towards the patient that often strengthens the doctor's sense of being abused or harassed by a real increase in demanding behaviors of his patients (Van Dierendonck et al., 2004).

Diminished personal accomplishment refers to a sense of incompetence as well as to reduced achievements and productivity at work. Attempts at compensation for this state lead to increased self-demands, longer working hours and greater work effort. Such attempts result in a temporary improvement of achievements, but at the same time contribute to a decrease in the individual's efficiency and to overworking. The latter in turn increase the risk of committing errors and negligence at work in the future. A long-term effect of such behaviors consists in a further lowering of self-esteem and aggravation of occupational burnout symptoms.

Occupational burnout leads to mental health deterioration, reduced effectiveness of coping with stress, and to a number of such behaviors as absenteeism or a wish to change or quit employment. In the case of people who decide to continue their career, burnout leads to a reduced effectiveness and productivity. This phenomenon seems to be particularly dangerous in the medical profession since it puts the patient's life and health at risk.

It seems therefore worthwhile to seek factors reducing the risk of occupational burnout. On the one hand, individual factors can be distinguished there, such as e.g. sense of coherence, self-efficacy, optimism, or sense of humor investigated in this study. They may be regarded as the individual's resources in confrontation with daily life stressors. Thus, they contribute to a more effective coping with stress, also occupational stress. On the other hand, there are environmental factors (considered to be social resources), including, among other ones, psychosocial working conditions and social support, especially that provided by co-workers and superiors.

Sense of humor seems to deserve special attention as a resource. It is a multidimensional construct in which a number of components can be distinguished: cognitive, emotional, behavioral, physiological, and social (Martin, 2000). Sense of humor can be defined as a relatively stable personality characteristic - to some extent independent of the continually changing situational context and the individual's inner state - that may serve to explain the observed regularities and consistence of his/her behavior. It is manifested also in a general tendency to engage in situations whose immanent feature is inconsistency. The essence of sense of humor is to perceive and explain discrepancies inherent in stimuli (cf. Radomska, 2002).

Considering sense of humor as a personality trait allows to distinguish the so-called humor style, i.e. the individual's way of utilizing humor in everyday life. Four humor styles have been described:

- affiliative style, connected not only with affirmation of self and others, but also with a tendency to amuse other people and reduce interpersonal tensions; displaying this humor style the doctor may be telling jokes or funny stories to improve his interlocutor's mood or communication in the patient-doctor or doctor-medical staff relationships;
- self-enhancing style, being first and foremost a coping strategy that allows to maintain a positive self-perception in stressful situations; this style is manifested by keeping at a healthy distance from negative or demanding events; a person utilizing this style is sensitive to funny, nonsensical or paradoxical aspects of daily life – owing to this humoristic approach to life the individual thus avoids unnecessary irritation and worrying;
- aggressive style, aimed at using and manipulating other people; a person utilizing this style is often perceived as someone sarcastic, attacking others and holding them up to ridicule in a way only seemingly amusing; a doctor with this humor style does not spare other people's feelings and frequently uses humor inappropriately to the situation, e.g. when informing about an unfavorable diagnosis, at the time of a sudden decision-making by the therapeutic team, or when talking to an apprehansive patient or his family;
- self-defeating style, manifested in self-deprecatory remarks, self-mockery, exposing one's weaknesses or demeaning abilities and competences in order to win other people's acceptance at any price, even at one's own expense (cf. Kazarian & Martin, 2004; Martin, 2004; Radomska, Filipek & Sobiecka, 2007).

It should be noted that affiliative and self-enhancing styles are regarded as adaptive or constructive humor styles that seem to optimize the individual's functioning, while both aggressive and self-defeating styles are considered to be maladaptive, contributing to destructive coping with daily life situations and to experiencing negative emotions (cf. Çeçen, 2007; Radomska et al., 2007).

