BURNOUT AND COPING STRATEGIES UTILIZED BY OCCUPATIONAL THERAPISTS IN ONTARIO

by

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Abstract

Introduction: Burnout is a familiar term for today’s health care professionals with emotional, psychological, physical, and social consequences for those who experience it. It leads to job dissatisfaction, low organizational commitment, absenteeism, as well as interpersonal conflict in teams and patient care.

Objectives: This mixed methods study has 3 objectives:

1. To determine the levels of burnout being experienced by a sample of occupational therapists practicing in Ontario.
2. To describe the practice issues faced by participants in their day-to-day work and
3. To describe the coping strategies participants employ to maintain their practice.

Methods: A concurrent embedded mixed methods research design was used. The mixed methods design collected quantitative and qualitative data. In the first phase, 63 participants completed a survey, which collected demographic information, responses on Maslach Burnout Inventory-General Survey and Areas of Worklife Survey, and their use of coping strategies. In the second phase, focus groups and interviews with 7 occupational therapists were conducted to learn about practice issues, and coping strategies used to address the identified demands.

Results: 34.8% of the participants reported high levels of emotional exhaustion, 43.5% of the participants reported high levels of cynicism and 24.6% report low professional efficacy. Unmanageable workload predicted 29.9% of the variance in emotional exhaustion. Rewards predict 15.5% of the variance in professional efficacy. Demands on time, lack of autonomy, lack of respect and conflict were identified as practice issues participants grapple with on a daily basis. Spending time with spouse/partner/family, maintaining balance between professional and personal lives, maintaining sense of control over work responsibilities and maintaining sense of humor were rated highly by participants as coping strategies they utilize to maintain their practice. Maintaining self awareness/self monitoring, focusing on satisfying aspects of work, importance of workplace/home community and boundaries emerged as additional coping strategies from the focus groups and interviews.

Conclusion: This study contributes to understanding the practice challenges for occupational therapists in the contemporary healthcare arena. It provides valuable insights into factors that contribute to therapist burnout and strategies they employ to maintain competent practice.
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Chapter 1
Introduction

1.1 Background

In the past 30 years, research has been conducted into burnout and job satisfaction for occupational therapists utilizing quantitative and qualitative methodologies in many countries including Australia, the United Kingdom, the United States of America (USA) and Canada. It reveals that work-related stress leads to job dissatisfaction, low organizational commitment, absenteeism, and high turnover; it affects the interpersonal functioning of teams and colleagues with increased conflict, substandard patient care, attrition, problems at home, and physical and mental health problems (Bailey, 1990a, 1990b; Balogun, Titiloye, Oyeyemi & Katz, 2002; Brown & Pranger, 1992; Davis & Bordieri, 1988; Laminman, 2007; Moore et al, 2006a, 2006b; Painter et al, 2003; Rees & Smith, 1991; Rogers & Dodson, 1988).

Burnout is a familiar term for today’s health care professionals. Fruedenberger (1980) proposed burnout as a concept defining it as ‘emotional, psychological, physical, social and spiritual characteristics experienced by helping professionals in varying levels of intensity’ (pp.). Maslach (1982) defined burnout as ‘when a person has reached a state of mental and physical exhaustion combined with a sense of frustration and personal failure’. Maslach and Leiter (1997) defined the key dimensions of burnout as overwhelming exhaustion, feelings of cynicism and detachment from the job, a sense of ineffectiveness and lack of accomplishment.

1.2 The Canadian Context

Since the 1990’s occupational therapists in Canada have practiced in an ever-changing landscape. Drastic cutbacks in public health spending resulted in hospital closures and transfer of services into the community. Many occupational therapists embraced new roles in the
community including becoming consultants or case managers and explored private practice opportunities (Green, Lertvilai & Bribriesco, 2001). Health system reforms in the following decade were primarily directed towards cutting costs, gaining efficiencies, integrating new technologies and meeting the needs of a more informed health consumer (von Zweck, 2004). The reform process has integrated hospitals to create ‘health science centers’, introduced program management models for greater efficiency and increased funding for services in the community. As program management models replaced traditional departments, there was also a greater push towards practicing inter-professionally and overall, a loss of a sense of familiar professional certainties due to role blurring and role overlap (Finlay, 2000).

As hospitals were under increasing pressure to balance their budgets, “senior” positions were lost within health profession departments and therefore mentorship roles were lost for new graduates who joined the department (Miller & Solomon, 2002). The hospitals introduced a ‘Professional Practice’ model and created part-time Professional Practice Leader positions for each discipline to fill that void. The Professional Practice model was meant to help implement evidence based practice models and deal with professional practice concerns.

Demands for greater accountability, autonomy and research utilization led to a change in the education requirements for entry-level therapists to a professional master’s training in 2008 across Canada (von Zweck, 2004). While the publicly funded system struggled with providing services, growth areas included self-employment and providing services for profit. These rapid changes have had an impact on how occupational therapy is practiced in the community, hospitals and chronic care/rehabilitation settings.

As an occupational therapist employed in a hospital setting for the last fourteen years, I have lived through the reform process. In the first phase of restructuring health services, all rehabilitation services in Kingston, Ontario were amalgamated at one hospital and services are
now ‘purchased’ by other hospitals within the city. I work as a purchased service personnel at another hospital within the city. In addition to clinical duties, I have chaired the Professional Practice Council at this hospital and held the position of Professional Practice Leader in Occupational Therapy for one year. I am part of an interprofessional clinical and research mental health team. My clinical work in mental health has brought me in contact with other health-care workers struggling with ‘keeping-up’ with the rapid changes in their environment. These experiences sparked my interest in researching the topic of stress and burnout amongst occupational therapists.

Wilkins (2007) in her study for Statistics Canada reviewed and analyzed the data from the 2003 Canadian Community Health Survey (CCHS) which surveyed nearly one in three employed Canadians (approx 5.1 million). This study reported that 47% of occupational therapists found most days at work as ‘quite’ to ‘extremely’ stressful. This study also ranked occupational therapists as the seventh most stressed health care provider behind nurses, medical lab technicians, and specialist and family physicians.

1.3 Ways of Coping with Burnout

Research in the field of burnout started as an attempt to make sense of what front line health workers were experiencing at work. Along with it grew a body of research and literature on how to ameliorate the stress placed on health care providers (Leiter & Maslach, 2004). This led to proliferation of strategies such as stress management programs and research on their efficacy. Lazarus and Folkman (1984) defined coping as “constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person” (pp. 141). They emphasize a process-based approach to coping and propose a transactional model that views the person and the environment in a dynamic, mutually reciprocal, bidirectional relationship. Leiter and Maslach (2005) have
outlined strategies for improving one’s relationship with work and align them with six areas of work life (workload, control, reward, community, fairness and values).

Research reveals that occupational therapists use coping strategies more frequently than most other health professionals (Rees & Smith, 1991). They utilize strategies such as balancing workload, maintaining therapeutic relationship with clients, defining one’s role on the team, supervision and training (Bassett & Lloyd, 2001), discussion with colleagues (Brice, 2001) and changing practice specialty (Bailey, 1990a, 1990b; Richardson & Rugg, 2006a, 2006b). Researchers in the discipline of psychology have recently proposed the term career-sustaining behaviors (Kramen-Kahn & Hansen, 1998; Rupert & Kent, 2007; Stevanovic & Rupert, 2004) to help gather systematic data about behaviors that contribute to positive self-care or coping strategies to maintain well-being and professional well functioning.

1.4 Research Methodology

This study utilizes a mixed methods research design. Few published studies on burnout have utilized mixed method research design. Mixed methods research uses a practical, outcome-oriented approach to answer complex research questions (Johnson & Onwuegbuzie, 2004). Combining qualitative and quantitative methods can provide information that might not be obtained by using either method alone. Mixed methodologies have several strengths such as the ability to generate and test theory, confirm findings, and obtain greater breadth and depth on a research topic; and drawbacks such as prolonged time to conduct the study, difficulties in procuring funding and knowledge of quantitative and qualitative methods (Johnson & Onwuegbuzie, 2004). Within mixed methods, various types of designs are possible by combining different data collection strategies and analyses. Furthermore, data from the qualitative and quantitative strand can be collected sequentially or concurrently (Creswell, 2009).
Schonfield and Farrell (2009) call for using qualitative and quantitative methods in the research of occupational stress to help work towards the common goal of understanding, and doing something about, stressors affecting workers. They propose that qualitative methods and more highly controlled quantitative methods, together, can help provide a comprehensive picture of the stress process. Smith (2006) wrote about the need for mixed methods in educational research stating that using one methodology alone may fail to capture the chaos, complexity, and contextuality of applied fields such as education. Schonfield and Farrell (2009) concur that this holds true for the field of occupational stress. They also caution that the methods should fit the research question; for example, a survey is useful to help quantify variables in the context of occupational stress. Jex, Adams, Elacqua and Lux (1997) favour the use of qualitative methods to capture descriptively the intensity of work-related stressors experienced by front line workers. Having workers describe their everyday work experiences in their own words is the most commonly used qualitative method for gaining information about their day-to-day stressors (Schonfield & Farrell, 2009). The benefit of utilizing qualitative methods is that the workers’ responses are not constrained by the response alternatives found in structured interviews or questionnaires (Schonfield & Farrell, 2009).

1.5 Problem Statement

In the past 30 years, research has been conducted into burnout and coping strategies utilizing quantitative and qualitative methodologies for occupational therapists in many countries. However, as there are several differences in how health care is managed and utilized among these countries, it is difficult to generalize the results of the studies conducted in other countries and apply them to the Canadian context. Brown and Pranger (1992) conducted the last published Canadian study in 1992, and as indicated above, health care has undergone several changes in the last 18 years. It will be useful from the point of view of the policy makers, educators and
managers of health care centers to learn about the experience of occupational therapists in mediating current job demands and the coping strategies they utilize to sustain their practice. This information may help with issues of organizational commitment, absenteeism, client and staff satisfaction, and may avoid costs related to short and long term disability leaves.

### 1.5.1 Research Purpose

The purpose of this study is to expand the existing knowledge about the levels of stress experienced by occupational therapists practicing in Ontario in their day-to-day work lives and the coping strategies they utilize to prevent burnout. This study seeks to answer the following research questions:

1. What are the levels of burnout experienced by practicing occupational therapists in Ontario?
2. What practice issues do occupational therapists face in their work life?
3. What coping strategies do occupational therapists utilize to maintain their practice?

### 1.6 Overview of Thesis

The general aim of this thesis was to explore job stresses and coping strategies employed to sustain practice by occupational therapists practicing in Ontario, Canada. This thesis is organized in five chapters. The first chapter has background information on burnout, the Canadian context and the research methodology chosen to gather knowledge. The second chapter contains a review of the literature on theories of burnout and coping strategies; instruments to measure both; and studies that have examined the phenomena of burnout, job satisfaction and coping strategies amongst occupational therapists. The third chapter describes the methodology used in this mixed methods study. The fourth chapter details the quantitative and qualitative results obtained and a model summarizing the integration of both data sets. The final chapter
discusses the results in light of the current literature, offers recommendations for practice and provides future directions for research.
Chapter 2
Literature Review

2.1 Process of Review

The goal of this literature review was to learn about theory related to burnout, its manifestation in occupational therapists and the coping strategies they employ to maintain their practice. Key words used to search the databases include occupational therapist, occupational therapy, personnel retention, retention, drop-out, job satisfaction, burnout, attrition, coping strategies. Databases surveyed included CINAHL, MEDLINE and PsychINFO.

2.2 Understanding Stress and Burnout

Selye, in 1950, was the first to describe stress as an ‘internal response to external stressors’. He proposed the General Adaptation Syndrome with its stages of fight/flight, adaptation and exhaustion phases. While this description helped to capture the individual’s internal experience of stress, it did not capture any features of the social and physical environment. Fruedenberger (1980) proposed burnout as a concept, defining it as ‘emotional, psychological, physical, social and spiritual characteristics experienced by helping professionals in varying levels of intensity.’ Maslach (1982) defined burnout as ‘when a person has reached a state of mental and physical exhaustion combined with a sense of frustration and personal failure.’

Maslach and Leiter (1997) proposed a revised definition that describes burnout as ‘psychological syndrome due to chronic interpersonal stressors at work’. They also defined the key dimensions as overwhelming exhaustion, feelings of cynicism and detachment from the job, a sense of ineffectiveness and lack of accomplishment. Burnout places the individual experience in a social context and specifically in the world of work. It is characterized by the presence of the
following elements: 1) *Emotional Exhaustion*: the feeling of being emotionally overextended, drained, and exhausted by the helping experience; 2) *Cynicism*: having negative or inappropriate attitudes towards clients such as feeling irritable, a loss of idealism and withdrawal by distancing oneself and pulling away from clients; and 3) *Inefficacy*: having feelings of reduced personal accomplishment, productivity, low morale and inability to cope.

### 2.2.1 How does burnout develop?

Several models have been proposed to describe how burnout develops over time. Cherniss (1980) proposed the ‘Transactional Model’, which describes the stages of burnout. According to the Transactional Model, job stressors (imbalance between work demands and resources) leads to individual strain (emotional response of exhaustion and anxiety) and finally to defensive coping (changes in attitude and behavior).

Maslach, Jackson and Leiter (1996) proposed the Phase Model. This model posits that *emotional exhaustion* is the first stage that develops as a clinician becomes over-involved emotionally and overwhelmed by demands placed by others. This individual may not experience empathy or respect for clients and may lack energy to complete his or her tasks. This leads to *depersonalization* where the clinician experiences feelings of detachment and dehumanization and responds to those feelings by avoiding getting involved and seeming indifferent to client’s needs and wishes. The clinician may display negativity towards others and the internal emotional experiences may include feeling guilty and upset. The final stage before burnout is *reduced personal accomplishment* where the individual may feel inadequate in relation to professional skills, may perceive that he or she has failed in some way and report low self esteem.
2.2.2 The Mediation Model of Burnout: The person within the context of work

In 1997, Maslach and Leiter re-conceptualized their theory of burnout and called it the ‘Mediation Model’. The development of the mediation model of burnout coincided with adapting the Maslach Burnout Inventory-Health Services Survey (MBI-HSS) to study burnout within occupations that are not people-oriented (Schaufeli, Leiter, Maslach & Jackson, 1996). Therefore, the new measure, the Maslach Burnout Inventory-General Survey (MBI-GS) defines burnout as a crisis in one’s relationship with work. The exhaustion component of the scale is generic and without reference to people as the source of the feeling. Similarly, cynicism alludes to a distant or indifferent attitude towards work rather than towards the recipients of one’s services.

Professional efficacy seeks to measure a sense of personal accomplishment at work, which comprises social and non-social aspects of social accomplishments. High scores on emotional exhaustion and cynicism and low scores on personal accomplishment reflect a high degree of burnout.

Additionally, Maslach and Leiter (1997) contend that the MBI-GS measures the participant’s relationship on a continuum from engagement to burnout. Engagement is defined by the authors as an energetic state exemplified by excellent performance at work and confidence in one’s effectiveness. Burnout, at the other end of the continuum, is marked by cynicism about one’s job and doubts in the individual’s ability to perform.

Leiter and Maslach (2000) identified six areas of the work environment as the most relevant to the relationships people develop with their work. This led to the development of the Areas of Worklife Survey (Leiter & Maslach, 2000) and Areas of Worklife Manual (Leiter, 2006). The survey frames job stressors in terms of person-job imbalances and identifies six key dimensions in which these imbalances take place. These six dimensions are workload, control, reward, community, fairness and values.
The workload dimension, especially where job demands exceed human limits, has been shown to have a consistent relationship with burnout, especially as related to emotional exhaustion of their phase model. The authors contend that work overload contributes to feelings of exhaustion and depletes an individual’s ability to recover and therefore to continue meeting the demands of their job. The control dimension refers to the perceived capacity of the individual to influence decisions at their work, exercise personal autonomy and gain access to resources for completing their work. Role conflict and role ambiguity can impact on one’s sense of control and can lead to difficulties getting the assigned work done. The reward dimension captures the extent to which rewards (monetary, social and intrinsic) are consistent with expectations. Insufficient rewards can increase the individual’s vulnerability to burnout. The community dimension points to the overall quality of social interaction at work including issues of conflict, mutual support, closeness and capacity to work as a team. As an example, a supervisor’s lack of support consistently correlates with emotional exhaustion. The fairness dimension looks at the extent to which decisions at work are fair and equitable. This key area postulates that individuals are more interested in procedural justice, (i.e., the extent to which the process is fair) rather than whether the outcome is in their favor. The values dimension is the least researched and relates to the ideals and motivations that attract people to their jobs. A common source of conflict cited is between the individual (high-quality service) and organization values (cost containment).

Leiter and Maslach (2004) contend that there is a complex relationship among the six areas of worklife and burnout rather than a simple additive relationship where each of the six areas would contribute separately to greater burnout. The authors contend that control is central to an employee’s ability to influence the people and processes that determine the quality of worklife and therefore acts as a starting point in the mediation model and will influence the degree to which people are able to achieve matches in the areas of workload, reward, fairness,
and community. The area of values plays an integrating role and mediates the relationship with the psychological experience of burnout or engagement. The model is attached in Appendix A.

2.2.3 Overview of assessments to measure burnout

Several self-report tools are published in the literature to assess job stress. The tool used most often is the Maslach Burnout Inventory-Health Sciences Survey (MBI-HSS), which is a 22 item self report questionnaire (Maslach & Jackson, 1996). A variation of Maslach Burnout Inventory is the Staff Burnout Scale for Health Professionals (SBS-HP) (Jones, 1980). The responses on the SBS-HP align along behavioral, cognitive, and psycho-physiological dimensions and this tool is usually used in conjunction with the MBI-HSS. The Occupational Stress Indicator (OSI) is another instrument that measures sources of work stress on health care staff (Cooper et al, 1988). The OSI measures work stress along six dimensions, which are: sources of pressure, type ‘A’ behavior pattern, locus of control, job satisfaction and mental and physical ill health. The Stress Profile is an 18 item questionnaire that measures stress in private life, at work and at leisure (Setterlind & Larsson, 1985). This instrument has been used extensively in diverse health and non-health related occupations.

The Maslach Burnout Inventory has three versions (Maslach, Jackson & Leiter, 1996). MBI-HSS is used to measure burnout in health service workers, the educator’s version (MBI-ED) and the general survey (MBI-GS). They are all comprised of three subscales namely emotional exhaustion, depersonalization and personal accomplishment for MBI-HSS and MBI-ED; exhaustion, cynicism and professional efficacy for MBI-GS. In this research, I chose to utilize the MBI-GS as the tool to assess burnout as it has been established to have a less skewed distribution than the original MBI-HSS (Maslach, Schaufeli & Leiter, 2001). The authors report that the improved distribution of MBI-GS permits a more thorough examination of all three aspects of burnout and eliminates the social desirability bias reflected in the highly skewed distribution of
the \textit{MBI-HSS}. Additionally the authors have established that the \textit{MBI-GS} measures a state of burnout that is consistent with that measured by \textit{MBI-HSS}.

