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BURNOUT IN OCCUPATIONAL THERAPY: AN ANALYSIS FOCUSED ON THE LEVEL OF INDIVIDUAL AND ORGANIZATIONAL CONSEQUENCES

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Following transactional models of burnout (Cherniss, 1980; Moreno-Jiménez, González-Gutiérrez & Garrosa, 2001), this paper examines the dimensions of burnout in occupational therapy, together with the organizational and job sources of the syndrome, associated with the different consequences reported in the literature. A sample of 110 occupational therapists working in the Madrid Autonomous Region were asked to fill out a written questionnaire. Hierarchical multiple regression analysis revealed highly significant associations between the syndrome and adverse consequences for the individual's health and interpersonal field and for the organization itself. Emotional exhaustion was found to be the most relevant burnout dimension. In addition, the study revealed the explanatory relevance of problems from outside that affect the work context, together with a number of other relevant factors that may act through burnout, such as work overload, task characteristics, lack of support and recognition from colleagues, and fear of malpractice.

De acuerdo con los modelos teóricos que llaman la atención sobre la consideración del burnout como un proceso transaccional entre la persona y el medio laboral (Cherniss, 1980; Moreno-Jiménez, González-Gutiérrez y Garrosa, 2001), el presente trabajo examina las dimensiones de desgaste profesional que, junto con los factores antecedentes organizacionales y profesionales del síndrome específicas de la profesión de Terapia Ocupacional, se encuentran asociadas a los diferentes niveles de consecuencias planteadas en la literatura sobre el síndrome. Para ello se empleó una muestra de 110 terapeutas ocupacionales que desempeñan su actividad clínica en la Comunidad Autónoma de Madrid. A través del desarrollo de un análisis de regresión jerárquica se ha observado la existencia de asociaciones altamente significativas entre el síndrome y la presencia de consecuencias adversas para la salud del individuo, así como para su área interpersonal y para la propia organización en la que desarrolla su actividad laboral, siendo el agotamiento emocional la dimensión más asociada a las mismas. Junto a ello, se ha identificado la relevancia explicativa de los problemas extralaborales que afectan al área laboral, así como de otros factores que podrían actuar a través de la generación de desgaste, como son la sobrecarga de trabajo, las características de la tarea, la falta de apoyo y reconocimiento por parte del equipo, y el miedo a la malpráctica.

INTRODUCTION

The first references to burnout syndrome appeared in the 1970s, when it began to be conceived as a problem characteristic of the caring professions (Freudenberger, 1974). However, a widely accepted operational definition was not achieved until 1981, the year in which Maslach and Jackson developed the Maslach Burnout Inventory (MBI) and defined burnout as an inadequate response to chronic occupational stress with three characteristic dimensions: emotional exhaustion, depersonalization and (lack of) personal fulfilment.

Despite theoretical refinement of the concept, there is currently no unanimously agreed definition of burnout. Even so, it is becoming more and more common to conceptualize it as a process that develops over time (Burke & Richardsen, 1996), and to approach it as a mechanism of coping with work stress involving several phases within its development (Rodríguez Marín, 1995; Gil-Monte & Peiró, 1997).

On top of this view of the syndrome has come its conceptualization as a transactional process between the characteristics of the work environment and those of a personal nature (Cherniss, 1980; Moreno-Jiménez, González-Gutiérrez & Garrosa, 2001), a process that can in the medium to long term give rise to a wide spectrum of negative consequences. These consequences can

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emerge at an individual level, with physical repercussions (chronic fatigue, headaches, muscular pain, insomnia, hypertension, etc.) or cognitive-emotional ones (feelings of helplessness, of failure or of anxiety; difficulties to concentrate or make decisions); at an organizational level (absenteeism, lack of continuity in posts, deterioration of service quality, etc.); and at a socio-family level (deterioration of interpersonal relations, increase in family problems, and so on).

These types of consequence are especially relevant in the area of healthcare, given the repercussions they may have on the quality of attention to patients (Moreno-Jiménez & Peñacoba, 1999). Furthermore, the healthcare context has been identified as one of particular risk for the appearance of the syndrome, due in large part to the emotional demands linked to working with patients (Maslach & Jackson, 1982; Deckard, Meterko & Field, 1994).