Recent research findings concerning sense of humor as a factor that facilitates coping with daily life problems seem to be especially interesting. Persons with a sense of humor tend to appraise stressors as a challenge (Kuiper & Olinger, 1998, cited after: Kuiper, Grimshaw, Leite & Kirsh, 2004), have better social relationships and stronger support networks (Martin, 2001), and when faced with difficulties can maintain a positive self-image and a high assessment of their competences (Lehman, Burke, Martin, Sultan & Czech, 2001). Besides, sense of humor seems to reduce anxiety or depression levels (Kuiper et al., 2004). Some studies evidenced a positive effect of humor on both mental and physical health (e.g. by raising the pain threshold, stimulating endorphin release, increasing immunocompetence, or reducing catecholamine and cortisol levels). However, the reported relationships frequently turned out to be weak or ambiguous, most probably due to the fact that the quality of humor had not been controlled (cf. Martin, 2004; Radomska, 2002, 2007).

Since the way of humor utilization should be controlled, in what follows humor style shall be in the focus of the study, being a concept narrower than the general construct of sense of humor.

Research conducted to date suggests that particular humor styles are significantly related to subjective health, satisfaction with social relations, experiencing positive emotions, or coping with daily hassles. Namely, affiliative and self-enhancing styles contribute to effective coping with stress, satisfactory social relations, and interpersonal conflict reduction. They are associated with openness, cheerful disposition, positive self-image, and striving for novel experiences. Moreover, as compared to the remaining two maladaptive styles, they are connected with lower anxiety and depression levels (cf. Çeçen, 2007; Kazarian & Martin, 2004). Therefore, it seems that the affiliative humor style should contribute to optimization of the doctor-patient relationship, as it may serve as a buffer against treating patients like objects and against frustration resulting from this type of contact.

Individuals utilizing maladaptive humor styles (i.e. aggressive and self-defeating humor) in daily life are characterized by higher neuroticism levels, low openness, rather unfavorable self-perception, they experience more negative emotions, and have less satisfactory social relations (cf. Saroglou & Scariot, 2002).

Summarizing, adaptive humor styles can be expected to significantly reduce the risk of the onset of particular occupational burnout components in a group of medical professionals, as well as the risk of burnout consequences both for the doctor and the patient.

Objectives

The aim of the study was to determine relationships between humor styles and psychosocial working conditions on the one hand and occupational burnout on the other hand among doctors.

Material and Methods

The cross-sectional study was conducted in the region of Silesia in 2006. Participants were 82 professionally active medical doctors (34 men and 48 women aged 25-67, mean age 36.6 years, *SD* = 8.13), working directly with patients.

They were examined using interview and questionnaire methods serving to collect data that describe the medical profession specificity (e.g. the grade and type of medical specialty, number of out-of-hours duties, type of medical facility). Moreover, the following instruments were used:

The *Maslach Burnout Inventory* (MBI) in the Polish adaptation by T. Pasikowski (Maslach, Jackson & Leiter, 1996; Pasikowski, 2004) for measuring the risk for occupational burnout. The MBI consists of 22 items assessed on a 7-point rating scale and allows to determine the risk of occupational burnout in terms of emotional exhaustion, depersonalization, and a sense of diminished personal accomplishments. A high score on the first two subscales denotes a higher risk of occupational burnout, while the higher is the score on the personal accomplishments scale, the better is the respondent's professional functioning and the lower risk of his/her burnout. The Cronbach α reliability coefficients for the MBI subscales ranged in this study from 0.63 to 0.87.

The *Psychosocial Working Conditions* (PWP, *Psychospołeczne Warunki Pracy)* questionnaire developed by M. Widerszal-Bazyl and R. Cieślak (Cieślak & Widerszal-Bazyl, 2000) served to characterize the doctors' working conditions. The following scales and subscales of the instrument were used in the study: a 25-item demand scale (with subscales of demands: intellectual, psychophysical, resulting from responsibility for safety, associated with the role conflictivity and overburdening); a 20-item scale of social support (with subscales of support provided by: superiors and co-workers); a 16-item scale of desirable changes. The PWP well-being scale was not used in the study. Respondents are asked to estimate each item on a 5-point rating scale; high scores denote a high level of a given work characteristic. The Cronbach α reliability coefficients for the PWP questionnaire subscales ranged in this study from 0.62 (for the role conflictivity and overburdening subscale) to 0.93 (for the support from superiors subscale).