\subsection*{2.2.4 Assessing the person’s relationship with work}

Maslach and Leiter (1997) recommend using the \textit{MBI-GS} and \textit{Areas of Worklife (AWS)} surveys together to assess the degree of match-mismatch between the person and their employer. The \textit{MBI-GS} measures the three core dimensions of a person’s experience with work: exhaustion–energy; cynicism–involvement; and inefficacy-accomplishment. The \textit{MBI-GS} is a 16 item questionnaire that maintains a consistent factor structure across a variety of occupations (Bakker, Demerouti & Schaufeli, 2002). This test was normed on 5259 respondents from Canada, Holland and Finland. The scale items are rated on a 7-point frequency scale ranging from 0 (never) and 1 (a few times a year or less) to 5 (a few times a week) and 6 (daily). Individuals who score high on \textit{emotional exhaustion} and \textit{cynicism} and low on \textit{personal accomplishment} are experiencing burnout. Conversely, the authors contend that individuals with low scores on \textit{emotional exhaustion} and \textit{cynicism} and high scores on \textit{personal accomplishment} are experiencing many aspects of engagement with work.

The \textit{AWS} (Leiter & Maslach, 2000) contains 29 items that produce six subscales on workload, control, reward, community, fairness and values. Respondents indicate their degree of agreement with the statements on a 5-point Likert-type scale ranging from 1 (strongly disagree), through to 3 (hard to decide), to 5 (strongly agree). It includes statements such as “I have enough time to do what’s important in my job” (workload). The scale has a consistent factor structure and shows high correlations with the three burnout dimensions measured by \textit{MBI-GS} (Leiter & Maslach, 2004). This standardized assessment tool was normed on approximately 17000 participants worldwide including over 4000 participants from Canada. This survey is often used with \textit{MBI-GS} to help organizations identify areas that need change and to help enhance
engagement with work. I chose to utilize the AWS along with MBI-GS to measure the degree of match or mismatch between the participants and their work in addition to determining the levels of burnout.

2.2.5 Job Satisfaction

Job satisfaction is another area closely related to stress and burnout. Herzberg (1966) was the first to propose that certain factors (“motivators”) are closely aligned with job satisfaction, whereas other factors (“hygiene”) are more likely to be associated with job dissatisfaction. Herzberg categorized motivator factors as variables related to the content of the job such as achievement, recognition, the work itself, responsibility and advancement. He categorized hygiene factors as related to the context of the job such as company policy and administration, supervision, working conditions, interpersonal relations and salary. According to Herzberg, the presence of motivator factors leads to job satisfaction but their absence does not lead to job dissatisfaction. Interestingly, he also posits that the presence of hygiene factors does not increase job satisfaction, but their absence can increase job dissatisfaction.

2.3 Occupational Therapy Studies on Burnout

Madill et al (1985) surveyed 119 Alberta occupational therapists using Life Roles Inventory and personal interviews. The participants had either left the profession or changed their area of practice to move outside of the traditional occupational therapy practice setting. The authors identified several themes to elucidate career patterns from the findings. The study revealed that most occupational therapists sought work in a setting where they had had a challenging and a successful work placement experience. It also indicated that occupational therapists usually sought out a second employment setting despite a first negative experience, but if that new practice setting failed to meet their needs, the likelihood of remaining in a traditional
practice setting was very low. The study found the average age of someone leaving or changing the profession was below 40 years of age.

Rogers and Dodson (1988) surveyed 99 occupational therapists practicing in the southeastern US using the MBI-HSS and reported that, on average, occupational therapists experienced less burnout (especially emotional exhaustion and depersonalization) than other human service professionals. They also noted that occupational therapists’ scores on personal accomplishment were comparable to the normal sample. A study by Bailey (1990a, 1990b) surveyed 696 occupational therapists using a 54-item questionnaire. These participants had left the profession either temporarily or permanently due to burnout. Bailey reported that the primary causes of burnout in occupational therapy were work overload, lack of control over the care provided, presumably poor social support from co-workers and supervisors, and the policies and procedures of their workplaces. Bailey reported the secondary causes of burnout to relate to the type of clientele, type of healthcare setting, work environment, employee’s personality, coping skills, perception of their profession, age of the respondents, nationality, gender, home environment, status and genetic traits. The author also reported that the largest group of respondents (35%) left the profession after 5 to 10 years of working, the next largest (21%) left after 10 to 15 years, and the third largest (19%) left after 0 to 5 years of working.

Brown and Pranger (1992) surveyed 89 occupational therapy personnel working in the Ontario psychiatric hospital system to determine their levels of burnout and to determine if a relationship existed between burnout, work environment factors and the sample’s demographic characteristics. They utilized the MBI-HSS to measure burnout and reported average levels of emotional exhaustion, depersonalization and personal accomplishment. They found that a caseload with a large percentage of clients diagnosed with schizophrenia, work pressure, age of
the respondents, income level, length of time working as psychiatric occupational therapist, caseload size and amount of overtime were factors impacting the level of burnout.

Balogun, Titiloye, Balogun, Oyeyemi and Katz (2002) surveyed occupational therapists and physiotherapists using the \textit{MBI-HSS} working in hospital and clinics in New York City and reported that there was no statistical difference in the level of burnout experienced by each of the two disciplines. Fifty eight percent of the sample experienced high \textit{emotional exhaustion}, 94% experienced high \textit{depersonalization} and 97% reported low \textit{personal accomplishment}, which the authors reported reflected higher prevalence of burnout than reported in previous studies of therapists.

Painter, Akroyd, Elliot and Adams (2003) surveyed 521 occupational therapists using the \textit{MBI-HSS}, who were members of American Occupational Therapy Association. They wanted to determine if type of health care setting had an impact on burnout levels. Their results indicated that 40% of respondents exhibited high levels of first stage of \textit{emotional exhaustion}, 75% had low levels of \textit{depersonalization} and 46% had high levels of \textit{personal accomplishment} as compared to four other health care professional groups. The authors also reported that occupational therapists working in chronic care settings (long term care, rehabilitation and psychiatric settings) demonstrated higher levels of emotional exhaustion in comparison to those working in the community or hospital settings.

Lloyd and King (2004) surveyed 196 occupational therapists and 108 social workers in Australian mental health to identify their levels of burnout and to see if there was a difference between the two allied health professions regarding their levels of burnout. They found that both groups experienced high \textit{emotional exhaustion}, moderate \textit{depersonalization} and high \textit{personal accomplishment}. Their study also corroborated the findings of Balogun et al (2002) that there was no significant difference between the two disciplines.
Studies measuring job satisfaction have reported that occupational therapists derive satisfaction through a sense of achievement from facilitating client improvement, clinical autonomy and job diversity, interpersonal relationships with co-workers, the nature of their job, multi-professional teamwork, adequate staffing, ongoing training and involvement in decision making (Davis & Bordieri, 1988; Moore et al, 2006a, 2006b). The same studies have reported job dissatisfaction to come from a perception of lack of clarity of the role of occupational therapist by colleagues and clients, lack of professional status, inadequate department budgets, organizational support for training/advancement, working conditions, unrealistic workload, and personal reasons. Rees and Smith (1991) conducted a large study and ranked occupational therapists as seventh most satisfied discipline of seventeen different occupational groups in Britain.

Laminman (2007) conducted a mixed methods study to determine the intentions and perceptions of occupational therapists working in the province of Manitoba regarding their career. She conducted a focus group (n = 6) to help develop a questionnaire, which was completed by 278 practicing occupational therapists in Manitoba. Laminman reported that 11% of respondents intend to leave the profession, 14% of the respondents were unsure if they would remain in the profession and the remaining 75% planned to continue practicing. Laminman reported that intrinsic factors such as lack of autonomy and lack of responsibility and extrinsic factors such as lack of respect from peers, frustration with the health care system, and inability to find the amount of work desired were cited as reasons for dissatisfaction with the occupational therapy profession by the respondents planning to leave the profession. The group that intended to continue practicing indicated that they found their work challenging, they experience rewarding feelings at work, responsibility, professional growth opportunities, positive relationships, recognition and respect from peers and their interdisciplinary team.
2.3.1 Studies utilizing the mediation model of burnout

To date no studies have been published utilizing the mediation model of burnout (MBI-GS and AWS) to measure the levels of burnout amongst occupational therapists and what aspects of their organizational life contribute to it.

Cho, Laschinger and Wong (2006) studied workplace empowerment, work engagement and organizational commitment of new graduate nurses by surveying 226 new graduates (with less than two years of nursing experience) working in acute care areas within hospitals who were randomly selected from the College of Nurses of Ontario registry list. Sixty six percent of these nurses reported severe levels of emotional exhaustion. They reported mismatches between the participants and their work settings in the area of workload, and fairness and matches in community, values, reward and control.

Laschinger and Wong (2006) studied the impact of staff nurse empowerment on person-job fit and on the continuum of work engagement and burnout by surveying a random sample of 322 nurses in acute care hospitals across Ontario. Fifty three percent of nurses were in the severe burnout category and the authors indicated that this level of burnout is considerably higher than previous studies of nurses in Ontario. The nurses reported the greatest degree of fit or match in the areas of worklife to community, values, and rewards. They reported the greatest degree of mismatch related to workload, fairness, and control.

Timms, Graham and Cottrell (2007) reported on matches and mismatches in areas of worklife for teachers employed in independent schools in Queensland, Australia. The authors surveyed 298 teachers and reported significantly more mismatch on workload. They also found that the teachers reported matches in the areas of control, reward, community, fairness, and values. The authors reported that only 6 of the 298 teachers reported working normal working hours, everyone else reported worked hours ranging from 40 to 60+ hours per week. The authors
measured burnout using the Oldenberg Burnout Inventory and reported significantly higher exhaustion rates than samples previously tested by this measure.

Lasalvia et al (2009) conducted a study to explore the influence of perceived organizational factors on job burnout by surveying 2000 mental health staff in Italy. More than one third of the participants (33.6%) reported severe emotional exhaustion, 25.7% reported severe cynicism and 23.7% reported reduced professional efficacy. The main predictors for emotional exhaustion were unmanageable workload and lack of control. The main predictors for cynicism were rewards, fairness, workload, and control subscales. The main predictors for efficacy were feelings of control, fairness, and having adequate rewards. The authors also report that low workload, high control, high reward, high fairness, positive changes in the workplace and high group cohesion are important protective factors against the risk of burnout.

Leiter, Frank and Metheson (2009) surveyed 2536 Canadian physicians to explore workload and values congruence in the context of burnout. They reported that women and men scored lower than the norm on emotional exhaustion dimension, and near norms for cynicism dimension. The authors reported that workload and values congruence predicted exhaustion and cynicism for men and women ($p < 0.001$).

Leiter, Gascon and Martinez-Jarreta (2010) conducted a study in Spain to determine if the mediation model of burnout depicts employee’s experiences of worklife and their evaluation of organizational change. This study surveyed 832 hospital based nurses and 603 physicians. Their study found that emotional exhaustion was highly correlated with cynicism. They reported a strong correlation between workload and emotional exhaustion.

2.4 Coping with Stress and Burnout

Cherniss (1980) recommended that interventions to alleviate burnout work to achieve the following goals:
- Reduce or eliminate external job demands through job and role restructuring
- Help the worker change their personal goals, preferences and expectations through staff development programs
- Help the worker meet demands by providing more resources such as para-professionals and volunteers

Lazarus and Folkman (1984) defined coping as “constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person” (pp. 141). They emphasize a process-approach to coping and propose a transactional model that views the person and the environment in a dynamic, mutually reciprocal, bidirectional relationship. They make a distinction between coping that is directed at managing a problem (problem-focused coping) and coping that is directed at regulating emotional response to the problem (emotion-focused coping). *Emotion-focused coping* includes cognitive processes to lessen emotional distress such as avoidance, minimization, distancing, selective attention, positive comparisons, and looking at the positives in a negative situation; and cognitive process to change the way an encounter is viewed without altering the situation (cognitive re-appraisal). *Problem-focused coping* is usually utilized to define the problem, generate alternative solutions, weighing the pros and cons of solutions, choosing one and acting on it.

Leiter and Maslach (2005) outlined strategies for improving one’s relationship with their work. These are aligned with the mediation model described above, i.e., *workload* (for example, negotiating a reduced workload with employer/manager), *control* (finding ways to increase autonomy), *reward* (maximizing rewards by adjusting one’s output), *community* (working towards conflict resolution), *fairness* (promoting respect), and *values* (maintaining integrity).
Researchers of professional satisfaction in psychology have examined personal coping and self care resources and favored the term *career-sustaining behaviors* to gather systematic information on activities or strategies for managing and promoting resiliency in the face of job related stressors (Kramen-Kahn & Hansen, 1998; Rupert & Kent, 2007; Stevanovic & Rupert, 2004). They have found that maintaining a balance between personal and professional lives with behavioral strategies to help achieve this balance, cognitive strategies such as maintaining self awareness and use of humor have been rated highly by the participants.

### 2.4.1 Occupational Therapist’s Use of Coping Strategies

Using the *Occupational Stress Indicator*, Rees and Smith (1991) found that the total score on coping strategies for occupational therapists was significantly higher than for the other health professionals. They were ranked second out of seventeen occupational groups studied in the use of coping strategies. The authors found that occupational therapy staff made significantly more use of social support and were more likely to break down their work into smaller chunks as a way of managing work pressure.

Freda (1992) surveyed 55 occupational therapists working in Adult Rehabilitation Centers in Washington State. The authors reported that years of experience affect what is important to therapists in their jobs. Patient care was reported as the most rewarding aspect for an occupational therapist with less than three years of experience and paperwork as the most stressful for all levels of staff. Freda also made a case for varied and increased responsibilities such as program development, managerial responsibilities, professional growth continuum through professional development and promotional opportunities to retain staff.

Painter and Akroyd (1998) surveyed 1531 occupational therapists in North and South Carolina on organizational commitment and reported that involvement in intrinsically self-rewarding tasks was a predictor for organizational commitment for hospital and ambulatory care
settings. The authors also reported that occupational therapists employed in ambulatory care settings rated general working conditions and task autonomy as important and salary and supervision was rated as important by hospital based occupational therapists.

Occupational therapy studies recommend stress management interventions including balancing workload, maintaining therapeutic relationship with clients, defining one’s role on the team, supervision and training (Bassett & Lloyd, 2001), discussion with colleagues, sharing responsibilities of clients with members of interdisciplinary team, maintaining boundaries between work and home, leisure activities (Brice, 2001) and changing practice specialty (Bailey, 1990a, 1990b; Richardson et al, 2006a, 2006b).

2.5 Occupational therapy knowledge in lifestyle balance

Burnout relates to work demands exceeding resources and implicitly an unbalanced workweek. Lifestyle or occupational balance has not been well researched in occupational therapy despite a long standing belief that a “general configuration of daily occupations can contribute to health and well-being” (Christiansen & Baum, 1997, pp. 592). Westhorp (2003) proposed a cycle for achieving occupational balance through:

- Being mindful of which activities promote health and which ones don’t by monitoring what is health promoting and valuable in one’s life.
- Deciding on health promoting balance in occupations (using one’s judgment regarding whether an activity is obligatory or desired, rest, recreation, work, self-care).
- Implementing change in occupations through accepting or declining new or old activities
- Monitoring current occupations and their meaning and value to one in an ever changing environment.
Matuska and Christiansen (2008) proposed a model of a balanced lifestyle that is resilient and health promoting. They define a balanced lifestyle as “a satisfying pattern of daily occupation that is healthful, meaningful, and sustainable to an individual within the context of his or her current life circumstances” (pp. 11). They used the term ‘satisfying’ to indicate congruence between actual participation in occupations and desired participation in occupations. They suggest that lifestyle patterns must consist of an array of occupations that enable individuals to:

- Meet basic needs for sustained biological health and safety
- Have rewarding and self-affirming relationships with others
- Feel engaged, challenged and competent
- Create meaning and a positive personal identity
- Use time and energy to meet important personal goals and promote renewal

Pentland and McColl (2008) further propose that choosing occupations based on what one values contributes to life balance.

2.6 Summary of the Literature Review

This chapter presents the theoretical advances in the field of worker burnout and engagement, sources of job satisfaction, coping strategies employed to prevent burnout and work-life balance. While burnout, job satisfaction and coping strategy utilization have been studied in occupational therapy over the last three decades, none of the published studies have undertaken a systematic study of the workplace variables that impact on the worker and lead to either burnout or engagement.
Chapter 3

Methods

The purpose of this study was to expand existing knowledge about the levels of burnout experienced by occupational therapists practicing in Ontario. This study objectives also included the elucidation of the practice issues the participants face in their work life and the coping strategies they utilize to prevent burnout.

3.1 Research Design

This study was conducted using a mixed methods design which refers to the use of more than one investigative approach in a single study, resulting in the collection of more than one type of data (Creswell, 2009). Mixed methods approaches allow a researcher to measure trends, prevalences, and outcomes and at the same time examine meaning, context and process (Creswell & Plano Clark, 2007). This study utilized quantitative and qualitative data collection approaches, which represent different paradigms and therefore their own values and techniques that guide how research is conducted, analyzed and reported (Creswell). Each paradigm reflects different philosophical beliefs (ontology) regarding how reality exists and ways that knowledge (epistemology) is acquired about this reality (Higgs, 2001).

This study utilized a mixed methods approach to gain a comprehensive view of stressors faced by occupational therapists in their worklife and the coping strategies they utilize to prevent burnout. Mixed methodology arises from a pragmatic worldview with the assumption that research on a topic benefits from utilizing a multitude of approaches. In this methodology, collection of quantitative and qualitative data is seen as compatible and is thought to provide a more complete picture as compared to one data collection strategy alone (Creswell, 2009). This
study utilizes the hermeneutics approach outlined by Paterson and Higgs, 2005 and later by von Zweck, Paterson and Pentland, 2008.

In using this concurrent embedded strategy, a questionnaire was utilized to collect quantitative data and was the primary source of data (Figure 1). Interviews and focus groups were conducted with a subset of the sample and were embedded or nested within the predominant method (Creswell, 2009). The study sought to answer the following research questions:

1. What are the levels of burnout experienced by practicing occupational therapists in Ontario?
2. What practice issues did the occupational therapists face in their work life?
3. What coping strategies did the participants employ to prevent burnout?