Despite the increasing attention paid to the different professions with the spectrum of health sciences, however, burnout in occupational therapy is still poorly represented at an empirical and bibliographical level.

Occupational therapists are healthcare professionals who, through the use of goal-related and scientifically guided occupation, attempt to make participation the key to the achievement of maximum levels of health, well-being and independence for the individual. The work conditions in which occupational therapists have to operate are varied, and sometimes inadequate, due perhaps to the profession's relatively short history, and this may explain why their functions are not widely known and their interventions often misinterpreted. In this sense, the work of these professionals is especially stressful, since not only must they deal with the sources of stress characteristic of all healthcare professions (Moreno-Jiménez & Peñacoba, 1999), but in addition are obliged to operate in contexts and conditions unsuited to their clinical work.

The first studies on burnout and occupational therapy appeared shortly after the publication of the MBI and the operational definition of the syndrome by Maslach and Jackson (e.g., Sturgess & Poulsen, 1983; Florian, Sheffer & Sachs, 1985). These early works already reflected a clear interest in studying the specific antecedent factors of burnout syndrome in the different fields and specialities of occupational therapy, and in attempting to identify the areas most susceptible to being affected by burnout.

In general, the sources of stress for the occupational therapist fall into two basic categories, as has been found to be the case for other professions, such as nursing (Graham, 1987; Moreno-Jiménez, González-Gutiérrez & Garrosa, 2001; Moreno-Jiménez, Garrosa & González-Gutiérrez; 2002), even though specific differences can be identified for occupational therapy. These categories are:

Direct relationship and contact with patients (Sweeney, Nichols & Kline, 1993; Brollier, Bender, Cyranowski & Velletri, 1987). Within this category, researchers have focused on specific characteristics of patients' health problems, such as their chronicity. Also of particular relevance is the type of patient the therapist is working with, such as the terminally ill, psychiatric patients or those infected with HIV (Hooley, 1997; Brown & Pranger, 1992; Piemme & Bolle, 1990). Other factors studied have been patients' lack of motivation, exposure to certain risks, fear of making errors during the treatment and lack of gratitude and feedback from patients (Sweeney, Nichols & Kline, 1993).

Relationship with the organizational environment as a system of labour and personal relations. In this category, research has identified sources of burnout such as time pressure, work overload, work with excessively large groups of patients (Short, 1984; Brown & Pranger, 1992; Freda, 1992), inadequate time management (Florian, Sheffer & Sachs, 1985), excessive paperwork leaving insufficient time with patients (Freda, 1992; Bailey, 1990), lack of resources (Sweeney, Nichols & Kline, 1993), salaries perceived as low (Painter, 1998; Bailey, 1990; Brown & Pranger, 1992), role ambiguity (Sweeney, Nichols & Kline, 1993), lack of professional recognition by colleagues and by society in general (Sweeney, Nichols & Kline, 1993), supervisory duties (Butler, 1972; Brown & Pranger, 1992; Eklund & Hallberg, 2000; Bassett & Lloyd, 2001), lack of support and feedback from supervisors and colleagues (Sweeney, Nichols & Kline, 1993), and general lack of rewards and recognition (Painter & Akroyd, 1998). Finally, an especially important source of burnout reported in some studies is constituted by changes currently occurring in the healthcare sector (Short, 1984; Painter & Akroyd, 1998).

On the other hand, the consequences of burnout syndrome in occupational therapists have not been so widely studied as stressors. In general, the same indivi-

dual, organizational and interpersonal consequences have been indicated as for other healthcare professions.

Furthermore, despite claims for a clear profile of risk for occupational therapists as a result of their exposure to a large number of specific work and organizational factors (Sweeney & Nichols, 1996; Bird, 2001), burnout syndrome has not been studied sufficiently to be able to identify with any degree of certainty the predispositional factors characteristic of this profession.