The *Humor Styles Questionnaire (*HSQ*)* (Martin, Puhlik-Doris, Larsen, Gray & Weir, 2003) in the Polish adaptation by A. Radomska, M. Filipek and J. Sobiecka

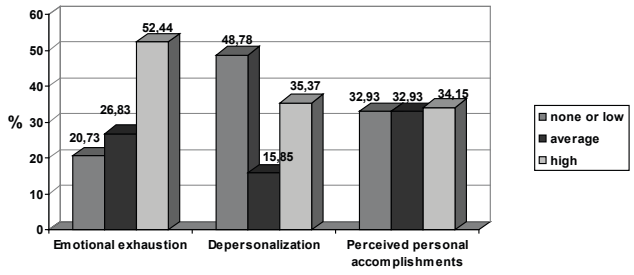

Figure 1. Occupational burnout levels among medical doctors (N = 82).

was used to investigate humor styles. The HSQ contains 28 items divided into four scales of 7 items each. The scales allow to assess particular humor styles (affiliative, self-enhancing, aggressive and self-defeating). Using a 7-point Likert-type rating scale respondents indicate the degree to which they agree with each of the statements. High scores denote a high level of a given humor style. The Cronbach α reliability coefficients for the Polish version of the HSQ ranged from 0.66 (for the self-enhancing humor style) to 0.79 (for the affiliative humor style) (Radomska et al., 2007).

Results

In the group under study 57.5% of the doctors were specialists, while the remaining 42.5% were in the course of their postgraduate medical specialty training. Surgical specialties were represented by surgeons and orthopedists (44% of the sample), while medical specialties included internists, psychiatrists, family doctors, and oncologists (56%). Their mean length of employment in the profession was 10.87 years (min. = 2; max. = 44; *SD* = 8.59). The participants worked on the average 55.25 hours per week (min. = 38; max. = 84) and had 4 out-of-hours duties per month (*M* = 4.32; min. = 0; max. = 14). On the average, each doctor was in charge of 22 patients at the same time (*M* = 21.66; min. = 7; max. = 60).

A very high percentage of the doctors were found to score in a way indicating at least an average level of occupational burnout (Fig. 1). Burnout scores were trichotomized with one-half of a standard deviation above and below the mean as cut points; thus three intervals of burnout scores were obtained: low, average, and high.

Severe occupational burnout symptoms were noted most often in the dimension of emotional exhaustion (in 79.27% of cases), and to a somewhat lesser degree in the dimension of self-perceived diminished personal accomplishments (in 67.08% of the respondents). As regards depersonalization, an at least average level of this burnout component was found in 51.22% of the doctors. Specialists and doctors in training did not differ in respect of any of the occupational burnout dimensions. However, men as compared to women were found to have a significantly higher level of self-perceived personal accomplishments ($t_{(80)}$ = -1.93; p<0.05) (see Table 1).

The main aim of the study was to seek relationships between humor styles, psychosocial working conditions and occupational burnout. Results of analysis of intercorrelations between the investigated variables are presented in Table 2.

Among the obtained data the negative correlations of depersonalization with both the length of employment (r_P = -0.25; p < 0.05) and the number of duties per month (r_P = -0.23; p < 0.05) seem to be particularly interesting.

Stepwise regression analysis was performed to determine which of the factors under study are of importance symptom severity in particular dimensions of occupational burnout. In the first step humor styles were introduced, in the second step – psychosocial working conditions, and in the third – length of employment in the medical profession. Table 3 shows the regression analysis results for emotional exhaustion.

The variables introduced in the analysis explain 55% of variance in the emotional exhaustion symptoms severity. In this model self-enhancing humor style and support from superiors turned out to be the most important predictors – the higher was the intensity of these two factors, the lower occupational burnout level. It should be noted also that both self-defeating humor style and demands resulting from the role conflictivity and overburdening had a detrimental effect. On the other hand, intellectual demands seem to serve a function protecting against emotional exhaustion. Results of regression analysis for depersonalization are presented in Table 4.