Figure 1: Study design using a concurrent embedded mixed methods approach

Quantitative and qualitative data were collected for each research question and the procedures are detailed in Table 1.
Table 1: Overview of Mixed Methods Research Design

<table>
<thead>
<tr>
<th>Objective</th>
<th>Methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td>To determine the levels of burnout being experienced by occupational therapists practicing in Ontario.</td>
<td>Administer Maslach Burnout Inventory-General Survey.</td>
</tr>
<tr>
<td></td>
<td>Explore individual perception of burnout in interview/ focus group.</td>
</tr>
<tr>
<td>To describe the practice issues faced by participants in their day-to-day work</td>
<td>Administer Areas of Worklife Survey</td>
</tr>
<tr>
<td></td>
<td>Explore practice issues in interview/ focus group</td>
</tr>
<tr>
<td>To describe the coping strategies participants employ to maintain their practice</td>
<td>Administer self developed questionnaire regarding coping strategies</td>
</tr>
<tr>
<td></td>
<td>Explore coping strategies in interview/focus group</td>
</tr>
</tbody>
</table>

Quantitative approaches are located in the post-positivist world-view. This world-view reflects a positivist philosophy and seeks universal truths about reality that can be discovered using objective, reductionist, and quantifiable measurements (Creswell, 2009). Such approaches identify and measure variables to predict, control, describe, generalize, test hypotheses, and/or cause and effect relationships (Creswell). Qualitative approaches, on the other hand, are located in the constructivist worldview. This worldview takes the stance that all people perceive and interpret reality differently (Creswell, 2009). Therefore, this approach explores multiple realities gained from different perspectives and seeks to synthesize the information to help develop a deep understanding of the issues (Hammell, 2002). Qualitative approaches consider individuals within their social context and look to develop insight into their beliefs, value systems, and the meanings they ascribe to experiences (Hammell). These two approaches can be used together to measure different aspects of the same phenomenon, producing a more holistic view of the phenomenon, and a greater depth of understanding of the issues being examined (Creswell, 2009).
As burnout has been studied extensively for the last thirty years and as several standardized assessment measures exist, the quantitative approach was chosen as the principle approach. Standardized measures such as the MBI-GS and AWS were chosen to help quantify the levels of burnout and matches and mismatches between the individual and employer/funding organization.

Hermeneutics was chosen as the qualitative approach to help understand the meanings occupational therapists ascribe to their experiences at work and assist in understanding and describing this shared reality. Hermeneutics is situated in the interpretive paradigm and seeks to study everyday experiences to further knowledge through describing, illuminating, theorizing, or seeking meaning (Higgs, 2001).

Hermeneutics was utilized to uncover themes in the interview and focus group data. Gadamer (1975) outlined the essential constructs in hermeneutics as the hermeneutic circle, dialogue and fusion of horizons. The researcher reads and re-reads the entire manuscript to gain understanding of the phenomenon as a whole (hermeneutic circle) and its individual parts (Bontekoe, 1996).

The hermeneutic circle is a process that explains “how what is understood forms the basis for grasping that which still remains to be understood” (Bontekoe, 1996, pg.2). Understanding is gained by alternating between considering the phenomenon as a whole and as something composed of individual parts (Bontekoe). This dialogue between the researcher and the text helps to gain knowledge and deepen understanding (Koch, 1996). According to Gadamer (1975), researchers bring their own expectations and meanings from their past experiences and frame of reference which helps to merge (fusion of horizons) with the new information and creates new knowledge and understandings.
3.2 Recruitment of Participants

Participants were recruited through convenience sampling. A copy of the e-mail recruitment letter (Appendix B) was submitted to Ontario Society of Occupational Therapists (OSOT) who deemed it too long. A revised recruitment letter (Appendix C) was designed and sent to OSOT after receiving clearance from ethics, which is detailed in section 3.7. Participants were recruited through inclusion of this recruitment letter in the September, 2009 monthly e-newsletter sent by OSOT to its members with a link to the survey stored at the Survey Monkey website, an on-line service that allows its members to create on-line surveys, collect data and export the data to their own computers. The researcher obtained a professional level membership at the Survey Monkey website with data encryption to help keep the data confidential. As an incentive to participate, participants were informed that their names would be entered in a draw for a prize and was included in the information letter.

Once participants completed the survey, they were directed to a Queen’s University secure website to enter their name in the draw for a prize and were asked about their interest in participating in a focus group or interview. All the individuals who answered in the affirmative were contacted. Fifteen individuals gave permission to the researcher to contact them for participating in a focus group. Six of these individuals declined participation citing work and family reasons. Of the remaining nine individuals, two could not participate due to scheduling and work conflicts. Three individuals participated in one focus group and two participated in a second focus group. Two individuals participated in individual interviews. Participation in the study may have been affected by an influenza (H1N1) outbreak in Ontario at that time.
3.2.1 Inclusion and Exclusion Criteria

The inclusion criteria for the study included the following: practicing as an occupational therapist in Ontario, membership in the Ontario Society of Occupational Therapists, and able to use a computer to access the survey online.

3.3 Data Collection Instrument

Data were collected through an online survey constructed by the researcher. Section 1 of the survey asked for demographic information regarding the respondents such as where they practice (their work setting), their level of education, and years of experience. Section 2 of the survey included the MBI-GS (Maslach, Jackson & Leiter, 1996), a widely used burnout measure, and AWS (Leiter & Maslach, 2000). The researcher applied for and received clearance from Psychometrics Canada to use MBI-GS (a Class ‘B’ assessment tool) (Appendix D). The researcher received permission from Centre for Organizational Research & Development, Acadia University to use these measures in exchange for sending them non-identifying data on both measures and demographic information (Appendix E). Section 3 of the survey presented a list of behaviors or cognitive strategies for prioritization by the respondents on a scale from 1 (not at all important) to 7 (extremely important) regarding importance for functioning effectively and maintaining positive attitude towards work (Appendix F).

The survey was designed as part of research methods and design course within the school of Rehabilitation Therapy at Queens’ University. The researcher sought feedback regarding the design from the course instructors; two occupational therapists practicing in local hospitals; and a physiotherapist and occupational therapist with research experience. Four occupational therapists filled the survey out as part of the pilot test and provided feedback to the researcher regarding the design and clarity. The occupational therapist in a research position suggested inclusion of a
demographic question regarding the number of years the responding therapist had been in their current job. The researcher included the question in the final survey.

3.3.1 Data Analysis

To determine the levels of burnout, the mean scores on each subscale of MBI-GS were calculated and compared to the mean norms of the overall sample (Maslach & Jackson, 1996). To determine matches and mismatches between the person and the organization, mean scores on each subscale of AWS were calculated and compared to the means of the normative sample. All statistical analysis was carried out using SPSS 17.0.

In order to determine whether parametric tests could be carried out, kurtosis and skewness statistics were calculated to ensure that the data were relatively normal. The kurtosis statistic varied from –1.453 to 1.488 except for being positively skewed for three of the coping strategies chosen overwhelmingly by the sample as very important to maintain their practice. The skewness statistic varied from –1.512 to .987 except for being positively skewed on one individual question about professional efficacy chosen overwhelmingly by the sample in the measure for burnout. Therefore it was assumed that the sample is normally distributed and the decision was made to carry out parametric testing.

Analyses of variance (ANOVA) analyses were conducted with the independent variables such as years of practice, hours worked as independent variables and the MBI-GS, AWS and coping strategies as dependent variables. In addition, the sample was divided into three groups: low, average and high levels of emotional exhaustion. Analyses of variance were conducted with the three MBI-GS subscales as independent variables, and the six subscales of AWS as the dependent variable to elucidate within and between group differences. Post-hoc Bonferroni tests were carried out to determine where the differences lay between the groups. Similar analyses
were conducted by dividing the sample into three groups: low, average and high levels of cynicism. These analyses were repeated by dividing the sample into three groups: low, average and high levels of professional efficacy. Step-wise regression analyses were conducted to determine which variables from the AWL survey were predictive of emotional exhaustion, cynicism and professional efficacy.

Descriptive statistics were computed to identify the coping strategies rated as most important by the occupational therapists. Analyses of variance were conducted with the emotional exhaustion subscale of the MBI-GS as the independent variable and the coping strategies as dependent variables to ascertain whether there is a difference in the coping strategies employed by occupational therapists in low, average and high levels of emotional exhaustion. These analyses were repeated for the categories low, average and high levels of cynicism and low, average and high levels of professional efficacy.

3.4 Qualitative Data Collection

This part of the study involved a qualitative research design using hermeneutics. The objective of the qualitative data collection was to describe personal experiences of burnout, and to elicit examples of practice issues occupational therapists face in their daily practice and the coping strategies they employ to maintain their practice. This information was collected through conducting focus groups and interviews.

3.4.1 Focus Groups

Focus groups help explain and explore social phenomena and help access this dimension beyond interviews (St. John, 2004). They are an efficient way to collect information, views and opinions from a number of people at the same time. Focus groups help people to ponder, reflect
and listen to experiences and opinions of others. This interaction helps people compare their own reality with others (Krueger & Casey, 2000). They have the additional advantage of helping people brainstorm and build on ideas of others (Paterson & Higgs, 2005).

The researcher utilized a semi-structured interview approach in conducting the focus groups and sent the questions (Appendix G) and definition of burnout and coping skills (Appendix H) in advance to help stimulate thinking and use the time together efficiently. The interview protocol was piloted as part of a research methods and design course by conducting a semi-structured interview with an occupational therapist in a research role. The researcher transcribed the interview and learned to generate themes.

3.4.2 Interview Protocol and Procedure

Focus groups and interviews were conducted by teleconference, due to geographic reasons, between October 26, 2009 and December 22, 2009. To ensure privacy, the calls were made from a private office in a hospital located in Kingston. These were conducted through www.freeconference.com, which includes facilities to audiotape the interviews in a digital format as well as a transcription referral service. The researcher subscribed to toll-free conference with web-recording feature. The participants could dial into the conference from their location within Ontario using a toll-free number with a participant code to enter the conference. This online service audiotapes the teleconference digitally and stores it on a password protected secure site.

Two focus groups and two individual interviews were conducted. The focus groups and interviews elicited participant experience of burnout, examples of day-to-day practice issues encountered by practicing occupational therapists and the coping strategies employed by them to continue practicing. The author elected to have the teleconferences transcribed by the agency sponsored service provider located in Sydney, Australia. This agency offered quick turn around,
the cost was comparable to local costs in Canadian dollars and was an innovative, confidential and convenient option.

3.4.3 Data Analysis Strategy

In this project, hermeneutics was used to gain understanding of the meanings occupational therapists ascribe to stressful situations they encounter at work and how they cope with those situations. Hermeneutics takes the stance that people interpret and engage in processes to understand what is important and real to them in order to create their own construction of reality (Koch, 1996). The researchers’ own experience as a practicing occupational therapist also helped inform the study as this represents a past horizon of the study.

Knowledge was constructed by repeated readings of the text, which lead to construction of meaning between the text and the researcher (Koch, 1999). Utilizing the hermeneutic circle (Bontekoe, 1996), the researcher attempted to understand the whole (the meaning participants ascribed to their experiences at work regarding being able to or not being able to cope with the demands) through grasping its parts (specific examples of not being able to cope with demands gathered from the focus groups and interviews), and “comprehending the meaning of the parts divining the whole” (Crotty, 1998, p.92).

The data collected through the focus groups and interviews represent the new horizon in this study. Different interpretations of the phenomenon (day-to-day practice issues, personal experience of burnout and coping strategies utilized to mitigate it) were brought together through dialogue with the text to produce a shared understanding of the stressors occupational therapists encounter currently in their practice. Past qualitative research on burnout and the researcher’s own experience as a practicing occupational therapist represent past horizon of the study. A fusion of horizons (Gadamer, 1975) occurred as new knowledge was gained through
interpretation of the data, leading to a deeper understanding of the current stressors occupational therapists face and the mediators (coping strategies) that help prevent burnout.

3.5 Mixed Methods Analysis

Creswell and Plano Clark (2007) recommend comparison through a matrix or discussion for concurrent data analysis. The matrix or table can present quotes from participants about the main findings of the study. Another way, which is quite commonly used, is to make comparisons by examining the similarities of the quantitative and qualitative data results in the discussion section of a study. In this method, the researchers often present a statistically significant finding of the study and follow it with a quote from one of the study participants that supports or disconfirms the quantitative result. In this study the researcher chose to merge the quantitative and qualitative data in form of a graphic to help paint an enhanced picture of the practice issues faced by occupational therapists practicing in Ontario and the coping strategies they currently utilize to sustain practice.

3.6 Trustworthiness

Trustworthiness aims to limit bias in interpretation by increasing the credibility and validity of the data analysis (Patton, 2002). According to Patton, judgments about credibility and quality of the research can be made if a set of criteria is followed to produce quality work. Creswell (1998) recommends using at least two of the following eight procedures in order to ensure trustworthiness of findings:

- Prolonged engagement in the field and persistent observation of the participants
- Triangulation, or using various sources of data, methods, investigators and theories
- Peer review or debriefing with a colleague regarding the findings
• Negative case analysis, in which initial patterns of data are revisited if contradictory patterns are found

• Clarifying researcher bias includes positioning of the researcher’s preconceived notions or experiences from the beginning of the study

• Member checking the findings with participants to ensure credibility

• Rich and thick description of quotes that provides the reader with the ability to make judgments as to whether the findings are transferable to another situation

• External audits that include an independent person evaluating the accuracy of the findings

In this study, several procedures were utilized to ensure trustworthy findings. Triangulation of different methods and analyses were used. Methods triangulation involves the use of quantitative and qualitative methods to help with comparative analysis (Patton, 2002). This study utilized MBI-GS and AWS: two standardized assessment tools commonly used to measure burnout. The list of coping strategies and behaviors was constructed by reviewing the relevant literature and has face validity. The thesis supervisor attended all except one teleconferenced interview. The researcher did the primary analysis of the interview and focus group data with spot checks by the supervisor. Several participants provided rich, thick quotes, describing the meaning of their experiences, which enhanced the credibility of the themes found. Additional review came from the thesis advisory committee. Additionally, the preliminary quantitative results were submitted in poster form to the World Federation of Occupational Therapists conference in May 2010 in Chile and presented by the thesis supervisor. The supervisor brought back comments of interest especially around coping strategies to help prevent burnout and build engagement.
3.7 Ethical Considerations

Ethical clearance for this study was received from the Queen’s University Research Ethics Board (REH-453-09) (see Appendix H). An amendment was made to the recruitment letter and ethics clearance was obtained for the revised version (see Appendix I).

Confidentiality was maintained by collecting data anonymously on the online survey. The researcher contacted the individuals who agreed to participate in the focus groups and interviews by email. Names of participants in the interview, and on their demographic information forms were converted into initials and later into numeric codes. The electronic audio-taped interviews and focus groups and their transcripts were stored on the principal investigator’s password protected personal computer. All paper materials were placed into a locked cabinet held in a private office at a local hospital.

Potential risks to the study participants were deemed to be minimal. Potential benefits were minimal and may have included increased awareness of warning signs of burnout and knowledge of coping strategies to mitigate it.
Chapter 4

Results

In this chapter, quantitative and qualitative data on the levels of burnout experienced by the sample of occupational therapists is presented. The quantitative section presents data from MBI-GS and AWS survey individually which is followed by a combined analysis to present the mediation model of burnout. The qualitative section presents themes identified regarding practice issues discussed in the focus groups and interviews. The next section will present quantitative and qualitative results on coping strategies the practicing occupational therapists employ to sustain their practice. Finally a model that integrates the quantitative and qualitative data from this study is presented.

4.1 Participant Characteristics

A link to the survey was included in an email newsletter through Ontario Society of Occupational Therapists on September 15, 2009. This email went to approximately 2587 practicing occupational therapists. The survey was administered through a 'Survey Monkey' website and was open for one month. Of the 76 individuals who started the survey, 63 submitted a completed survey (see Table 2 for details). The average age of the respondents was 40.21 years with the range being 26 to 67 years. The respondents indicated that they had been practicing as occupational therapists for an average of 14.72 years with the minimum at 6 months and the maximum at 44 years. Nineteen of the respondents (27.5%) worked part time (less than 35 hrs per week), 27 worked full time (39.1%) (between 35 and 40 hours per week) and 11 (15.9%) worked over 40 hours per week. Four of the respondents (6.3%) held two jobs. Fifty four (85.7%) respondents indicated that they were direct service providers, 4 (6.3%) were administrators, 3 (4.8%) were consultants and 2 (3.2%) were in other positions. The sample was compared
proportionally to the Canadian Institute for Health Information (CIHI), 2010 report and found to be representative of the population of occupational therapists practicing in Ontario. CIHI is a not-for-profit, independent organization that collects and disseminates information on health and health care in Canada including information on human health workforce database.