Thus, on the basis of the research discussed above, and bearing in mind the progressive development of the occupational therapy profession, there is a need to study the syndrome of burnout within it. The present work attempts to analyze the relationship of stress sources characterizing the occupational therapy profession and the burnout syndrome dimensions to the different consequences at both the individual and organizational level.

METHOD

Sample

The study sample was made up of 110 occupational therapists from the Madrid Autonomous Region working in clinical practice. Of these, 89% were women and 10% were men. Mean age was 30.3 years (SD= 8.9 years). Mean years of experience in the profession was 7.5 years (SD = 8 years), with a mean of 5.5 years in the same job (SD = 6.9 years). As regards the area in which participants were employed, work with geriatrics constituted the highest proportion, with 63.6 %, the remainder being distributed as follows: 12.7 % in physical and neurological rehabilitation, 9.1% in psychiatry, 8.2% in employment guidance and integration, 1.8% in drug-addiction and social marginalization, and 1.8 % in orthopaedics and technical support.

Table 1
Cronbach's alpha values for the scales included in the study

	Scale	Nº ítems	Alpha
Stressors	Conflictive interaction with work team	5	.78
	Interaction with patients and relatives	17	.86
	Overload	11	.83
	Contact with illness and death	5	.80
	Role ambiguity	6	.84
	Lack of cohesión	5	.81
	Lack of proper foundation for occupational therapy work	6	.79
	Task characteristics	6	.76
	Factors from outside work	7	.79
	Fear of malpractice	5	.85
	Appeals and reports against the therapist	5	.77
	Supervisión	8	.80
	Knowledge about/recognition of occ. therapy	7	.83
	Lack of independence	6	.83
	Wage conditions	4	.75
Burnout	Emotional exhaustion	12	.92
	Depersonalization	12	.80
	Lack of personal fulfilment	5	.82
Consequences	Psychological	23	.95
	Organizational	13	.92
	Socio-family	5	.87
	Physical	10	.89

Instruments

Specific stressors scale for the occupational therapy profession.

Assessment of the sources of stress characteristic of clinical work in occupational therapy was carried out through a bank of items generated on the basis of a bibliographical review and interviews with occupational therapists working in the Madrid Autonomous Region.

The subscales, designed on a rational basis (given the small sample size, which has so far made it impossible to carry out a factor analysis of the elements), assess the following variables: *conflictive interaction with colleagues, interaction with patients and their families, overload, contact with illness and death, role ambiguity, lack of cohesion with work team, lack of proper foundation for occupational therapy work, task characteristics, influence of factors from outside work, fear of malpractice, imbalance between resources and demands, interaction with supervisor, lack of knowledge about/recognition of occupational therapy, lack of independence, and wage conditions.*

The *Specific stressors scale* is made up of a total of 103 items with responses on a Likert-type scale of 1-4, where 1 is *totally disagree* and 4 *totally agree*. The internal consistency of its subscales, tested in the sample of 110 occupational therapists, is satisfactory, with Cronbach's alpha values ranging from 0.75 to 0.86 (see Table 1).

Burnout and consequences dimensions of the Nursing Professional Burnout Questionnaire (Cuestionario de Desgaste Profesional de Enfermería, CDPE; Moreno-Jiménez, Garrosa & González-Gutiérrez, 2000).

The CDPE is an assessment instrument used within the framework of a theoretical model that considers burnout as a process of transaction between the characteristics of the job context specific to nursing, the characteristics of the individual and the type of coping people use (Moreno-Jiménez, Garrosa & González, 2000). The aim

of this instrument is to assess a large part of the variables involved in the process of professional burnout in nursing: sources of stress, the burnout syndrome and its consequences. At the same time, it incorporates specific scales for evaluating the resistant personality (Kobasa, 1982) and the commonest coping strategies employed (Lazarus & Folkman, 1984).

In the present study we used the scales related to the syndrome (29 items) and the scales of associated consequences (51 items), which are Likert-type, where a response of 1 signifies *total agreement* and a response of 4 signifies *total disagreement*. The internal consistency of these scales, tested by the authors, gives alpha values of between 0.80 and 0.94 (Moreno-Jiménez, Garrosa & González, 2000). For the present sample these coefficients offered satisfactory results, with alpha values ranking from 0.80 to 0.95 (see Table 1).