Table 1
Occupational burnout severity among doctors by gender.

Occupational burnout dimensions	Doctors– total (n = 82)		Men (n = 34)		Women (n = 48)		Levene's F test	t
	M	*SD*	*M*	*SD*	*M*	*SD*		
Emotional exhaustion	27.84	12.20	26.19	11.68	28.61	12.45	0.17	0.83
Depersonalization	10.20	7.60	10.62	7.65	10.00	7.64	0.16	-0.34
Self-perceived personal accomplishments[a]	33.62	6.86	35.73	6.93	32.64	6.67	0.22	-1.93*

Note:
[a] a high score on the self-perceived personal accomplishments scale denotes a low level of occupational burnout
* p < 0.05

Table 2
Correlations of humor styles, psychosocial working conditions, and length of employment with occupational burnout.

Variable	Occupational burnout		
	Emotional exhaustion	Depersonalization	Perceived personal accomplishments[a]
Affiliative humor	-0.24*	-0.16	0.24*
Self-enhancing humor	-0.32**	-0.23*	0.29**
Aggressive humor	0.20	0.29*	-0.12
Self-defeating humor	0.09	0.16	-0.02
Number of working hours per week	0.18	0.32**	0.09
Number of duties per month	-0.09	-0.23*	-0.05
Number of patients	0.42**	0.44**	-0.04
Intellectual demands	-0.18	-0.18	0.26*
Demands – role conflictivity and overburdening	0.37***	0.41***	-0.12
Psychophysical demands and responsibility	-0.01	-0.19*	0.11
Cognitive control	-0.41***	-0.31**	0.35***
Behavioral control	-0.25*	-0.28*	0.22*
Desire for change at workplace	0.43**	0.26*	-0.20
Support from superiors	-0.43***	-0.16	0.21*
Support from co-workers	-0.29**	-0.05	0.26*
Support from close friends and family	-0.21	-0.06	0.25*
Length of employment	-0.09	-0.25*	0.04

Note:
[a] a high score on the self-perceived personal accomplishments scale denotes a low level of occupational burnout
N = 82
* p<0.05; ** p<0.01; *** p<0.001

Table 3
Results of stepwise regression analysis – emotional exhaustion regressed on humor styles, psychosocial working conditions and length of employment among doctors.

Variable	R^2	ΔR^2	β	F
Self-enhancing humor	0.25	0.25	-0.45***	9.69***
Self-defeating humor			0.27***	
Number of patients	0.58	0.33	0.20*	12.73***
Demands – role conflicitvity and overburdening			0.32**	
Intellectual demands			-0.30***	
Support from superiors			-0.38***	
Length of employment	0.60	0.02	-0.16	11.71***
Adjusted R^2 = 0.55				

Note:
N = 82
* p<0.05; ** p<0.01; *** p<0.001

The introduced variables explained 49% of variance in depersonalization symptoms severity in the group of medical doctors. A number of variables turned out to have the most pronounced effect, namely: demands related to the role conflictivity and overburdening (the higher, the more severe depersonalization), affiliative humor style, and psychophysical demands as well as these connected with responsibility for safety (the higher intensity of these factors, the lower was cynicism level). Among other factors significantly contributing to depersonalization the number of patients in the doctor's charge, and aggressive humor style should be mentioned.

And finally, as regards the dimension of self –perceived personal accomplishments, the variables introduced in the model explained 34% of variance (Table 5).

The results suggest that a high level of intellectual demands, the individual's cognitive control, a high level of support provided both by superiors and co-workers, and self-enhancing humor style have an important role of protecting against occupational burnout symptoms. On the

Table 4
Results of stepwise regression analysis – depersonalization regressed on humor styles, psychosocial working conditions and length of employment among doctors.