Table 2: General Characteristics of Study Participants

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td>5</td>
<td>7.9</td>
</tr>
<tr>
<td>Women</td>
<td>58</td>
<td>92.1</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>10</td>
<td>15.9</td>
</tr>
<tr>
<td>Married/permanent relationship</td>
<td>48</td>
<td>76.2</td>
</tr>
<tr>
<td>Separated/Divorced</td>
<td>5</td>
<td>7.9</td>
</tr>
<tr>
<td><strong>Occupational Therapy Education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diploma</td>
<td>3</td>
<td>4.8</td>
</tr>
<tr>
<td>Bachelor’s Degree</td>
<td>39</td>
<td>61.9</td>
</tr>
<tr>
<td>Master’s Degree</td>
<td>21</td>
<td>33.3</td>
</tr>
<tr>
<td><strong>Workplace</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community</td>
<td>35</td>
<td>56.5</td>
</tr>
<tr>
<td>General Hospital</td>
<td>19</td>
<td>30.6</td>
</tr>
<tr>
<td>Long Term Care</td>
<td>8</td>
<td>12.9</td>
</tr>
</tbody>
</table>

**Characteristics of Participants in Focus Groups and/or Interviews**

Three individuals (ID 3-5) participated in one focus group and two (ID 1 and 2) participated in a second focus group. Two individuals (ID 6 and 7) participated in individual interviews. All the participants were female. The data collection for this phase coincided with influenza (H1N1) outbreak in Ontario, which may have affected the participation rate in this study (Table 3).
Table 3: Characteristics of Focus Group/Interview Participants

<table>
<thead>
<tr>
<th>ID</th>
<th>Age</th>
<th>Educational Background</th>
<th>Years of Practice</th>
<th>Current Practice Setting</th>
<th>Work Status (Full Time (FT)/Part Time (PT)/Non Practicing (NP))</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>31</td>
<td>BScOT</td>
<td>7.5 Yrs</td>
<td>Adult Outpatient Rehab (Acquired Brain Injury &amp; Cerebral Palsy)</td>
<td>FT</td>
</tr>
<tr>
<td>2</td>
<td>34</td>
<td>BScOT; MSc (Rehab Science)</td>
<td>8 Yrs</td>
<td>Community (Adults 65+)</td>
<td>FT</td>
</tr>
<tr>
<td>3</td>
<td>41</td>
<td>BScOT</td>
<td>19 Yrs</td>
<td>Children’s Rehab Centre</td>
<td>FT</td>
</tr>
<tr>
<td>4</td>
<td>40</td>
<td>BScOT, MScOT</td>
<td>17.5 Yrs</td>
<td>Private Practice</td>
<td>PT</td>
</tr>
<tr>
<td>5</td>
<td>67</td>
<td>Physical/Occupational Therapy Diploma, BScOT</td>
<td>43 Yrs</td>
<td>Private Practice (Adults)</td>
<td>NP</td>
</tr>
<tr>
<td>6</td>
<td>34</td>
<td>MScOT</td>
<td>4.5 Yrs</td>
<td>Inpatient pediatric rehab &amp; complex continuing care (0-18 yrs)</td>
<td>FT</td>
</tr>
<tr>
<td>7</td>
<td>53</td>
<td>BScOT</td>
<td>33 Yrs</td>
<td>Private Practice</td>
<td>NP</td>
</tr>
</tbody>
</table>

4.2 Burnout

4.2.1 Quantitative Data

Burnout was measured through the *MBI-GS* and the *AWS*. Data from both surveys are presented separately followed by analysis of the overall findings to present a mediation model of burnout.
Maslach Burnout Inventory-General Survey Results

The overall results show that occupational therapists in this sample fell in the average range of burnout for *emotional exhaustion* and *professional efficacy* dimensions (Table 4). They scored in the high range of burnout in the *cynicism* dimension. This test was normed on 5259 respondents from Canada (3253), Holland (1717) and Finland (289).

Table 4: Overall Statistics of Subscale Scores on the Maslach Burnout Inventory-General Survey

<table>
<thead>
<tr>
<th>MBI-GS Subscales</th>
<th>M</th>
<th>SD</th>
<th>Low</th>
<th>Average</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exhaustion</td>
<td>2.81</td>
<td>1.26</td>
<td>&lt;2.00</td>
<td>2.01-3.19</td>
<td>&gt;3.20</td>
</tr>
<tr>
<td>Cynicism</td>
<td>2.23</td>
<td>1.40</td>
<td>&lt;1.00</td>
<td>1.01-2.19</td>
<td>&gt;2.20</td>
</tr>
<tr>
<td>Professional Efficacy</td>
<td>4.39</td>
<td>0.90</td>
<td>&gt;5.00</td>
<td>4.01-4.99</td>
<td>&lt;4.00</td>
</tr>
</tbody>
</table>

Dividing the sample into the three categories of burnout (low, average and high) reveals that the respondents fall in all three sub-groupings with slightly higher number of respondents in the high levels of burnout (Table 5).

Table 5: Prevalence of Burnout in the sample (n = 63)

<table>
<thead>
<tr>
<th>Burnout Traits</th>
<th>Low n (%)</th>
<th>Average n (%)</th>
<th>High n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional Exhaustion</td>
<td>22 (31.9%)</td>
<td>17 (24.6%)</td>
<td>24 (34.8%)</td>
</tr>
<tr>
<td>Cynicism</td>
<td>16 (23.2%)</td>
<td>17 (24.6%)</td>
<td>30 (43.5%)</td>
</tr>
<tr>
<td>Professional Efficacy</td>
<td>17 (24.6%)</td>
<td>27 (39.1%)</td>
<td>19 (27.5%)</td>
</tr>
</tbody>
</table>
Areas of Worklife Survey Results

T-tests were conducted to compare the results obtained to the Canadian data available (Table 6). For workload, the sample was statistically different from the Canadian data in that the practicing occupational therapists reported significantly more agreement with the statement “I have enough time to do what is important in my job”, \( t(62) = 3.42, p<0.01 \). Regarding control, the occupational therapists reported more control, \( t(62) = 5.71, p<0.01 \) than the national sample and greater autonomy in their work, \( t(62) = 6.69, p<0.01 \). Regarding rewards, the occupational therapists reported that they feel their work and efforts are appreciated at a significantly higher rate than the national norm, \( t(62) = 4.50, p<0.01 \) and noticed, \( t(62) = 2.87, p<0.01 \). The occupational therapist’s sense of community and support at work did not differ from the national sample. Regarding fairness, the occupational therapists differed significantly from the national sample in indicating that the managers allocate resources \( t(62) = 2.91, p<0.05 \) and treat all employees fairly, \( t(62) = 2.75, p<0.05 \) and favoritism does not determine decisions at work, \( t(62) = 4.26, p<0.01 \). Occupational therapists differed from the national data in indicating that they do not have to compromise their values at work \( t(62) = 2.38, p<0.05 \).

Table 6: Summary of t-tests comparing results of Areas of Worklife to norms (Canada)

<table>
<thead>
<tr>
<th>Areas of Worklife</th>
<th>M (SD)</th>
<th>Norms (Canada) M (SD)</th>
<th>t</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workload</td>
<td>2.73 (0.73)</td>
<td>2.62 (0.79)</td>
<td>1.23</td>
<td>0.22</td>
</tr>
<tr>
<td>Control</td>
<td>3.60 (0.87)</td>
<td>3.14 (0.85)</td>
<td>4.26</td>
<td>0.00*</td>
</tr>
<tr>
<td>Rewards</td>
<td>3.26 (0.80)</td>
<td>3.08 (0.91)</td>
<td>1.80</td>
<td>0.08</td>
</tr>
<tr>
<td>Community</td>
<td>3.40 (0.92)</td>
<td>3.40 (0.80)</td>
<td>0.06</td>
<td>0.96</td>
</tr>
<tr>
<td>Fairness</td>
<td>3.09 (0.78)</td>
<td>2.76 (0.76)</td>
<td>3.41</td>
<td>0.00*</td>
</tr>
<tr>
<td>Values</td>
<td>3.61 (0.80)</td>
<td>3.50 (0.68)</td>
<td>1.05</td>
<td>0.30</td>
</tr>
</tbody>
</table>

*p<0.01
Analysis of Burnout for the sample utilizing the Mediation Model

Correlations between variables measuring burnout (MBI-GS) and those assessing matches and mismatches (AWS) between the person and the organization were computed. Results are presented in Table 7. Exhaustion was highly positively correlated with cynicism ($r = .66, p < .01$) and both were negatively correlated with professional efficacy. Exhaustion and cynicism were negatively correlated with the six areas of worklife. The strongest correlations were between workload and exhaustion ($r = -.55, p < .01$) followed by rewards and professional efficacy ($r = .46, p < .01$). Additionally, values and cynicism ($r = -.38, p < .01$) and rewards and cynicism ($r = -.36, p < .01$) were negatively correlated. Within the six areas of worklife, the strongest correlation was between values and fairness ($r = 0.70, p < .01$); values and control ($r = 0.61, p < .01$); values and rewards ($r = .55, p < .01$). Fairness and control were also strongly correlated ($r = .56, p < .01$) as were rewards and control ($r = .53, p < .01$) and community and rewards ($r = .50, p < .01$).

Table 7: Correlations between MBI-GS and AWS

<table>
<thead>
<tr>
<th>Variables</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Exhaustion</td>
<td>_</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Cynicism</td>
<td>.66**</td>
<td>_</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Efficacy</td>
<td>-.08</td>
<td>-.19</td>
<td>_</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Workload</td>
<td>-.55**</td>
<td>-.21</td>
<td>-.02</td>
<td>_</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Control</td>
<td>-.30*</td>
<td>-.22</td>
<td>.21</td>
<td>.35**</td>
<td>_</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Rewards</td>
<td>-.28*</td>
<td>-.36**</td>
<td>.46**</td>
<td>.24</td>
<td>.53**</td>
<td>_</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Community</td>
<td>-.27*</td>
<td>-.26*</td>
<td>.15</td>
<td>.21</td>
<td>.20</td>
<td>.50**</td>
<td>_</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Fairness</td>
<td>-.19</td>
<td>-.29*</td>
<td>.11</td>
<td>.28*</td>
<td>.56**</td>
<td>.48**</td>
<td>.39**</td>
<td>_</td>
<td></td>
</tr>
<tr>
<td>9. Values</td>
<td>-.27*</td>
<td>-.38**</td>
<td>.20</td>
<td>.23</td>
<td>.61**</td>
<td>.55**</td>
<td>.36**</td>
<td>.70**</td>
<td>_</td>
</tr>
</tbody>
</table>

** Correlations significant at $p < .01$ * Correlations significant at $p < .05$
Levels of emotional exhaustion have been established to be the best predictor of burnout (Maslach & Leiter, 2004). A one-way ANOVA was conducted to determine the variance on the responses to Areas of Worklife survey for occupational therapists reporting low, average or high levels of exhaustion. Results show that statistically significant differences exist between groups in all areas and are outlined in Table 8.

**Table 8: Summary of ANOVA for differences in score on AWS for occupational therapists with low, average or high levels of exhaustion**

<table>
<thead>
<tr>
<th></th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Workload</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between Groups</td>
<td>7.16</td>
<td>2</td>
<td>3.58</td>
<td>8.32**</td>
</tr>
<tr>
<td>Within Groups</td>
<td>25.82</td>
<td>60</td>
<td>0.43</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>32.97</td>
<td>62</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Control</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between Groups</td>
<td>8.59</td>
<td>2</td>
<td>4.29</td>
<td>6.67**</td>
</tr>
<tr>
<td>Within Groups</td>
<td>38.64</td>
<td>60</td>
<td>0.64</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>47.23</td>
<td>62</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Rewards</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between Groups</td>
<td>7.76</td>
<td>2</td>
<td>3.88</td>
<td>7.26**</td>
</tr>
<tr>
<td>Within Groups</td>
<td>32.05</td>
<td>60</td>
<td>0.53</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>39.80</td>
<td>62</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Community</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between Groups</td>
<td>6.10</td>
<td>2</td>
<td>3.05</td>
<td>3.96*</td>
</tr>
<tr>
<td>Within Groups</td>
<td>46.29</td>
<td>60</td>
<td>0.77</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>52.40</td>
<td>62</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Fairness</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between Groups</td>
<td>4.54</td>
<td>2</td>
<td>2.27</td>
<td>4.09*</td>
</tr>
<tr>
<td>Within Groups</td>
<td>33.33</td>
<td>60</td>
<td>0.56</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>37.87</td>
<td>62</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Values</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between Groups</td>
<td>5.24</td>
<td>2</td>
<td>2.62</td>
<td>4.55*</td>
</tr>
<tr>
<td>Within Groups</td>
<td>34.52</td>
<td>60</td>
<td>0.58</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>39.76</td>
<td>62</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**p<0.01, *p<0.05**
To understand the contributions of the six areas of worklife on the level of emotional exhaustion, post-hoc Bonferroni tests were carried out to determine where the differences lay between the groups. Results indicate that statistically significant differences exist between all groups for workload, control, and rewards. For the community and fairness dimensions of work, statistically significant results are detectable between individuals with low and average levels of exhaustion. For the values dimension of work, statistically significant differences are detectable between individuals with low and high levels of exhaustion. Details are outlined in Table 9.

Table 9: Multiple comparisons (Bonferroni) for identification of differences in AWS for respondents with low (1), average (2) and high (3) level of emotional exhaustion

<table>
<thead>
<tr>
<th></th>
<th>Comparisons</th>
<th>Mean Difference</th>
<th>Significance (α)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workload</td>
<td>1 vs. 2</td>
<td>0.64</td>
<td>0.011</td>
</tr>
<tr>
<td></td>
<td>1 vs. 3</td>
<td>0.74</td>
<td>0.001</td>
</tr>
<tr>
<td>Control</td>
<td>1 vs. 2</td>
<td>0.85</td>
<td>0.005</td>
</tr>
<tr>
<td></td>
<td>1 vs. 3</td>
<td>0.70</td>
<td>0.013</td>
</tr>
<tr>
<td>Rewards</td>
<td>1 vs. 2</td>
<td>0.78</td>
<td>0.005</td>
</tr>
<tr>
<td></td>
<td>1 vs. 3</td>
<td>0.70</td>
<td>0.006</td>
</tr>
<tr>
<td>Community</td>
<td>1 vs. 2</td>
<td>0.71</td>
<td>0.045</td>
</tr>
<tr>
<td>Fairness</td>
<td>1 vs. 2</td>
<td>0.66</td>
<td>0.023</td>
</tr>
<tr>
<td>Values</td>
<td>1 vs. 3</td>
<td>0.61</td>
<td>0.026</td>
</tr>
</tbody>
</table>

A stepwise regression analysis was conducted to ascertain which areas of worklife predict emotional exhaustion in this study. The results showed that workload is the only variable predictive of emotional exhaustion. Workload predicted 29.9% of the variance in the exhaustion trait. All six areas of worklife together predicted 35.3% of the variance in emotional exhaustion for the sample. Details are presented in Table 10.
Because workload emerged as a predictor of emotional exhaustion in this study, it was examined in further detail. A one-way ANOVA was conducted to determine the variance on the responses to individual questions on workload in *Areas of Worklife* survey for occupational therapists reporting low, average or high levels of emotional exhaustion. The results showed that their responses differed on four of the questions, as outlined in Table 11.

---

**Table 10: Summary of Regression Analysis of AWS predicting burnout**

<table>
<thead>
<tr>
<th>Variable</th>
<th>$b$</th>
<th>SE $b$</th>
<th>$\beta$</th>
<th>$t$</th>
<th>Sig.</th>
<th>$R^2$</th>
<th>$\Delta R^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant</td>
<td>6.47</td>
<td>0.79</td>
<td>_</td>
<td>8.16</td>
<td>0.00</td>
<td>_</td>
<td>_</td>
</tr>
<tr>
<td>Workload</td>
<td>-0.85</td>
<td>0.20</td>
<td>-0.49</td>
<td>-4.23</td>
<td>0.00</td>
<td>.546</td>
<td>.299</td>
</tr>
<tr>
<td>Control</td>
<td>-0.11</td>
<td>0.22</td>
<td>-0.08</td>
<td>-0.51</td>
<td>0.61</td>
<td>.559</td>
<td>.313</td>
</tr>
<tr>
<td>Rewards</td>
<td>-0.07</td>
<td>0.23</td>
<td>-0.04</td>
<td>-0.29</td>
<td>0.77</td>
<td>.569</td>
<td>.324</td>
</tr>
<tr>
<td>Community</td>
<td>-0.19</td>
<td>0.18</td>
<td>-0.14</td>
<td>-1.08</td>
<td>0.29</td>
<td>.579</td>
<td>.335</td>
</tr>
<tr>
<td>Fairness</td>
<td>0.30</td>
<td>0.26</td>
<td>0.19</td>
<td>1.15</td>
<td>0.25</td>
<td>.584</td>
<td>.341</td>
</tr>
<tr>
<td>Values</td>
<td>-0.27</td>
<td>0.26</td>
<td>-0.17</td>
<td>-1.02</td>
<td>0.31</td>
<td>.595</td>
<td>.353</td>
</tr>
</tbody>
</table>

*Note: $b =$ regression coefficient, SE $b =$ standard error in $b$, $\beta =$ standardized value of regression coefficient, $R^2 =$ variance in correlation, $\Delta R^2 =$ change in R*
Table 11: Summary of ANOVA for differences in scores on Workload for occupational therapists with low, average or high levels of exhaustion

<table>
<thead>
<tr>
<th>Workload</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>After work I come home too tired to do the things I like to do.</td>
<td>21.35</td>
<td>2</td>
<td>10.67</td>
<td>14.46**</td>
</tr>
<tr>
<td>I have so much work to do on my job that it takes me away from my personal interests.</td>
<td>21.36</td>
<td>2</td>
<td>10.68</td>
<td>9.22**</td>
</tr>
<tr>
<td>I have enough time to do what is important to me on my job.</td>
<td>8.31</td>
<td>2</td>
<td>4.15</td>
<td>4.0*</td>
</tr>
<tr>
<td>I leave my work behind when I go home at the end of the workday.</td>
<td>9.90</td>
<td>2</td>
<td>4.94</td>
<td>3.55*</td>
</tr>
<tr>
<td>I go home at the end of the workday.</td>
<td>93.56</td>
<td>62</td>
<td>1.39</td>
<td></td>
</tr>
</tbody>
</table>

**p<0.01, *p<0.05

Post-hoc Bonferroni tests showed that statistically significant differences were detectable for most of the answers provided by individuals with low, average and high levels of emotional exhaustion for the individual questions (Table 12). No statistically significant differences were detected between the respondents in the low and average level of emotional exhaustion related to ‘leaving their work behind at the end of the day’. Interestingly, there was no statistically significant difference between the respondents in the low and high levels of emotional exhaustion related to having ‘enough time to do what is important in their job’.
Table 12: Multiple comparisons (Bonferroni) for identification of differences in Workload for respondents with low (1), average (2) and high (3) levels of emotional Workload

<table>
<thead>
<tr>
<th>Workload</th>
<th>Comparisons</th>
<th>Mean Difference</th>
<th>Significance (α)³</th>
</tr>
</thead>
<tbody>
<tr>
<td>After work I come home too tired to do the things</td>
<td>1 vs. 2</td>
<td>1.03</td>
<td>0.001</td>
</tr>
<tr>
<td>I have so much work to do on my job that takes</td>
<td>1 vs. 3</td>
<td>1.32</td>
<td>0.000</td>
</tr>
<tr>
<td>I have enough time to do what is important to me</td>
<td>1 vs. 2</td>
<td>0.96</td>
<td>0.023</td>
</tr>
<tr>
<td>I leave my work behind when I go home at the end</td>
<td>1 vs. 3</td>
<td>0.91</td>
<td>0.035</td>
</tr>
</tbody>
</table>

Furthermore, high levels of *cynicism* have been established as another dimension of burnout (Maslach & Leiter, 2005). A one-way ANOVA was conducted to determine the variance on the responses to Areas of Worklife survey for occupational therapists reporting low, average or high levels of *cynicism*. The results showed that statistically significant differences exist in all areas except *control* and are outlined in Table 13.
Table 13: Summary of ANOVA for differences in scores on AWS for occupational therapists with low, average and high levels of cynicism

<table>
<thead>
<tr>
<th></th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workload</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between Groups</td>
<td>3.54</td>
<td>2</td>
<td>1.77</td>
<td>3.61</td>
<td>0.033</td>
</tr>
<tr>
<td>Within Groups</td>
<td>29.43</td>
<td>60</td>
<td>0.49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>32.97</td>
<td>62</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rewards</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between Groups</td>
<td>6.54</td>
<td>2</td>
<td>3.27</td>
<td>5.90</td>
<td>0.005</td>
</tr>
<tr>
<td>Within Groups</td>
<td>33.26</td>
<td>60</td>
<td>0.55</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>39.80</td>
<td>62</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between Groups</td>
<td>9.07</td>
<td>2</td>
<td>4.54</td>
<td>6.28</td>
<td>0.003</td>
</tr>
<tr>
<td>Within Groups</td>
<td>43.33</td>
<td>60</td>
<td>0.72</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>52.40</td>
<td>62</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fairness</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between Groups</td>
<td>4.20</td>
<td>2</td>
<td>2.10</td>
<td>3.74</td>
<td>0.029</td>
</tr>
<tr>
<td>Within Groups</td>
<td>33.68</td>
<td>60</td>
<td>0.56</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>37.87</td>
<td>62</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Values</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between Groups</td>
<td>7.48</td>
<td>2</td>
<td>3.74</td>
<td>6.95</td>
<td>0.002</td>
</tr>
<tr>
<td>Within Groups</td>
<td>32.28</td>
<td>60</td>
<td>0.54</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>39.76</td>
<td>62</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Post-hoc Bonferroni tests were able to detect statistically significant differences between the low, average and high levels of cynicism groups for the rewards and values dimensions of work. For workload and fairness aspects of work, statistically significant differences exist between the individuals reporting average and high levels of cynicism. The community
dimension detected statistically significant differences between low and high levels of cynicism.