The burnout and consequences scales of the CDPE were included in the present study on the assumption that, in contrast to what occurs with the block of specific antecedents, the items referring to these aspects of the process do not refer to characteristics exclusive to the nursing profession. Thus, in principle, the items making up these scales can be used for evaluating the burnout process in any healthcare professionals working in the clinical context.

Sociodemographic data sheet

Finally, participants were required to fill in a sociodemographic sheet that recorded data relevant to the case of occupational therapists (sex, age, number of patients attended per day, etc.).

PROCEDURE

First of all, we identified the institutions in the Madrid Autonomous Region that offered an occupational therapy service. To each of these we sent by mail a copy of the questionnaires, a letter of presentation, the request for collaboration and a stamped, addressed envelope for return of the relevant documents. Two weeks later we began a process of telephone follow-up until a sufficient number of questionnaires had been received. Of the 276 questionnaires sent out, at the time of carrying out the present study a total of 110 had been returned, representing a response rate of around 40%.

RESULTS

The descriptive data related to participants' scores on each scale of the questionnaire included in the present study are shown in Table 2.

On the Specific stressors for occupational therapy scale, the highest mean scores were obtained for *Contact with illness and death* (M = 2.80; SD = 0.62), *Lack of*

Table 2
Basic descriptive data for the variables studied

	Variables	Mean	SD	Max.	Max.
Stressors	Conflictive interaction with work team	2.15	.64	3.60	1,00
	Interaction with patients and relatives	2.41	.44	3.94	1.06
	Overload	2.68	.56	3.91	1.14
	Contact with illness and death	2.80	.62	4.00	1.00
	Role ambiguity	2.57	.67	4.00	1.00
	Lack of cohesión	2.06	.66	3.60	1.00
	Lack of proper foundation for occupational therapy work	2.72	.62	4.00	1.00
	Task characteristics	2.46	.60	3.67	1.00
	Factors from outside work	1.97	.53	3.57	1.00
	Fear of malpractice	2.62	.68	4.00	1.00
	Appeals and reports against the therapist	2.61	.70	4.00	1.00
	Supervision	2.43	.60	3.75	1.00
	Knowledge about/recognition of occ. therapy	2.90	.60	4.00	1.43
	Lack of independence	2.03	.67	4.00	1.00
	Wage conditions	2.98	.66	4.00	1.00
Burnout	Emotional exhaustion	2.49	.64	3.92	1.00
	Depersonalization	1.87	.43	3.58	1.00
	Lack of personal fulfilment	1.73	.61	4.00	1.00
Consequences	Psychological	1.98	.60	3.83	1.00
	Organizational	2.15	.66	3.77	1.00
	Socio-family	2.03	.76	4.00	1.00
	Physical	2.06	.64	4.00	1.00

knowledge about/recognition of occupational therapy (M = 2.90; SD = 0.60), and *Low wages* (M = 2.98; SD = 0.66). Lowest means were for *Lack of cohesion with work team* (M = 2.06; SD = 0.66), *Influence of factors from outside work* (M = 1.97; SD = 0.53) and *Lack of independence at work* (M = 2.03; SD = 0.67). Among the professional burnout dimensions, the occupational therapists in the sample obtained the highest mean score in *emotional exhaustion* (M = 2.49; SD = 0.64) and the lowest in *lack of personal fulfilment* (M = 1.73; SD = 0.61). Finally, with regard to consequences, participants scored similarly in the different variables, the highest mean score being for repercussions at an organizational level (M = 2.15; SD = 0.66).

In addition to the descriptive analysis of the variables, we ran a hierarchical multiple regression analysis using the stepwise method with a confidence level of 0.95. We thus calculated regression models for each of the professional burnout consequences studied, at the individual, organizational and interpersonal levels, introducing the stressors first, followed by the burnout dimensions.