Variable	R^2	ΔR^2	β	F
Affiliative humor	0.13	0.13	-0.35*	2.12*
Self-enhancing humor			-0.07	
Aggressive humor			0.21*	
Self-defeating humor			0.09	
Number of patients	0.54	0.41	0.23*	6.86***
Demands – role conflictivity and overburdening			0.36*	
Psychophysical demands and responsibility			-0.26*	
Cognitive control			-0.16	
Number of working hours per week			0.12	
Length of employment	0.57	0.03	-0.19	6.81***
Adjusted $R^2 = 0.49$				

Note:
$N = 82$
* p<0.05; ** p<0.01; *** p<0.001

Table 5
Results of stepwise regression analysis - self-perceived personal accomplishments[a] regressed on humor styles, psychosocial working conditions and length of employment among doctors.

Variable	R^2	ΔR^2	β	F
Self-enhancing humor	0.13	0.13	0.40**	2.96*
Aggressive humor			-0.22	
Self-defeating humor			-0.15	
Cognitive control	0.44	0.31	0.41**	5.17***
Intellectual demands			0.55***	
Psychophysical demands and responsibility			-0.50**	
Support from co-workers			0.41**	
Support from superiors			0.41*	
Length of employment	0.44	0.00	0.02	4.51***
Adjusted $R^2 = 0.34$				

Note:
$N = 82$
* p<0.05; ** p<0.01; *** p<0.001
[a] a high score on the self-perceived personal accomplishments scale denotes a low level of occupational burnout

other hand, high levels of psychophysical demands and of requirements associated with responsibility for other people's safety contribute to a diminished sense of personal accomplishments.

Discussion

The obtained results confirm that occupational burnout is common among medical professionals, including junior doctors who have just begun their professional career. This observation is consistent with other research findings reported from other countries where also a high prevalence of burnout was noted among doctors in the course of their specialty training (cf. Thomas, 2004). The phenomenon can be explained by the very strident and increasing demands confronting young doctors, who at the same time receive low remuneration and meet with difficulties in carrying out the specialty training program.

Although burnout symptoms were relatively the least severe as regards depersonalization, this problem still affected a half of the sample. It should be noted that depersonalization is the burnout dimension most painful for the patients. Since emotional exhaustion (the most frequent symptom in our study) very often leads to depersonalization enhancement (cf. Van Dierendonck et al. 2004), more attention should be paid both to prevention research and prevention programs targeted at doctors. However, in the research into the doctor-patient relationship the focus is on the needs and problems of the latter.

The study results indicate that men have a significantly higher sense of personal accomplishments, which may be explained by the fact that as compared to women they have definitely greater possibilities of professional development. It is men who are more often appointed to supervisory positions, have more out-of-hours duties and better chances in specialty choice, particularly as regards surgical specialties. On the other hand, in a study conducted among faculty members Tümkaya (2006) found that women manifested emotional exhaustion symptoms more frequently than did men. These disproportions suggest that it is women who should be the foremost target for self-esteem boosting interventions and stress management programs.

A significant relationship between humor styles and occupational burnout was confirmed in the study. Self-enhancing humor style contributing to lower levels of burnout symptoms turned out to be especially important. The protective effect of this humor style consists probably in looking for positive aspects of even most difficult situations. In consequence, such events are not experienced as too oppressive and overwhelming (cf. Çeçen, 2007; Kazarian & Martin, 2004). As regards affiliative humor style, its protective effect on the depersonalization dimension most likely involves tension release in relations with other people. Similar findings were reported by Talbot and Lumden (2000) – according to the authors, utilization of sense of humor as a strategy of coping with stress leads to a reduction of depersonalization levels. On the other hand, aggressive style contributes to depersonalization enhancement by increasing interpersonal tensions. These results were corroborated by other studies (Dorz, Novara, Sica & Sanavio, 2003), in which sense of humor as a coping strategy was positively correlated with emotional exhaustion and depersonalization. These correlations were interpreted by the cited authors as due to the fact that the items of the scale used in their study pertained to making fun of the situation and turning it into a joke. Thus, it seems possible that individuals who experience burnout more often use the so-called "black humor".