The results are presented in Table 14.

**Table 14: Multiple comparisons (Bonferroni) for identification of differences in AWS for respondents with low (1), average (2) and high (3) levels of cynicism**

<table>
<thead>
<tr>
<th>Comparisons</th>
<th>Mean Difference</th>
<th>Significance (α)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workload</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 vs. 3</td>
<td>0.56</td>
<td>0.031</td>
</tr>
<tr>
<td>Rewards</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 vs. 1</td>
<td>-0.61</td>
<td>0.032</td>
</tr>
<tr>
<td>3 vs. 2</td>
<td>-0.68</td>
<td>0.012</td>
</tr>
<tr>
<td>Community</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 vs. 3</td>
<td>0.93</td>
<td>0.002</td>
</tr>
<tr>
<td>Fairness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 vs. 3</td>
<td>0.56</td>
<td>0.048</td>
</tr>
<tr>
<td>Values</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 vs. 1</td>
<td>-0.64</td>
<td>0.019</td>
</tr>
<tr>
<td>3 vs. 2</td>
<td>-0.73</td>
<td>0.005</td>
</tr>
</tbody>
</table>

Regression analysis was conducted to determine which variables from the AWL predict cynicism in the sample. None of the variables make a statistically significant contribution to predicting cynicism. These variables predict 20% of the variance in the levels of cynicism.

One-way ANOVAs were conducted to determine the variance on the AWL for low, average and high levels of professional efficacy. Only the rewards dimension was statistically significant ($F = 5.95$, $p = .004$). Post hoc Bonferroni tests indicated that individuals reporting high levels of professional efficacy ($MD = .85$, $p = .003$) felt more rewarded by their work than individuals reporting low levels of efficacy.

Regression analysis was conducted to ascertain which areas of worklife predicted professional efficacy in this study. The results showed that rewards was the only variable predictive of professional efficacy. Rewards predicted 15.5% of the variance in the efficacy trait. All six areas of worklife predicted 23.5% of the variance in professional efficacy. The results are presented in Table 15.
Rewards has been established as a predictor of professional efficacy in this study and therefore examined in further detail. A one-way ANOVA was conducted to determine the variance on the responses to individual questions on rewards in the AWL survey for occupational therapists reporting low, average or high levels of professional efficacy. The results showed that their responses differed on three of the questions and are outlined in Table 16.
Table 16: Summary of ANOVA for differences in scores on Rewards for occupational therapists with low (1), average (2) and high (3) levels of professional efficacy

<table>
<thead>
<tr>
<th>Workload</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>I receive recognition from others in my work</td>
<td>Between Groups 8.75</td>
<td>2</td>
<td>4.38</td>
<td>4.26*</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>61.66</td>
<td>60</td>
<td>0.74</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>70.41</td>
<td>62</td>
<td></td>
</tr>
<tr>
<td>My work is appreciated</td>
<td>Between Groups 5.57</td>
<td>2</td>
<td>2.79</td>
<td>4.40*</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>37.99</td>
<td>60</td>
<td>0.63</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>43.56</td>
<td>62</td>
<td></td>
</tr>
<tr>
<td>My efforts usually go unnoticed (Reverse scored)</td>
<td>Between Groups 6.92</td>
<td>2</td>
<td>3.46</td>
<td>5.78**</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>35.94</td>
<td>60</td>
<td>0.60</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>42.86</td>
<td>62</td>
<td></td>
</tr>
<tr>
<td>I do not get recognized for all the things I contribute (Reverse scored)</td>
<td>Between Groups 6.27</td>
<td>2</td>
<td>3.14</td>
<td>2.84</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>66.14</td>
<td>60</td>
<td>1.10</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>93.56</td>
<td>62</td>
<td></td>
</tr>
</tbody>
</table>

**\( p < .01 \), *\( p < .05 \)

Post-hoc Bonferroni tests showed that statistically significant differences were detectable for the answers provided by individuals with low, average and high levels of professional efficacy for the individual questions (Table 17).
Table 17: Multiple comparisons (Bonferroni) for identification of differences in Rewards for respondents with low (1), average (2) and high (3) levels of professional efficacy

<table>
<thead>
<tr>
<th>Rewards</th>
<th>Comparisons</th>
<th>Mean Difference</th>
<th>Significance (α)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I receive recognition from others in my work.</td>
<td>1 vs. 2</td>
<td>0.60</td>
<td>0.18</td>
</tr>
<tr>
<td>My work is appreciated</td>
<td>1 vs. 3</td>
<td>0.98</td>
<td>0.016</td>
</tr>
<tr>
<td>My efforts usually go unnoticed (Reverse scored)</td>
<td>1 vs. 2</td>
<td>0.35</td>
<td>0.49</td>
</tr>
<tr>
<td></td>
<td>1 vs. 2</td>
<td>0.78</td>
<td>0.014</td>
</tr>
<tr>
<td>I do not get recognized for all the things I contribute (Reverse scored)</td>
<td>1 vs. 3</td>
<td>0.42</td>
<td>0.26</td>
</tr>
<tr>
<td></td>
<td>1 vs. 3</td>
<td>0.88</td>
<td>0.004</td>
</tr>
</tbody>
</table>

4.2.2 Qualitative Data Results

In this section, data from focus groups and interviews related to the participants’ experience of burnout and the practice issues they encounter at work is presented.

Participant Experience of Burnout

The seven participants indicated that they were attracted to sign up for the focus group because they felt it was an important topic which is not adequately addressed in their entry to practice curriculum. They indicated that they have noted periods of high stress in themselves and in their colleagues especially as organizations are going through enormous transformations. They alluded to the fiscal climate of restraint and therefore job cuts with everyone being asked to do more with less. The prevailing motivation is captured succinctly by the comments made by participant 3 (P3) included below.

“I think that my interest in it is just having reflected on my own career in times of periods of stress and feeling burnt out and watching some of my co-workers. I think certainly
particularly at this time when the economy’s so tight and everybody’s budget is tight and we’re all being asked to do more with less, but I think it’s a very timely topic and one that really does need to be in the forefront of people’s discussions sometimes in the workplace. (P3)

Three of the participants, who reported low levels of burnout, spoke of being able to mediate work stressors through using strategies such as taking a vacation, knowing that their practice fluctuates and keeping a focus on work-life balance.

“I think I know when I am ready for a vacation. So I think you start to, you are not quite as patient with people at work I think. I think usually once I have had some time off I come back and I feel like I am able to cope again.” (P6)

“I think there are certainly ebbs and flows where you feel more down and maybe there’s a continuum of burnout and I’m probably somewhere along the milder end of the continuum, but I feel like there was a point where I had a number of clients, it just happened that way, that weren’t progressing and they didn’t appear to be interested in progressing and I found that quite challenging. I think that cynicism piece in your definition jumped out at me when you said that, because that’s not typically how I approach my practice, but I found myself having more negative attitudes towards clients and that kind of thing. Then they moved on and my case load rallied a bit, so I felt like I moved back along the continuum a bit on that burnout scale.” (P4)

“No I have not had a personal experience with burnout. Like I said before I really attribute that to my very focused and ... yes, the cogent focus on keeping balance in my life and keeping work to work and home to home.” (P2)

Two of the participants identified themselves in the average range of burnout and one of them spoke of her home life spilling into work as a contributing factor.

”You have these days of ups and downs where you’re excited about your career and then periods when you are frustrated, where it feels like slogging, not sure you want to go on and you start looking at alternatives, but I think I’ve been lucky enough to say that they haven’t been severe , I’ve never had to leave the career. I have changed jobs in the past during those periods of time, because it does, I think, sometimes help to have a change or look for something that does align better with my hope for my values, but certainly there are times, and I anticipate that there will be times in the future that I hit those low points and wonder about whether this is the right job for me.” (P3)
“I understand burnout is a continuum and I would say I was probably on the mild to moderate end. I don’t think it was severe because I certainly didn’t stop being able to function. I did go through a period maybe one to two years ago where I was feeling quite exhausted. Just feeling over extended between work and school and I was transitioning from one job to another and I had taken on a lot of extra responsibilities in and around that transition which were quite overwhelming for me. That’s the emotional exhaustion dimension, I am looking at the cynicism dimension. I did find I was feeling probably a loss of idealism more than anything else. I guess I was just feeling really discouraged at my capacity to deal with the extent of the need and my capacity to make a difference. I’m glad to say since then that has improved as I have grown into my role a little bit, but it was a fairly new team with a fairly new role. I am the only OT on it and it was not easy for me to figure out where my energy made the most difference. I think initially I was using my time the way I used to in my former role and it was effective there but it wasn’t effective in the new role. It took me quite a while to figure that out. I was going to school part time. I have only been married for two years so we’re renovating our home so there is a lot going on at home. My husband was a full time student, so he was really stressed as well and not always able to support around the household, so I was maybe doing more of the housework than I really had time for. I just felt really overloaded and in terms of efficacy I certainly had a reduced feeling of personal accomplishment in that I didn’t feel able to keep up with the demands and maybe that’s because nobody could have, but it was hard on my morale for sure. I did feel quite discouraged about my work for a while there. “(P1)

Two of the participants identified themselves as burnt out and spoke of their experiences through that journey.

” I’m not getting referrals from CCAC. I am not getting paid for what I do in private practice. I am in burnout. I have taken time off my profession to try to cope with those type of things…depressing, because I’ve a lot of education and experience that is not being utilized, that is the primary thing; frustrated, angry.”(P5)

“The fact that I went into total burnout in Nov/08. I went into the hospital for 3 months. When I came out it was clear to me that I could not go back to the work I was doing. I was anxious, depressed and overwhelmed. My GP gave me an antidepressant that almost killed me. What was leading up to was burnout, fed up, and overwhelmed by the work I was doing.” (P7)
Participants also wanted to send a clear message to policy makers, educators, administrators, colleagues and professional associations about the importance of this topic. Participants asked for time to be allotted for a discussion of this topic while students are training to become an occupational therapist or later one when they are practicing. One participant captured it succinctly:

“I think it really critical to educate our students early, not only about work life balance but also about things like compassion fatigue and secondary traumatic stress and so on, because they are going to encounter those in their practice. My education was a few years ago but I don’t remember hearing a thing about it, I don’t know if that has changed. People really need to know about that and they need to be prepared, they need to understand the symptoms to watch for in themselves and in each other and to know what they can do; and to know that it’s normal. I think we’re often taught to distance our inner emotions and our personality from our practice and certainly that’s very important, however we don’t stop having feelings just because we’re at work and when you see somebody suffering it does affect you in some way. I think we need some safe venues to talk about that and I guess that would be a message to other clinicians and perhaps professional associations, just that I think clinicians need to support each other with this stuff. We need to acknowledge that it goes on and that it’s normal and that it comes and goes, this compassion fatigue thing. We need to have some venues to talk about it.” (P1)

Another participant pointed out the ripple effect of sudden changes in healthcare policy and the impact it has on front line staff.

“Just being mindful, aware of the impact of their actions, that their actions, while they might seem kind of menial to them to slash a budget line or what not can make a big difference in the life of a healthcare provider which in turn makes it more difficult for them to provide the healthcare that they’re supposed to providing. It’s that whole trickle-down effect and sometimes I don’t actually trust or believe that they understand the implications of some of the decisions that they make.” (P2)

Another participant asked for recognition of teaching and research as valuable contributions by clinicians apart from client care.

“I guess for them [administrators] to understand all of our competing demands like you sort of mentioned earlier that it is not always just clinical work that is competing for our time. And I think looking at caseload is important in terms of being able to service the kids properly and also recognizing the teaching I think would be a big one and opportunities to be more involved with research because it is, that is a big part of our,
like evidence-based practice so we don't always get to be involved with the actual research part day-to-day anyways.” (P6)

4.3 Practice Issues

Focus groups and interviews with participants revealed commonalities and differences regarding factors that impact on their day-to-day practice. Overall, four major themes emerged from the focus groups and interviews (see Table 18 for a summary of the themes and sub-themes).

Table 18: Clusters of Common Themes for day-to-day practice issues

<table>
<thead>
<tr>
<th>1. Demands on time</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Burgeoning workload</td>
</tr>
<tr>
<td>b) Unrealistic demands</td>
</tr>
<tr>
<td>c) Juggling clinical and non-clinical duties</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Conflict</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Mismatch in values with the organization</td>
</tr>
<tr>
<td>b) Lack of health care resources</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Lack of respect</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Need to provide constant justification</td>
</tr>
<tr>
<td>b) Lowered morale over bureaucratic delays</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. Lack of autonomy</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Unable to customize practice</td>
</tr>
<tr>
<td>b) Policies and procedures of the workplace</td>
</tr>
<tr>
<td>c) Coordinating care</td>
</tr>
</tbody>
</table>

1. Demands on time

Participants spoke of their burgeoning workload as the main practice issue they struggle with on a daily basis. They spoke of carrying a wait-list, working overtime, feeling the pressure to discharge and feeling overwhelmed at times with the amount of work. Balancing competing priorities such as clinical and non-clinical duties, urgent versus chronic care cases, as well as
work-life balance were cited several times by participants as something they struggle with. Participants spoke of unrealistic demands made of them by their managers or clients or families of clients, pressure to discharge clients into the community and attempting to find programs to meet their needs, as well as being asked to stretch their scope of practice as a major source of stress.

One participant, who works in a community-based team providing care to seniors, spoke of her experience of carrying a wait-list as something she struggles with.

“I am the only OT on my team. Right now I have ... I've had 18 new referrals in the past six weeks, which is astronomical for me, not for some, but for me. I certainly find that ... when knowing that people are waiting for a service and some are struggling and that weighs on my mind.” (P2)

Another participant, who works in inpatient pediatric rehabilitation unit, spoke of the constant pressure to discharge clients into the community from inpatient settings.

“So I think because I work in Inpatients, so, there is a constant pressure, for kids to be discharged so that the beds can be freed up for other kids; so workload definitely comes up quite a bit. We do have some control over our workload by saying that we are full in terms of what we can manage. I think there is always pressure from higher up to fill the beds though and to have people move out into the community as quickly as they can.” (P6)

Several of the participants characterized this as an obligation to the clients, an internal demand they place on themselves, which is captured by one participant’s comment below.

“I never ... I guess I feel like I am never doing enough. There is just so much to do and you can only ever do a little piece of it at a time. The needs are always there. Some of my clients would love to see me every week for a long period of time and I just can’t sustain that. Even though I may be working within a manageable framework at any given time, it always feels as if there is so much more ... or there is pressure, maybe I just perceive it, to do more and more.” (P1)

One participant spoke of constantly trying to balance the needs of her clients in her split position.
“I guess being split between a few different programs is another thing that’s sometimes challenging because the complex continuing care kids are always there; so the more urgent things come from the rehab clients so I often find that my time on complex continuing care is taken up by other things that come up throughout the day that need to be done more urgently I guess.” (P6)

Another participant spoke of feeling frustrated with the constant time constraints that keep her from doing her job the way she would like to.

“I never really get to do what I would love to ideally do because of time constraints. Somebody or some piece of that always is not getting done as well as I would love to have in an ideal world where you have all the time to connect with all the people that you would like to connect with and arrange things in a way that is comfortable and convenient for families and everybody else involved… I really like the variety in my job that way and so at times they are certainly some of the things I celebrate in my job, but at other times they certainly provide the biggest challenges, trying to figure out what would be most helpful in the limited amount of time that I have to give.” (P3)

Several participants spoke of working overtime and realizing that they need to limit it. One participant was able to quantify her overtime hours after reflecting for a while through one of the focus groups and that is captured in her comment below.

“I certainly do work unpaid overtime each week pretty reliably. It is something that I have made an effort to limit because I am aware that it is not good for me and I just have to limit it, …I probably work an average of half an hour of unpaid overtime each day just with, probably even more than that just with cutting into my lunch hour, skipping breaks, working that extra 20 minutes before you go home kind of thing. That does add up.” (P1)

One participant in private practice spoke of a frustrating experience of procuring an assistive device for an individual in a nursing home and trying to meet the requirements of the agency that hired her, the funding agencies and finding the right device based on the health needs of the client.

“I had a case manager that wanted a wheeled shower commode chair. That is one that self propels the client to move it wherever and I went to all these manufacturing conferences that they hold in Toronto once a year through Shopper’s and asked the manufacturers there do you have such an animal? I went two years in a row and they kept saying no, there isn’t anything like that available yet; so they were working on it. Another side of this is that I was also responsible for the funding for the device, so I was
looking at searching for the device and asking various pockets of money to pay for the device, I’m not too sure how much it cost. And each funding piece has its own timeframes and their own, well you have to deal with March of Dimes first, then you deal with the developmentally challenged and you have to do it all in sequence. That’s very hard to do. And then when you find a device, which I did, it didn’t meet all the criteria that the client and the agency wanted, so they were very upset with me. Upset to the point, and I hope you don’t mind me saying it, but upset to the point they’ve refused to send me anymore referrals.” (P5)

Another participant who works in a pediatric inpatient rehabilitation setting, spoke of the unrealistic demands she faces from the families of the children admitted there.