The regression model for *psychological consequences* explains 74% of their variance. The antecedent factors making up this model are: influence of outside factors of a personal nature on work (β = 0.130; p = 0.043), lack of independence (β = 0.324; p = 0.000) and role ambiguity (β = - 0.357; p = 0.000). As it can be seen, in the case of role ambiguity the regression coefficient is of an inverse type. Together with these, the model is configured by the three dimensions of professional burnout: emotional exhaustion (β = 0.459; p = 0.000), depersonalization (β = 0.152; p = 0.019) and lack of personal fulfilment (β = 0.176; p = 0.020). With the entry into the equation of these three dimensions, fear of malpractice and lack of cohesion with work team, which initially emerged as predictor variables, lose their significance within the final model. Finally, it is important to note the greater predictive power of emotional exhaustion.

Table 3
Results of the hierarchical multiple regression analysis for the consequences of professional burnout, taking as predictor variables the stressors and dimensions of professional burnout

	Regression coefficients		Determination coefficients	
	Beta	t	R2 cor.	F
Psychological consequences				
Factors from outside work	0.130	2.047*		
Fear of malpractice	0.112	1.766		
Lack of independence	0.324	4.977**		
Role ambiguity	-0.357	-5.198**		
Lack of cohesión	0.095	1.673		
Emotional exhaustion	0.459	6.205**		
Depersonalization	0.152	2.375*		
Lack of fulfilment	0.176	2.361*	0.736	39.042**
Organizational consequences				
Task characteristics	0.108	1.225		
Wage conditions	0.125	1.824		
Interaction with work team	0.053	0.720		
Emotional exhaustion	0.506	5.475**		
Depersonalization	0.174	2.385*	0.590	32.399**
Socio-family consequences				
Factors from outside work	0.342	3.809**		
Overload	0.172	1.823		
Emotional exhaustion	0.258	2.710**	0.391	24.375**
Physical consequences				
Factors from outside work	0.213	2.647**		
Overload	0.091	1.076		
Interaction with work team	0.061	0.791		
Emotional exhaustion	0.504	5.431**	0.511	29.422**

* p < 0.05 ** p < 0.01

In the case of *organizational consequences*, the model is made up of two professional burnout variables, emotional exhaustion (β = 0.506; p = 0.000), and depersonalization (β = 0.174; p = 0.019), explaining 59% of the variable. With the incorporation of the syndrome dimensions, the three stressors making up the initial regression models become non-significant variables. Once more, emotional exhaustion shows the greatest degree of association with the dependent variable.

Socio-family consequences are explained to a level of 39% by the influence of outside factors on work (β = 0.342; p = 0.000) and emotional exhaustion (β = 0.258; p = 0.008). Again, emotional exhaustion enters the equation and, with it, the overload variable loses its predictive capacity it showed in the initial model. In this case, the influence of factors from outside work shows the greatest predictive power.

The regression equation for *physical consequences* is made up of influence of outside factors on work (β = 0.213; p = 0.009) and emotional exhaustion (β = 0.504; p = 0.000). The model explains 51 % of the criterion variable. Emotional exhaustion is once again the most predictive variable.

DISCUSSION

The present study highlights the importance of the work and organizational aspects specific to the profession of occupational therapy as potential sources of burnout that can have serious consequences for individuals and for the organization in which they are employed. Regression models showed percentages of explained variance the majority of which exceeded 50%, the strongest predicti-

ve power being found for the burnout dimensions, and specifically emotional exhaustion.

Thus, consideration of the psychological, physical, socio-family and organizational consequences of professional burnout in the present sample reveals the strong association between these factors and the dimensions of the syndrome. Psychological consequences are associated with emotional exhaustion, depersonalization and lack of fulfilment. Organizational consequences are related to both emotional exhaustion and depersonalization. Finally, the subject's physical and socio-family consequences are associated only with emotional exhaustion.