As regards psychosocial working conditions, the study confirmed the effect of stringent demands connected with overburdening and role conflictivity on aggravated burnout symptoms among doctors. This effect had been emphasized earlier by other authors (cf. Ogińska-Bulik, 2006; Van Dierendonck et al., 2004). Another effect evidenced in our study seems interesting, namely, the protective influence of intellectual demands on occupational burnout. If the demands do not exceed the doctors' capabilities, perhaps they may stimulate their personal and professional development and contribute to greater job satisfaction. On the other hand, the negative effect of demands associated with psychophysical overburdening and responsibility on self-perceived personal accomplishments may be explained in terms of both tiredness and lack of satisfaction resulting from limited resources necessary for the fulfillment of responsibilities. Medical professionals in Poland are often faced with the necessity of limiting their intervention to the cheapest treatment options, since due to economic or legal reasons they cannot use the full range of treatment methods. This situation precludes them from using their medical skills to the full, and any attempts at acting otherwise expose them to criticism from their supervisors.

The protective effect of demands associated with responsibility on depersonalization noted in the study may be due to a closer doctor-patient relationship necessitated by the circumstances of a systemic limitation of treatment methods. When the possibilities of additional diagnostic tests are limited and patients' claims are increasing, the risk of committing a professional error leads to a more salient role of interview and physical examination in the diagnostic process, i.e. of the elements implicating the doctor's direct contact with the patient. The effect of a larger number of out-of-hours duties on lower depersonalization level found in the present study may be interpreted likewise. Doctors on duty have to be more self-dependent, there can be no responsibility, and thus they have to devote more attention to the patients and their problems.

In turn, the negative correlation between length of employment and depersonalization may result from the acquirement of greater interpersonal skills and ability of distancing from negative patient attitudes by more experienced doctors. Moreover, greater professional authority of doctors with longer history of employment may be also of some importance in this respect, since they may be perceived by the patients as more trustworthy. It should be noted that in Poland the issues of interpersonal communication and relations are still included to a very small degree only in the curricula of medical studies and postgraduate specialty training programs, although the necessity for these problems inclusion is often emphasized.

A highly significant effect of support received at the workplace, diminishing the risk of occupational burnout was found in the study. The protective role of support was stressed by many authors. Van Dierendonck and collaborators (2004) indicated that social support was a variable mediating between the feeling of being harassed by the patients and doctors' emotional exhaustion. From the occupational burnout perspective the support provided at the workplace, both by supervisors and co-workers, seems to be of pivotal importance (cf. Lindblom, Linton, Fedeli & Bryngelsson, 2006). Support constitutes this area of psychosocial working conditions that depends to a large extent on doctors themselves. Thus, taking care of good relations with one's colleagues and supervisors, developing one's interpersonal skills, contributing to a friendly atmosphere at work should become one of major tasks in the medical profession.

Considering sense of humor and social support to be valuable resources allowing the individual to cope with workplace stress more effectively, we should like to refer to the conservation of resources theory by S. Hobfoll (2006). According to the theory, people who have more resources have a better chance for attaining further profits. The skill of utilizing and enlarging one's resources, particularly those depending to a large degree on the doctors themselves, seems to be important in this context.

Conclusions

The presented results indicate that occupational burnout is a serious problem in the medical profession, also among junior doctors. Difficult psychosocial working conditions contribute to an aggravation of occupational burnout symptoms, therefore possibilities of introducing real changes in the organization of doctors' work should be investigated. Besides systemic changes in the medical profession also individual doctors' possibilities of improving their professional situation seem to be important. Particular attention should be paid to the protective role of support provided by supervisors and co-workers that counteracts the onset of burnout symptoms. Our study evidenced also a possibility of sense of humor utilization as a resource allowing to cope better with difficulties at the workplace and to reduce the risk of burnout.

Therefore, it seems worthwhile to develop occupational burnout prevention programs for doctors, with a special emphasis on social skills training and on enhancement of such resources as workplace support and adaptive humor styles utilization.

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