“I mean families’ expectations are sometimes a bit too high, that is a definite struggle. And families that are not at the ... not dissatisfying but they aren’t at the place where they can accept the child’s injury is challenging in terms of moving ahead with discharge planning.” (P6)

Regarding scope of practice, participants spoke of either being asked to stretch their scope or being sometimes treated as a technician, and finding both of those unsatisfactory.

“I think that that’s always playing in the background where people are asking you to do things that are outside your scope or stretch yourself a bit to do someone else’s role, to cover or piecemeal together where someone might not be available. I think it’s just being constantly mindful of that and setting your own boundaries and trying to stick to that, although it gets tiring as well to say ‘no’ half the time, but it’s definitely there in my practice anyway where people are asking me to do either a case management role, or cover off on things for other therapists who might be away or sick or whatever, or they can’t find a therapist to do that particular service.” (P4)

Participants spoke of constant pressure to discharge clients from the inpatient setting into the community and try referring them to programs that have strict admission criteria and long waiting lists as a struggle day to day.

“Running out of time and not feeling like I am able to, just rushing and having to get things finished. Sometimes knowing that the kids are being discharged without the service is always in place in the community that is challenging. Trying to coordinate, I think a slight mis-communication can sometimes be...I don't know if it is dissatisfying but it is definite struggle day-to-day.” (P6)
Another participant spoke of feeling overwhelmed at times while trying to juggle clinical, non-clinical and outside practice work commitments.

"I think another aspect of my job that is challenging is the committees. I have been with my workplace now for more than seven years and I think I have a bit of a reputation for being someone who gets things done. So I have a tendency to end up on committees and some of them you can say ‘no’ to and some of them that’s really difficult to do, if you want to remain employed [laughs]. I find that there is a sort of a snowballing like quite outside the practice work itself, which is demanding. You get all this ... I find that I accumulate a lot of extra commitments and sometimes that can feel ... sometimes they're rewarding, but sometimes they can just be really overwhelming too." (P1)

2. Conflict

Participants spoke of mismatch in their values and the organizations they work for. They identified scenarios such as lack of adequate orientation when providing coverage, being asked to sign off on clients they hadn’t seen, prescribe equipment or make recommendations that they didn’t agree with. Participants spoke of feeling fatigued when providing care to chronic care patients where the probabilities of making gains were limited. They also spoke of lack of health care resources, which had led to long wait times for services for their clients. One participant, who provides services in the community, characterized it as insufficient knowledge of the scope of occupational therapy practice in her comment:

"just a general lack of knowledge of occupational therapy generally by those that are managing people, not necessarily those in our profession or co-professionals, but those that come in with no professional background at all that are telling you that you should be doing this, this, this and this; it just doesn’t seem viable at all. Again, I guess there’s a conflict of values and that sort of stuff where they come in and they feel that you’ve done enough, they discharge the client even though you’re not ready, the client’s not ready, this general lack of knowledge of what we do and why we do it." (P5)

A participant, who agreed to be interviewed individually as she was on long-term leave of absence due to burnout, spoke of her experience of practicing privately in the auto-insurance industry, which she characterized as not a good fit for her.
“The industry looks like a huge human assembly line, people work for the insurer, they have these report templates, where the OTs say “yay” or “nay” that this person is entitled to benefits. I worked mostly with lawyers and my agenda was not to alter reports…my tack was to represent things as they are, you will see on paper what I saw and my independent conclusions. We were fine for a while until we came to loggerheads where they wanted me to change things or make recommendations that I thought were unsafe. I said ‘no’, I will not do that.” (P7)

One participant spoke of her experience of trying to provide interim coverage at a hospital and the unrealistic demands placed on her.

“I’ve also done interim type work substituting for OTs on vacation and that. It’s in another agency that contacts me and I find that the one time I went into a general hospital for two-week holiday relief I told them I could only do it part-time and they kept pushing and pushing, I did everyday one week, but it still went back to the three the following week. Lack of orientation, they automatically feel that you should know the hospital, you should know the routine. This agency also demanded that if a client referral was made you would have to sign off. You would have to say, yes, you’re responsible for that client, whether you had the time to do it or not, just so that they could say they had no wait times.” (P5)

Another participant who works with the adolescent population spoke of her feelings of frustration and conflict, as she was not able to resolve the issue of obtaining services for her client in a timely manner.

“A lot of my clients may require technological adaptations for using a computer and it’s surprisingly difficult to connect them with clinics that can do that … there is quite restrictive admission criteria for many of the clinics and they are only in particular locations and clients may have trouble getting to them. Some of them have wait-lists for as long as a year and that’s nobody’s fault exactly but it’s hard to explain that to the client who really wants to get this done yesterday because they have just gotten into college and they really want to be able to write essays, in less than a year.” (P1)

A participant, who works with pre-school age children, spoke of feeling conflicted while working in a system that calls for a transition of the health care team at the same time as the children are starting school as something that concerns her.
“you run up against systems that don’t make any sense for families or for myself as an employee. So where that seems unfair and that might just be things of like…an example might be how the program is set up and how the funding works so that families get seen by one therapist up until they enter school and at this time it’s a great transition for families. They lose their support that they have known since this child’s birth, so they come to a completely new set of therapists and a completely new environment and it doesn’t make sense to families or to me that the transition would take place exactly at that time.” (P3)

3. Lack of respect

Participants indicated feeling a need to provide constant justification for their decisions or fees charged, not feeling respected, asked to stretch their scope of practice, and losing morale over not being able to launch a new treatment program due to bureaucratic delays.

A participant in private practice spoke of her experience in working within the auto sector and the fact that she finds the constant justification for occupational therapy service tiring.

“I have a private practice that’s mostly the auto sector and I have...constant paperwork pieces is a practice issue for sure, but it’s that constant justification of services and funding and I think it’s just the repetitiveness that you’re always going up against someone who doesn’t actually believe either that the client really has an injury or that what you’re recommending will really assist them, so it’s that constant going to battle at some point almost every time, so it wears you down over time.” (P4)

Another participant spoke of not feeling respected as a member of the multidisciplinary team and having to justify why a case needs to remain open because some of the occupational therapy interventions are not complete.

“Typical OT I guess, I am going to do what the clients want me to do and if it’s something is really important to them then I am going to really try and make it work. I am not going to let their case be closed on short notice because the nurse doesn’t see or the family doc hasn’t just tried the new medication, so well we’re just going to close the file. Well, no, we’re not, because the OT interventions are working and we’re going to go ahead with those. I think it comes down to respect honestly. I don’t think it would matter whether I was OT or not, I think just some people just don’t respect an alternative point of view. They are comfortable with the tried and true and the traditional, what’s worked for the past 20 years and how they have worked for the past 20 years and they don’t want to change.” (P2)
One of the participants who provides care to a pediatric population in the community spoke of her frustration at having to justify how she designs her work day and week as the administration would like to reduce mileage costs.

“you get feedback that your mileage is too high, that you should schedule people differently so your mileage is not too high and yet sometimes it doesn’t make sense. Of course it always makes sense to see people in the same area on the same day if at all possible, but it’s not always realistic to do that, because child A goes to childcare on Monday/Wednesday/Friday and child B goes to day care on Tuesday/Thursday and so there’s no possible way to see them in the same location on the same day. Those kinds of issues and scheduling is always a challenge. I think again it’s just that, I think, is more of a respect piece that people are recognizing that you are working hard to make things as efficient and effective as possible; and when you get feedback outside of a context, so you haven’t had a discussion about it or asking why, they’re just saying everybody needs to put their mileage down, because their mileage costs are way too high. Those kinds of things I think are things that I carry with me longer than I thought.” (P3)

Another participant spoke of her and her team losing morale due to delays in obtaining approval to start a new program in their facility.

“I think often my colleagues and I, maybe, become discouraged when we’re trying to progress with something, we have an idea for practice that really makes sense in our setting and we’re trying to move it forward but there is just so much resistance moving up. There is so much requirement for paperwork and need to know, and the environmental scan and the resources and then you have to run a pilot, there is a very elaborate process. Any one of those steps can get stalled for significant periods of time during which time the team might lose interest or morale.” (P1)

Another participant spoke of her frustration in justifying services for someone with a brain injury after an automobile accident and having to wait to commence treatment until the auto-insurance company approved it.

“it’s highly based on the insurance adjustors’ relative mood or awareness of brain injury or whatever it may be and so it can often delay treatment to the point where the client can be in jeopardy. A recent example that a young student who was recently identified was just a mild brain injury and needed really minimal services and the adjustor didn’t particularly believe that that was necessary, so she sent my recommendations off to an independent examiner and that took six to eight weeks to get a response back when they deemed it was necessary, but in that timeframe the student had almost finished his second semester and almost lost his year because the funding was delayed for the support that had been recommended, so then we’re in a position of having to scramble and really try
to support him at a much more intense level than what would have been necessary had
the funding been in place in the first place, so that’s grinding of the wheel and so I feel
heavy at times.” (P4)

4. Lack of autonomy

Participants spoke of a lack of autonomy in their ability to customize their practice
regardless of where they practice, whether in large amalgamated organizations, in the community
or in private practice. One participant, who practices in an outpatient rehabilitation clinic for
adults with acquired brain injury and cerebral palsy indicated feeling constrained by
organizational policies and procedures which were not pertinent to her own practice but need to
be followed.

“... my workplace, it’s quite a large organization so there is a lot going on corporately to
tap into and to pay attention to and there is a lot of practices in my organization that
aren’t really tailored to my practice setting and that we have to sort of work around.
That’s just another factor to throw into the mix; that we don’t, as an organization there
isn’t a lot of autonomy and a lot of ability to really tailor our practices.” (P1)

She further went on to elaborate and gave an example related to her organization’s
response to the H1N1 influenza outbreak:

“...our organization has in-patient and out-patient facilities and a lot of our policies are
oriented more towards the in-patient facilities. I, of course work in the out-patient
facility. For instance, we are having to go to a series of mandatory talks on infection
control right now, which I think we would all agree is important. However the talks have
largely consisted of bedside glove and gown routines and so on. If I am being required to
give up half my lunch break to learn about something that I don’t actually do, it doesn’t
make a lot of sense to me. The organization requires us to do this and no doubt has very
good reasons for it. It’s just sort of puzzling.” (P1)

Another participant, who practices in the community and works with older adults, spoke
of working for a large organization, which involves an urban organization governing a rural team.
She spoke of the challenges it poses for her on a daily basis:
“I just don’t trust the people making decisions about the healthcare dollars and I am not entirely confident in the management of my team in their ability to promote the importance of the work that is done in the area because it’s ... we have urban governance of a rural team and in a lot of the communication we get; they just don’t seem to capture the nuances of working in a rural area. It’s kind of the distrust thing ... I don’t have faith in my leadership.” (P2)

Clinical workload and not being able to control it due to lack of human resources was cited by several participants.

“I find for me workload is a big part of it. There are aspects of my job that I can say no to, but there are a lot of aspects that I can’t. For instance right now I have a client case load of about a hundred clients. ... I did negotiate with my employer about what is reasonable, but there isn’t a lot that they can do without increasing the size of the team and they don’t have the resources to do that.” (P1)

Participants spoke of working in large organizations where they feel that there are a lot of competing priorities and feel frustrated by some of the recent moves to amalgamate smaller hospitals into large health care centers and its impact on their work.

“... relations within administration aren’t always easy and especially as I mentioned in a big organization where I think there is a lot of competing priorities. I just don’t think we always feel like we are the priority or that we have ready access to the resources we need. There is some really frustrating stuff, like purchasing. It can take us up to three months to order a box of CDs that we need for our group. It can take multiple emails back and forth and reiterating of orders and tracking down of misplaced orders that were sent back. I guess it’s a function of a big organization. They gain efficiency in that they only need one purchasing department for six hospitals, but then they lose efficiency in that it doesn’t actually work that well and people spend a lot more time trying to just get it to go. That kind of stuff is difficult.” (P1)

Juggling clinical and non-clinical duties as part of their workday was mentioned by several of the participants, especially those working in large organizations.

“you’re balancing the needs of the workplace itself. You’re trying to juggle all of your clients and you’re doing the best you can and then you get called in for a half day
Participants spoke of the importance of the workplace community and the impact it has on their day-to-day practice. One participant who practiced in the private auto-insurance sector spoke of her isolation from her peers and shared that the only way she was able to connect with them was through attending conferences and workshops.

“I found myself isolated, alone. The ‘workplace community’...the OTs are extremely competitive, cut throat to look good to the referral sources. They seemed to have a monetary agenda. Of all the things an OT can do, auto-insurance is the most lucrative.” (P7)

This sentiment was echoed by another participant in private practice as well.

“I just don’t have a peer group to talk to except in situations like this or taking courses and those sorts of things. The ones that are in the community doing private practice are sort of left out in the lurch somewhat and to bounce ideas off other people.” (P5)

Another participant who practices in a pediatric inpatient facility, spoke of the importance of coordinating care to help carry out treatment plans.

“We work closely with a pretty big team, so like social work, PT, nursing there is quite a big multidisciplinary team we work with, which is helpful because especially with PT I work very closely with and then the feeding clinic work closely with the speech pathologist so it is definitely nice to have the support of another profession. It is sometimes hard to coordinate everything between everyone, especially with nursing who helps carry out a lot of the intervention plans day-to-day that part is sometimes challenging. Just coordinating the care because there are so many people involved.” (P6)

4.4 Coping Strategies

This section presents quantitative and qualitative data results on coping strategies the occupational therapists employ to sustain their practice.
4.4.1 Quantitative Results

The survey asked the respondents to rate a list of 24 coping strategies on a scale of 1 to 7 with 1 being *Not at all important* to 7 being *Extremely Important*. Their responses are itemized from most frequently used to the least in Table 19.

### Table 19: Coping Strategies: Quantitative Findings

<table>
<thead>
<tr>
<th>Coping Strategies</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>M</strong></td>
<td><strong>SD</strong></td>
</tr>
<tr>
<td>Spend time with spouse/partner/family</td>
<td>6.63</td>
</tr>
<tr>
<td>Maintain balance between professional and personal lives</td>
<td>6.14</td>
</tr>
<tr>
<td>Maintain sense of control over work responsibilities</td>
<td>6.06</td>
</tr>
<tr>
<td>Maintain sense of humor</td>
<td>6.00</td>
</tr>
<tr>
<td>Take regular vacations</td>
<td>5.73</td>
</tr>
<tr>
<td>Have the autonomy to vary work responsibilities</td>
<td>5.63</td>
</tr>
<tr>
<td>Feel like an equal member of the multi-disciplinary team</td>
<td>5.63</td>
</tr>
<tr>
<td>Engage in physical activities</td>
<td>5.60</td>
</tr>
<tr>
<td>Spend time with friends</td>
<td>5.57</td>
</tr>
<tr>
<td>Engage in hobbies</td>
<td>5.57</td>
</tr>
<tr>
<td>Try to maintain therapeutic relationship with clients</td>
<td>5.56</td>
</tr>
<tr>
<td>Maintain professional identity/values</td>
<td>5.51</td>
</tr>
<tr>
<td>Maintain self awareness/self monitoring</td>
<td>5.48</td>
</tr>
<tr>
<td>Discuss work frustrations/seek support from colleagues</td>
<td>5.43</td>
</tr>
<tr>
<td>Remain active in professional development</td>
<td>5.22</td>
</tr>
<tr>
<td>Reflect on satisfying experiences of work</td>
<td>5.17</td>
</tr>
<tr>
<td>Perceive client’s problems as interesting</td>
<td>5.10</td>
</tr>
<tr>
<td>Seek case consultation</td>
<td>5.02</td>
</tr>
<tr>
<td>Define my role on the team</td>
<td>4.76</td>
</tr>
<tr>
<td>Communicate with my managers</td>
<td>4.68</td>
</tr>
<tr>
<td>Discuss work frustrations with spouse/partner/family</td>
<td>4.63</td>
</tr>
<tr>
<td>Maintain regular contact with referral networks</td>
<td>4.19</td>
</tr>
<tr>
<td>Turn to spiritual beliefs/activities</td>
<td>3.92</td>
</tr>
<tr>
<td>Change practice specialty</td>
<td>3.05</td>
</tr>
</tbody>
</table>

*Note: M = Mean; SD = Standard Deviation*

One way ANOVAs were conducted to determine if there is a difference in the use of coping strategies between the occupational therapists based on their level of *emotional exhaustion* (Table 20). The results revealed that occupational therapists with a high degree of *emotional exhaustion* reported lower use of the coping strategies ‘maintain self awareness, monitoring’,


\( F(2, 60) = 5.34, p = 0.007 \), ‘maintain sense of control over work responsibilities’, \( F(2, 60) = 3.95, p = 0.002 \) and ‘maintain sense of humor’, \( F(2, 60) = 4.21, p = 0.020 \).

**Table 20: Summary of ANOVA for differences in use of coping strategies between occupational therapists with respect to levels of exhaustion (low, average and high)**

<table>
<thead>
<tr>
<th>Coping Strategy</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintain self awareness/monitoring</td>
<td>Between Groups</td>
<td>9.62</td>
<td>2</td>
<td>4.81</td>
<td>5.34</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>54.09</td>
<td>60</td>
<td>0.90</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>63.71</td>
<td>62</td>
<td>0.90</td>
<td></td>
</tr>
<tr>
<td>Maintain sense of control over work responsibilities</td>
<td>Between Groups</td>
<td>3.93</td>
<td>2</td>
<td>1.96</td>
<td>3.95</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>29.82</td>
<td>60</td>
<td>0.50</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>33.75</td>
<td>62</td>
<td>0.50</td>
<td></td>
</tr>
<tr>
<td>Maintain sense of humor</td>
<td>Between Groups</td>
<td>5.90</td>
<td>2</td>
<td>2.95</td>
<td>4.21</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>42.10</td>
<td>60</td>
<td>0.70</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>48.00</td>
<td>62</td>
<td>0.70</td>
<td></td>
</tr>
<tr>
<td>Discuss work frustrations with spouse/partner/family</td>
<td>Between Groups</td>
<td>13.33</td>
<td>2</td>
<td>6.67</td>
<td>3.41</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>117.27</td>
<td>60</td>
<td>1.95</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>130.60</td>
<td>62</td>
<td>1.95</td>
<td></td>
</tr>
</tbody>
</table>

The post-hoc Bonferroni tests revealed that the statistically significant differences lie between individuals reporting average levels of *emotional exhaustion* and high levels of *emotional exhaustion* for all except the coping strategy of discussing work frustration with spouse/partner/family. The results are reported in Table 21.
Table 21: Multiple comparisons (Bonferroni) for differences in use of coping strategies with respect to low (1), average (2) and high (3) levels of emotional exhaustion

<table>
<thead>
<tr>
<th>Coping Strategy</th>
<th>Comparisons</th>
<th>Mean Difference</th>
<th>Significance (α)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintain self awareness/monitoring</td>
<td>2 vs. 3</td>
<td>-0.975</td>
<td>0.006</td>
</tr>
<tr>
<td>Maintain sense of control over work responsibilities</td>
<td>2 vs. 3</td>
<td>-0.627</td>
<td>0.020</td>
</tr>
<tr>
<td>Maintain sense of humor</td>
<td>2 vs. 3</td>
<td>-0.728</td>
<td>0.024</td>
</tr>
<tr>
<td>Discuss work frustrations with spouse/partner/family</td>
<td>1 vs. 3</td>
<td>-0.076</td>
<td>0.035</td>
</tr>
</tbody>
</table>

Similarly, one way ANOVAs were conducted to determine the differences in use of coping strategy with respect to level of *cynicism* and they did not reveal any differences between the individuals reporting low, average and high levels of cynicism. One way ANOVAs to determine the differences in use of coping strategy with respect to levels of *professional efficacy* revealed that individuals with high levels of professional efficacy report more frequent use of ‘keeping in touch with referral networks’ \( (F(2, 60) = 6.045, p = .004) \). Post-hoc Boneferroni tests revealed detectable differences between low and average levels of *professional efficacy* \( (MD = 1.19, p = .013) \) and between low and high levels of professional efficacy \( (MD = 1.38, p = .002) \).