Emotional exhaustion emerges, then, as the burnout dimension most closely related to the different levels of consequences, as has repeatedly been pointed out in the literature (Golembiewski., Muzenrider & Stevenson, 1986; Gil-Monte & Peiró, 1997; Maslach & Jackson, 1981; Richardsen, Burke & Leiter, 1992; Koeske & Koeske, 1989). Together with this dimension, depersonalization and lack of fulfilment emerge as relevant predictor variables in the case of psychological symptoms, probably as a consequence of the attitudinal component that characterizes them. In this latter case, the antecedent factors of a work and organizational nature are predictive, together with the specific burnout dimensions. Thus, an interesting inverse relationship emerges between role ambiguity and psychological consequences, which can only be explained through the effects of multicollinearity between the independent variables. Therefore, after the inclusion of other antecedent factors in the regression equation, the effect of role ambiguity appears to be stripped of its most pathogenic element, leaving only a "flexibility" component, which would be positively associated with psychological health.

Moreover, special note should be taken of how, in the regression equations on the different types of consequences, the initial effect of the syndrome's organizational and social antecedents is assumed mainly by the burnout dimensions. This highlights the importance of professional burnout as a mediating variable within the process that leads to loss of health, adverse effects on the individual's interpersonal relationships and deterioration in the functioning of the organization itself.

Among the antecedent factors whose initial effect in the regression equation disappeared with the entry of the burnout dimensions are fear of malpractice and lack of cohesion (for the case of psychological consequences), task characteristics and wage conditions (for the case of organizational consequences), interaction with the team and overload (also for the case of organizational consequences) and overload (for the case of physical consequences).

Fear of malpractice is one of the stress factors to which researchers have drawn most attention recently in health-care professions such as medicine (Moreno-Jiménez & Peñacoba, 1999). Likewise, many studies have identified work overload as an important source of burnout, specifically with the dimension of emotional exhaustion (Leiter, 1988, 1991; Jackson, Schwab & Schuler, 1986; Jackson, Turner & Brief, 1987), and this has also been indicated by authors such as Short (1984), Brown and Pranger (1992) and Freda (1992) for the field of occupational therapy. This makes it an important risk factor, on exercising its action through emotional exhaustion, which, as indicated previously, is probably the burnout dimension most closely related to the different levels of consequences (Golembiewski., Muzenrider & Stevenson, 1986; Gil-Monte & Peiró, 1997; Maslach & Jackson, 1981; Richardsen, Burke & Leiter, 1992; Koeske & Koeske, 1989). This same explanatory process could be employed for the case of task characteristics (such as monotony, lack of feedback or lack of meaning), identified by Pfenning and Husch (1994) as a critical element strongly associated with emotional exhaustion.

The nature of the interpersonal relationship within the work team is a variable frequently identified as a potential source of burnout when there is a lack of social support and scarce cohesion (Burke, Shearer & Deszca, 1984; Ross, Altmaier & Russell, 1989; Gaines & Jermier, 1983; Savicki & Cooley, 1987). Within the field of occupational therapy, this factor has been indicated as a critical variable by Sweeney, Nichols and Kline (1993), so that it comes as no surprise to find it in this study as an important predictor of the physical and organizational consequences of the burnout process that seems to exercise its effect indirectly via the burnout.

Problems from outside the work environment constitutes the only antecedent factor that behaves in a predictive way, regardless of the presence or absence of burnout. Although the study of outside problems that affect the work context is an area of research into stress that is currently undergoing rapid development (Menaghan, 1991; Parkes, 1998), there is still quite limited consideration of this factor in relation to professional burnout. Nevertheless, it would appear necessary to examine this

element as a possible bidirectional variable, since it may not only be an antecedent of burnout and of a certain type of consequence for the individual, but may also, in turn, constitute an effect of these.

The high predictive capacity demonstrated by the burnout dimensions and the stressors specific to occupational therapy in relation to the different types of consequences studied shows the importance of the design of healthy work environments. In this regard, it is particularly important to achieve work contexts featuring activities with small groups of patients, teamwork with support from supervisors and colleagues, enrichment of work through feedback on its results, sufficient job independence to give meaning to the therapists themselves, and so on. Furthermore, the development of systems aimed at promoting a favourable interaction between the occupational therapists' work and non-work contexts – for example, through flexible working hours that would allow them to attend to their non-work problems – is crucial if we are to prevent the deterioration of their general well-being, given the bidirectionality indicated between these two aspects (González-Gutiérrez, Peñacoba, Gallardo, Moreno-Jiménez & Garrosa, 2001).

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