### 4.4.2 Coping Strategies-Qualitative Findings

Participants spoke of various coping strategies to help sustain them in the workplace. These include strategies such as setting boundaries between home and work, balancing the needs of the workplace and home life, utilizing time management strategies to maximize productivity, seeking support from formal and informal social networks, setting goals and priorities, physical self care, and turning down tasks if needed. They also spoke of focusing on satisfying aspects of work such as seeing clients improve, contributing in program development, mentoring others and
professional development activities as things that sustain them. A summary is presented in Table 22.

Table 22: Coping Strategies: Qualitative Findings

<table>
<thead>
<tr>
<th>1. Boundaries</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Maintain work-home boundary</td>
</tr>
<tr>
<td>b) Negotiating workload / other commitments</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Workplace / Home Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Supportive family / friends</td>
</tr>
<tr>
<td>b) Supportive colleagues</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Monitoring self/maintaining self awareness</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Time management strategies</td>
</tr>
<tr>
<td>b) Goal setting</td>
</tr>
<tr>
<td>c) Pacing self</td>
</tr>
<tr>
<td>d) Physical self care</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. Focus on satisfying aspects of work</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Seeing clients improve</td>
</tr>
<tr>
<td>b) Participating in program development</td>
</tr>
</tbody>
</table>

Participants spoke of keeping boundaries between work and home life as an important strategy they keep in place to prevent burnout.

"Trying to leave work at work at the end of the day, like I don't take things home and try not to...like we've access to our emails from home, but I really try not to get in the habit of looking at it and doing that from home, because I think it is just a bad habit. I don't take reports home and all those things that sort of draw out your workday." (P6)

Participants also spoke of the importance of workplace community to help them get through their day.
“I have a wonderful group of co-workers where my office is. We get together every morning and we chat over coffee. It might be that one of them is having a jewelry party this Thursday night, or it might be the really tough case that someone saw and we’re brainstorming all together. There is definitely a feeling of ‘we’re in it together’ and it’s ‘I have got these people waiting and these pressures and I am feeling overwhelmed’ you know what, I am overwhelmed too and we’re all in it together, so that really helps I think.” (P2)

Some participants emphasized the need to “check in” with themselves around the reasons for feeling overwhelmed as something that keeps them productive through their day.

“I think a lot of healthcare professionals really are cognizant of the importance of our work and how much is at stake for our patients and really try to do it all. I think some of that pressure comes from them and some of it comes from ourselves. For me it has been helpful on days when I feel really overwhelmed to just stop and just question my thinking a little bit and just say ‘do you really have to do this?’ or would it just be good if you did this. Do you have to do this as fast as you think you have to do it or can you be generous and give yourself a little more time? Just challenge my assumptions a little bit about how I have to do my job.” (P1)

For some participants the checking in is related to reviewing time management strategies:

“[I] think one of the coping strategies for me when I am feeling burned out is to just pull back and really look at my time management strategies. I am lucky enough in the facility that I am in to really be able to make decisions myself without having too many outside influences about how often I see people and when I see them and where I see them. Really making the time to map out what is more reasonable for me” (P3)

Another participant spoke of pacing herself through the day by taking breaks:

“And making sure I take my lunch most days, because a lot of people you end up sitting at your desk or working through lunch. So I try and go down to the cafeteria to take the hour and sometimes go for a walk as well; so I think it is important to do those things.” (P6)

This participant also emphasized the importance of setting goals such as finishing reports as an important strategy that helps her feel that she can keep up with her work.
“And just getting my work done it feels...I’ve been getting reports done and all that stuff makes me feel better as well. So just blocking time to get things finished and off your list of things to do.” (P6)

Most participants spoke of the importance of physical self care to manage burnout and included limiting caffeinated drinks, eating healthy, having good sleep hygiene along with exercise.

“I think starting from just the physical self care like I gave up caffeine completely and I am still off it which was fantastic for me, it really improved my sleep and helped me to feel less stressed during the day. I made a rule that I have to leave work no more than 15 minutes late, two to three times week and I have been pretty good about that. Sometimes it stretches a little bit, but I am pretty good about making sure that I don’t stay late every single night. Revisiting my sleep, I have always been very good with exercise but just making sure that I always had as much time as I wanted for that.” (P1)

Some participants spoke of negotiating their workload and turning some tasks down as important part of their coping strategy skills set.

“I think people really will, they will give you as much as you can take. I mean they will, and quite often there is no shortage of work but I think it’s up to each of us to figure out what our limits are and then try to defend them a little bit and try to communicate that to other people and also try to communicate it to ourselves, so that we’re not feeling really guilty about how much we can’t do. Ultimately none of us is going to solve the problem. Most of our clients have chronic health conditions; they will always have their needs. That’s just how it is to be a person really. Taking on the task of making it all better is insurmountable and its only going to make us unhappy, but if we can just bite off a little piece and do our best with that and then take on another realistic time-limited goal and do our best with that, that is sustainable I think in a career.” (P1)

Participants spoke of choosing to focus on satisfying aspects of their job as an important part of their coping skills menu. Seeing clients improve was spoken of most frequently as a satisfying aspect of the job.
“If the satisfaction of seeing people improve, that they are able to do what they couldn’t do before, like having access to go shopping, or go to the library, or go to the doctor’s, just to be able to get around and see that friend down the hall. And the same thing you get, not necessarily always in words, but maybe in smiles and gestures, so I find that the most satisfying.” (P5)

Some participants spoke of being able to participate in program development as satisfying to them.

“I am also lucky that in my role I get to participate in some program development stuff and it feels really neat to be involved in creating something new and something that is maybe going to make care more efficient or involve clients in a way that they will enjoy and find more meaningful than what we have been doing. I get to do some public speaking too which I love. There is just the sort of life long learning aspect of it too.” (P1)

One participant spoke of the support she feels in her work on a multidisciplinary team.

“We overlap…I feel we overlap quite a bit in different ways. Our roles are fairly well defined I think but there is also flexibility, so with the PT I can look at transfers or we sort of just discuss it between ourselves and just make sure it is covered. I don’t feel tension around this is part of my job that ‘this shouldn’t be yours’ sort of thing. I think we all just try to help each other out as much as we can.” (P6)

Another participant spoke of her peers and families and clients she works as inspirational.

“just the people you meet along the way, whether the co-workers or where family members. I have just had the opportunity to meet some really phenomenal, inspirational people and have felt privileged to be a part of their lives.” (P3)

4.5 Coping strategies to enable balance and decrease burnout: A model

The mixed methods analysis provided a greater depth of understanding of practice issues related to burnout, worker burnout and engagement. It was noted that the practice issues identified through focus groups and interviews were consistent with AWS subscales. Similarly, the coping resources matched the problem-focused and emotion-focused coping strategies identified in the literature (Lazarus & Folkman, 1984). Overall, the qualitative data further
illustrated the quantitative data by providing specific examples of occupational therapists’ coping strategies and practice issues.

The model in Figure 2 is a synthesis of findings in this study and depicts the workplace demands placed on occupational therapists on the left side along with the coping strategies they utilize to sustain their practice on the right side. The practice issues identified in the focus groups and interviews are consistent with most of the six subscales identified within Areas of Worklife survey, for example, the theme of demands on time supported the high scores emerging in the workload dimension of AWS; lack of autonomy supported the control dimension of AWS etc. The model further depicts that when practice issues become overwhelming for the individual, it might tip them into burnout. On the other end, use of problem-focused coping strategies such as maintaining boundaries or emotion focused coping strategies such as maintaining self awareness can help a worker feel energetic, involved and effective at work.
In summary, 34.8% of the participants reported high levels of emotional exhaustion, 43.5% of the participants reported high levels of cynicism and 24.6% reported low levels of professional efficacy. Unmanageable workload predicted 29.9% of the variance in emotional exhaustion. Rewards predicted 15.5% of the variance in professional efficacy. Demands on time, lack of autonomy, lack of respect and conflict were identified by occupational therapists as practice issues they grapple with on a daily basis.

Spending time with family, maintaining balance between home and work, maintaining sense of control over work responsibilities and keeping a sense of humor were coping strategies rated highly by the occupational therapists in this study. In addition, this study highlighted differences in the use of coping strategies between individuals reporting low and high levels of emotional exhaustion and professional efficacy.
Chapter 5
Discussion

In this chapter I will discuss the findings from my research as compared to the work of others reported in the literature. I will critique my research relative to my three research questions related to levels of burnout, practice issues and coping strategies. Next I present my findings related to one pertinent article on work-life balance and follow with recommendations from my participants relative to key literature. Finally I discuss the limitations of my research, implications for further research and my overall conclusions.

5.1 Levels of burnout

The MBI is recognized as the leading burnout measure which generates information on three dimensions namely, emotional exhaustion, cynicism and professional efficacy. High scores on the emotional exhaustion and cynicism subscales, along with low scores on professional efficacy, are indicative of high levels of burnout. Conversely, low scores on emotional exhaustion and cynicism subscales and high scores on professional efficacy are indicative of high levels of engagement. My overall results show that occupational therapists who participated in this study fall in the average range of burnout for emotional exhaustion, high range for cynicism and average range for professional efficacy using MBI-GS. My participants had high correlations between emotional exhaustion and cynicism, negative correlations between emotional exhaustion and efficacy, and cynicism and efficacy, which were in keeping with the findings reported by Leiter (2006) and Leiter, Gascon and Martinez-Jarreta (2010).

After dividing the group into those experiencing low, moderate and high levels of burnout, the results indicate that 34.8% of the respondents feel highly emotionally exhausted, 43.5% have high feelings of cynicism and 27.5% report lower levels of professional efficacy. In
addition, 31.9% report low levels of emotional exhaustion, 23.2% report low levels of cynicism and 24.6% report high levels of professional efficacy. This allowed for a comparison between the groups reporting high and low levels of burn out in the quantitative data analysis.

As most previous studies have focused on measuring burnout, they tend to report in more detail on the ‘burnt out’ group. The levels of burnout found in this study are in keeping with the findings reported by Brown and Pranger (1992) in their survey of 89 psychiatric occupational therapy personnel working in Ontario with the exception of this study finding higher levels of cynicism. The higher levels of cynicism may be reflective of the current environment of increased stress in health care system now as compared to the 1990s. It is difficult to compare the findings from my study to the Wilkins (2007) study, which reported that 47% of occupational therapists report finding most days at work quite stressful. Some of the difficulty comes from my study measuring burnout as compared to the Wilkins (2007) study measuring stress.

The levels of emotional exhaustion in my study are slightly lower than those reported by Painter et al (2003) who surveyed 521 occupational therapists registered with American Occupational Therapy Association and reported that 40% had high levels of emotional exhaustion and lower levels of cynicism. The levels of emotional exhaustion in my study are slightly lower than the levels reported by Lloyd and King (2004) in their study of Australian mental health occupational therapists and social workers. These differences may be due to the work environments in the two countries (Canada and Australia) or perhaps due to uniqueness of working in mental health environments. Mental health personnel as a group have been studied more due to concerns about their burning out and tend to report higher levels of burnout than the other groups as reported in a systematic review of the literature by Edwards and Burnard (2003). Similarly Balogun et al (2002) in their study of occupational therapists and physiotherapists
working in hospitals and clinics in New York City reported higher levels of emotional exhaustion in 58% of the population. All of these studies utilized MBI-HSS to measure burnout.

5.2 Practice Issues

Another goal of this study was to determine which areas of worklife contribute to burnout through the administration of AWS and data collection through focus group and interviews. The quantitative findings are consistent with the reported direct relationship between unmanageable workload and exhaustion (Cho et al, 2006; Lasalvia et al, 2009; Laschinger and Wong, 2006; Leiter, 2000; Leiter et al, 2009; Leiter et al, 2010; Timms et al, 2007). In this study, unmanageable workload predicted 29.9% of the variance in emotional exhaustion. A central finding of the study is that occupational therapists have stated that they don’t have enough time to do their job and that it takes them away from pursuing their personal interests. A secondary and important finding is that occupational therapists have reported a more positive evaluation of all other areas of their worklife (control, reward, community, fairness and values). They report feeling that they have control over their work responsibilities, their work efforts are appreciated, they have a supportive community at work, are treated fairly, and their values are in keeping with the organizations they work for. This is similar to the findings by Timms, Graham and Cottrell (2007) in their survey of 298 teachers in Queensland, Australia. All six AWS predicted 35.3% of the variance in emotional exhaustion component of burnout. Interestingly none of the variables from AWS make a statistically significant contribution to predicting cynicism. It is possible that other factors not measured by this study contribute to feelings of cynicism and need to be investigated further.

Another important finding of this study is a direct relationship between rewards and high levels of professional efficacy. Rewards predict 15.5% of the variance in the efficacy trait and all six AWS together predict 23.5% of the variance. The occupational therapists in my study, which
report feeling highly effective at work state that their work is noticed and appreciated by others. This is in keeping with the findings reported by Lasalvia et al (2009) and Laminman (2007).

Qualitative findings of this study shed light on the practice issues encountered by the occupational therapists in their day-to-day practice. The issue of demands on one’s time was identified as a major theme in this study with sub-themes of burgeoning workload, unrealistic demands placed by clients, their families and administrators, and juggling clinical and non-clinical duties. Feeling conflicted due to mismatch between the person and the values of the organization and lack of health care resources were identified as issues by the participants in this study. Not feeling respected through having to provide justification, losing morale due to bureaucratic delays, and lack of autonomy to customize practice were additional themes that emerged in my study. These are similar to the findings reported by Bailey (1990a, 1990b), Brown & Pranger (1992), Davis & Bordieri (1988), Laminman (2007) and Moore et al, (2006a, 2006b).

5.3 Coping Strategies

This study provides insights into coping strategies that occupational therapists deem important in preventing burnout and fostering resilience in the face of ongoing demands of work. Four of the strategies were rated 6 or higher on a 7-point rating scale, which would indicate that occupational therapists view these as essential in maintaining a positive attitude and helping to build a sustainable career. Two of these strategies were externally focused and therefore more behavioral in nature (i.e., ‘spend time with spouse/partner/family’ and ‘maintain balance between professional and personal lives’) and two were internally focused and therefore cognitive in nature (i.e., ‘maintain sense of control over work responsibilities’ and ‘maintain sense of humor’).

The focus group and interviews added a fifth coping strategy of ‘maintain self awareness/self-monitoring’ through ‘reviewing time management strategies’ periodically, ‘setting
goals to accomplish tasks’, pacing self by taking breaks during the work day and ‘enhance physical self care’ through regular program of exercise, reducing caffeine, and engaging in relaxation programs. These quantitative and qualitative findings are in keeping with those reported by Brice, 2001; Kramen-Kahn and Hansen, 1998; Painter et al, 1998; Rupert and Kent, 2007 and Stevanovic and Rupert, 2004.

My research revealed that occupational therapists with a high degree of emotional exhaustion reported lower use of the coping strategies ‘maintain self awareness, monitoring’, ‘maintain sense of control over work responsibilities’, ‘maintain sense of humor’ and ‘discuss work frustration with spouse/partner/family’. Individuals reporting high levels of professional efficacy report more frequent use of ‘keeping in touch with referral networks’ as compared to those reporting low levels of professional efficacy. These are unique findings of this study not reported elsewhere in the published literature.

Lasalvia et al (2009) endorse the use of individually oriented approaches such as coping strategies to help professionals alleviate their sense of exhaustion. They do caution that individual strategies can be relatively ineffective in the workplace as professionals have much less control over the stressors than they do in the private domains of their lives. This study endorses stress management interventions previously identified in the occupational therapy literature such as balancing workload (Bassett & Lloyd, 2001), discussion with colleagues, sharing responsibilities of clients with members of interdisciplinary team, maintaining boundaries between work and home, and use leisure activities (Brice, 2001). Previous findings of needing to define one’s role on the team due to lack of clarity of the occupational therapy role on the team (Bassett & Lloyd, 2001; Davis & Bordieri, 1987; Moore et al, 2006a, 2006b) and changing practice specialty (Bailey, 1990a, 1990b; Richardson and Rugg, 2006) were not rated as highly by the study participants. These are interesting findings and need to be investigated further.
5.4 Work-life balance

The Person-Environment-Occupation (PEO) model (Law et al, 1996) assumes that the three main components (the person, their environment, and the occupations they engage in) interact continuously across time and space along one’s life span. A harmonious fit between the three leads to optimal occupational performance. The idea that human beings do better with a balanced lifestyle is an underlying premise in occupational therapy. Evaluation of a balanced or unbalanced lifestyle usually takes the form of examination of time use in various occupations. Matuska and Christiansen (2008) proposed a model of lifestyle balance, which goes beyond time use and looks at dimensions such as feeling challenged and engaged and create meaning and a positive personal identity. This model can be utilized to examine the notion of work-life balance. This application helps to expand the focus beyond “doing” occupations at the level of the individual and incorporates an individual’s strengths, values and purpose.

Hakansson and Matuska (2010) related the findings of their study of experiences, perceptions and attitudes about lifestyle balance of 19 women with stress related disorders to the theoretical model of life balance by Matuska and Christiansen (2008). Their findings provided additional validity for the life balance model and the authors called for applying this model to healthy individuals to see whether this model is a valid representation of life circumstances that create a balanced life. In an effort to critique my own findings, I have compared my participant’s views of feeling balanced or unbalanced relative to the five dimensions of the lifestyle balance model proposed by Matuska and Christiansen (2008). This model is useful in examining work-life balance as proposed by Matuska and Christiansen (2008) in the top row relative to my findings in the bottom two rows of Table 23.
Table 23: Comparison of my themes from this study against Lifestyle Balance Model
Dimensions adapted from Matuska & Christiansen (2008)

<table>
<thead>
<tr>
<th>Feeling balanced**</th>
<th>Meet basic needs for sustained biological health and safety*</th>
<th>Rewarding &amp; self-affirming relationships with others*</th>
<th>Feel engaged, challenged &amp; competent*</th>
<th>Create meaning &amp; positive personal identity*</th>
<th>Organize time &amp; energy to achieve goals and renewal*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monitor self/maintain self awareness</td>
<td>Feeling balanced**</td>
<td>Monitor self/maintain self awareness</td>
<td>Supportive workplace/home community</td>
<td>Feel like an equal member of the multi-disciplinary team</td>
<td>Focus on satisfying aspects of job</td>
</tr>
<tr>
<td>Maintain sense of self</td>
<td>Feedback from clients</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling unbalanced**</td>
<td>Becoming ill with stress, anxiety and feeling overloaded</td>
<td>Not feeling heard</td>
<td>Overwhelmed by workload</td>
<td>Lack of respect</td>
<td>Working overtime</td>
</tr>
</tbody>
</table>

* Lifestyle balance dimensions proposed by Matsuka and Christiansen (2008), ** themes generated by Gupta (2010)

5.5 **Recommendations for occupational therapists**

The coping strategies rated highly by participants in this study suggest that practicing occupational therapists may benefit from the following recommendations:
5.5.1 Strive to maintain a balance between professional and personal life

The strategy of maintaining balance can be implemented by developing behaviors that help foster a healthy balance between work and home life. This strategy has been rated highly by other studies (Brice, 2001; Leonard and Corr, 1998; Rupert and Kent, 2007; Stevanovic and Rupert, 2005). In this study, spending time with spouse/partner/family, taking regular vacations, spending time with friends, and engaging in hobbies were endorsed by the participants as ways of balancing the demands of work and home life. These activities fit with one aspect of a model of a balanced lifestyle proposed by Matuska and Christiansen (2008). They are examples of using time and energy to meet important personal goals and to promote renewal.

5.5.2 Strive to keep work demands in perspective

The strategy to keep perspective has been rated highly in studies by Bassett and Lloyd, 2001; Kramen-Kahn and Hansen, 1998; Rupert and Kent, 2007; Stevanovic and Rupert, 2005. Maintaining a sense of control over work demands and maintaining a sense of humor were highly endorsed by the participants in this study. The sense of control may come through turning accepting or declining new or old occupations as suggested by Westhorp (2003) or choosing activities that are more in keeping with one’s values (Pentland and McColl, 2008).

5.5.3 Develop self-awareness and engage in self monitoring

The strategies of maintaining self awareness and self monitoring suggested by my participants (endorsed in studies by Brice, 2001; Rupert & Kent, 2007; Stevanovic & Rupert, 2005) are critical in helping practicing therapists make good choices about which work activities to take on and in taking corrective action (such as turning down an extra assignment) if necessary to avoid excessive stress. Westhorp (2003) proposed a similar strategy of being mindful of activities that are health promoting and valuable in an individual’s life and striving to increase those occupations as an initial step in her cycle for achieving occupational balance.
5.6 Study limitations and further research

The present study has several limitations. One limitation of this study was the small number of participants. The participants were recruited through a link in an email newsletter by OSOT and therefore may not present a full picture of the experience of burnout, day-to-day practice issues and coping strategies utilized by occupational therapists in Ontario. Non-respondents may have been overwhelmed by work demands or too burnt out to respond. They may also not have identified with the subject matter as they do not feel that they have burnout. Recruitment through personal contact by email and mailing surveys out to members of OSOT may have yielded a higher return rate.

Second, none of the independent variables were predictive of the levels of burnout. A cause and effect conclusion cannot be drawn from the findings reported in this study as this is a correlational study. It is likely that other contextual variables not considered in this study may have exerted a significant role in the prediction of burnout.

Third, the present study is limited by its reliance on self-report, cross sectional data, which does not allow for the determination of causal relationships. The participants in this study were volunteers who were not randomly selected but were a sample of convenience. Typically, volunteer subjects are more motivated than non-volunteers and their data often show less variability. Additionally, the data are susceptible to response bias inherent in self-report questionnaires.

Fourth, given the small sample size and the provincial governance of health care in Canada, it may be difficult to generalize the findings to the population of occupational therapists practicing in the Province of Ontario in Canada. There are regional variations in the delivery of health care within Canada and differences exist in work environments and demands placed on the practicing therapists. Therefore, it would be useful to replicate this study in other provinces or on
a national level. It might also be useful to compare the burnout levels between occupational therapists practicing in private sector and those in public sector.

The qualitative portion of the study was designed as a hermeneutic approach. Seven participants were interviewed once either individually or in a focus group. Additionally, these were conducted by telephone. This method may have interfered with arriving at the true ‘meaning’ of feelings of burnout, practice issues and coping strategies participants use. Other qualitative research methodology such as utilizing an ethnographic approach to examine practice issues and coping strategies could yield a thicker description and interpretation of the culture of occupational therapists. By employing an ethnographic approach, the researcher would have been able to observe participants in their day-to-day work life and conduct individual interviews over an extended period (Creswell, 1998).

5.7 Implications for future research

Longitudinal and intervention studies of the effects of the different health care environments and organizational structures on therapist burnout and engagement warrants further studies, especially since the Canadian health care system faces many challenges with limited resources. Including administrators’ and colleagues’ viewpoint in the study would help to place the findings into the workplace context.

More mixed methods research is needed about occupational therapists working in various settings to gain an understanding of the factors that promote burnout and engagement. The area of work engagement is an emerging field (Leiter and Maslach, 2004) and it would be helpful to conduct studies to learn about the factors that help occupational therapists feel energized, involved and effective at work.

Occupational therapists employed in mental health settings have been studied extensively to learn about their feelings of burnout, job satisfaction and coping strategies. Von Zweck (2004)
reported on the recent move to master’s level training for entry-level therapists and rise in numbers of occupational therapists in private practice. The occupational therapists in private practice reported feeling fragmented and isolated in this study. Studies designed to survey these groups and to learn about their practice issues would help elucidate their specific concerns and ways to ameliorate them.

5.8 Implications for clinicians, educators and administrators

The training of new occupational therapists should include information on signs and symptoms of burnout, compassion fatigue and work-life balance. The students can be taught self-monitoring techniques through journaling activities and having safe venues to talk about their feelings or reactions such as discussion forums (in-class or online). The clinicians will similarly benefit from participating in workshops on the above-mentioned topics. Moderated discussion forums and links to online resources through the provincial and national associations may help to further fill this need.

Institutions, professional associations and policy makers need to take corrective action regarding the contribution of unmanageable workload towards feelings of emotional exhaustion found in this study. It appears that cost containment at the institutional and policy level is operating in very complex ways. The corrective action might be done through forming task groups to discuss current workload level requirements; the balance between clinical service delivery time and functional time; and other non-clinical duties such as participating in program development, committees, research and education.

This study also reveals that having one’s efforts noticed and appreciated contribute to feelings of professional efficacy. Educators, occupational therapists and their colleagues and administrators can utilize this information through instituting ways of recognizing excellence at work through formal and informal employee recognition programs.
5.9 Conclusions

This study contributes to understanding the practice challenges for occupational therapists in the contemporary health care arena. This study utilized the mediation model of burnout (Maslach and Leiter, 1996) to determine the levels of burnout in a sample of practicing occupational therapists in Ontario. The study found that 34.8% of the participants reported high levels of emotional exhaustion. Unmanageable workload predicted 29.9% of the variance in emotional exhaustion. The study found that 43.5% of the respondents reported high levels of cynicism. The variables from areas of worklife survey predicted 20% of the variance in cynicism. The study found that 24.6% of the participants reported low levels of professional efficacy. Rewards predicted 15.5% of the variance in professional efficacy.

Demands on time, lack of autonomy, lack of respect and conflict were identified as practice issues by occupational therapists participating in this study. They also identified several coping strategies they employ to sustain their practice. They are setting boundaries/limits, importance of workplace/home community, maintaining self-awareness / self monitoring and focusing on satisfying aspects of the job. These are presented as a model of balance between practice issues and coping strategies. This study also found the life balance model proposed by Matuska & Christiansen (2008) useful in examining work-life balance.

The information from this study is useful for clinicians, educators, administrators and policy makers as there is a need to take a proactive approach to ensure delivery of high quality care through creating an environment that promotes worker engagement and promotes resiliency.
References


Canadian Institute for Health Information (2010). *Workforce trends of occupational therapists in Canada*. Ottawa: CIHI.


Appendix A: Mediation Model of Burnout (Maslach & Leiter, 2004)

Appendix B

Email Recruitment Letter for Research Study

Burnout and Coping Strategies utilized by Practicing Occupational Therapists in Ontario

Burnout is a familiar term for many and is characterized by “emotional, psychological, physical, social and spiritual characteristics experienced by helping professionals in varying levels of intensity” (Fruedenberger, 1980).

I am an occupational therapist and a graduate student at Queen’s University in the Rehabilitation Science program. I am conducting a study to answer the following questions: What levels of burnout is being experienced by occupational therapists practicing in Ontario? What practice issues do they face in their work-life? What coping strategies do they employ to maintain their practice? My study has been granted approval by the Queen’s University Health Sciences Research Ethics Board.

My study will be conducted in two phases. The first phase involves completing a survey that will take you approximately 10-15 minutes to fill out. You can click the link below to complete the survey. Please note that names of all participants who submit a completed survey will be put into a draw for an IPOD. Your name will be entered into a database that is separate from your responses to preserve your anonymity. Only my supervisor and I will have access to the data you provide, and your name will not appear in any reports or publications. Participation is entirely voluntary. By proceeding to the survey, you are indicating your consent to be a participant in this phase of the study.

The second phase involves participation in a focus group to discuss the topic in further detail. The focus group will be held after work hours in a mutually convenient location and will be approximately 90 minutes in length. If you are interested in participating in the focus group, please contact me at 613-544-3400 ext. 2592 or by email at mailto:2sg11@queensu.ca.

If at any time you have further questions, problems or adverse events, you can contact Sangeeta Gupta at telephone number (613)-544-3400 ext. 2592, or Dr. Margo Paterson at (613) 533-6094.
at the School of Rehabilitation Therapy or Dr. Elsie Culham, Director of the School of Rehabilitation Therapy at (613) 533-6727. If you have questions regarding your rights as a research subject, you can contact Dr. Albert Clark, Chair, Research Ethics Board at 613-533-6081.

Thank you,

Sangeeta Gupta, B. Sc. OT, OT Reg (Ont.)
MSc Candidate, Queen’s University

Dr. Margo Paterson, Ph. D.
Faculty Supervisor, Queen’s University

If you consent to participate in this study, click “continue”. Otherwise, you may exit the study.
Appendix C
Revised Recruitment Notice

Research Study explores Burnout in Ontario Occupational Therapists
OSOT has partnered with Sangeeta Gupta, an OT and graduate student at Queen’s University in the Rehabilitation Science program to support research to answer the following questions: What levels of burnout are being experienced by occupational therapists practicing in Ontario? What practice issues do they face in their work-life? What coping strategies do they employ to maintain their practice? The first phase involves completing a 10 minute online survey. OSOT encourages your participation. This work will inform OSOT with data that can be used to help define services to meet membership needs and to inform government and other funders re issues affecting the OT workforce.

Click here for more information and to complete the survey. Names of all participants who submit a completed survey will be put into a draw for an IPOD.

Appendix D: Qualification form to use MBI-GS

Qualification Form

If this is your first test with Psychometrics Canada and you are ordering a test with a 'B' or a 'C' marked after it, please complete and sign this form. Students ordering tests for research must complete and have their supervising faculty member sign this form. Certain tests distributed and published by Psychometrics Canada are available only to users who have the appropriate training and credentials, and who adhere to the principles of proper test usage, including the knowledge of tests and their limitations.

To purchase 'B' materials, you must have a degree from an accredited college or university and have satisfactorily completed a course in the interpretation of psychological tests and measurement at an accredited university or college.

To purchase 'C' materials, you must fulfill all qualifications for 'B' users, and must also possess an advance degree in a profession that provides training in the interpretation of psychological tests.

ADDRESS

Name: Nandita Gupta
Address: 34567 Main St, New York, NY 10001
Phone: 555-123-4567

LEVEL OF TRAINING

Degree: Bachelor
Field: Psychology
Institution: Queens University
Year: 1999

Member of these Professional Organizations:
Canadian Association of Psychological Consulting

Qualification Workshops

Purpose for using the test

Therapy/Consulting
Health Care
Training Development

Personal Development
Personal Counseling
Marital Counseling

Organizational Development
Management Development
Camp Development

Business Consulting
Career Counseling

Professor's Signature

I declare that I have fulfilled the test's requirements and that the information provided is true and correct.

Professor's Signature: Dr. John Doe

University: Queens University
Department: Psychology

Date: 01/01/2023
Appendix E: Permission to use MBI-GS and AWS

Acadia University
Wolfville, NS B4P 2R6
Ph. (902) 585-1671 Fax (902) 585-1051
cord@acadiau.ca

MBI-GS: Researcher Permission Agreement
Please fill out all yellow entry fields before printing document.

Full Name: SANGEETA GUPTA.
Full Mailing Address: 24 SEAFORTH ROAD,
                     KINGSTON K7M 1E2.
Telephone: 613-544-3400 ext 2592. Fax Number: 613-544-9666.
E-mail Address: GUPTA@QUEENSUN.QUECARE.CA
University Name & Address: QUEENS UNIVERSITY

The following constitutes and agreement between

Of
hereinafter called Researcher, and the Centre for Organizational Research & Development of Acadia University, Wolfville, NS, Canada, hereinafter called COR&D.

COR&D shall provide the researcher with a master copy of the Maslach Burnout Inventory—General Scale (MBI—GS). The researcher is responsible for copying the MBI—GS and working with the organization for the distribution of the survey and collection of completed answer sheets.

The researcher will retain full rights to the data for publication. The researcher will forward COR&D a copy of the MBI—GS data (with demographic variables such as gender, age, occupation, and tenure, and the response rate) as part of its normative record. It will include a description of the organization(s) in which the survey occurred. COR&D shall retain rights to use these data within analyses of its larger data set but will not publish analyses based on these data alone. Analyses of a data set that includes any data arising from this project will give acknowledgement to the researcher as the source of the data.

The researcher will provide COR&D with a copy of any articles submitted for publication arising from this project. This is to keep COR&D informed of the development of the researcher’s ideas regarding the survey and to inform COR&D about the participating organization(s). The research will not distribute the MBI—GS to any other party. The text will not be copied in any publication, research reports, or theses arising from the research.

All copies of the MBI—GS will include the following text:

"Reproduced by special permission of the authors from the MBI-GS by Wilmar Schaufeli, Michael P. Leiter Christina Maslach and Susan Jackson. Copyright 1996 by Consulting Psychologists Press. All rights reserved. Further reproduction is prohibited without written consent."

The researcher agrees to only use the Survey for the purposes of his/her research project as outlined below:

Name of thesis or research project: BURNOUT ACCLIMATING STRATEGIES UTILIZED BY DIABETIC CANIN OCCUPATIONAL THERAPIST.
Anticipated start date: JUNE/09 completion date: MAY/010.
Size of research sample: APPROX 100 PARTICIPANTS.

The undersigned agree to abide by the terms of this agreement (please sign document after printing):

Signatures
Researcher
Date
COR&D
Date

99
Centre for Organizational Research & Development
Acadia University

Complete and return to:
Box 220
Acadia University
Wolfville, NS B4P 2R6
Ph. (902) 585-1671 Fax (902) 585-1051
CORD@Acadiau.ca

Areas of Worklife Survey: Student Permission Agreement

Full Name: SANGEETA GUPTA

Full Mailing Address: 24sending Rd, Kingston, ON K7M 5E2

Telephone: 613-544-3504 Fax: 613-544-9666

Email Address: gupta.c.120@uOttawa.ca

The following constitutes and agreement between SANGEETA GUPTA (Name, please)

Of Queen's University, 366 King Street West, Kingston, Ontario, K7L 505, hereinafter called Researcher, and the Centre for Organizational Research & Development of Acadia University, Wolfville, NS, Canada, hereinafter called COR&D. The researcher

shall provide the researcher with a master copy of the Areas of Worklife Survey. The researcher is responsible for copying the Areas of Worklife Survey and working with the organization for the distribution of the survey and collection of completed answer sheets.

The researcher will retain full rights to the data for publication. The researcher will forward COR&D a copy of the Areas of Worklife data (with demographic variables such as gender, occupation, and tenure) as part of its normative record. COR&D shall retain rights to use these data within analyses of its larger data set but will not publish analyses based on these data alone. Analyses of a data set that includes any data arising from this project will give acknowledgement to the researcher as the source of the data.

The researcher will provide COR&D with a copy of any articles submitted for publication arising from this project. This is to keep COR&D informed of the development of the researcher's ideas regarding the survey and to inform COR&D about the participating organization(s).

The researcher agrees to only use the Survey for the purposes of his/her research project as outlined below:

Name of thesis or research project: BURNOUT & CAREER SUSTAINABILITY: REMEDIES OF CELEBRITY

Anticipated start and completion dates: Date

Size of research sample: Date

The undersigned agree to abide by the terms of this agreement:

Signatures

Researcher

COR&D

Date

Date
Appendix F: Worklife and Coping Survey

Section 1: Information about you.

1. Are you male or female? Please mark your response with an X or Check
   Male:  
   Female:  

2. How old are you as of today’s date? Please insert the appropriate number of years
   Age:  yrs

3. What is your current marital status? Please mark your response with an X or Check
   Single:  
   Married/In a Permanent Relationship:  
   Separated/Divorced:  

4. What is the highest level of education you have received in occupational therapy? Please mark your response with an X or Check
   Level of Education:  Bachelors’  
   Master’s  
   Doctorate  

5. How long have you been practicing as an occupational therapist? Please mark your response in years or months (if you have been practicing less than a year)
   Years:  
   Months:  

6. What is the nature of the employer(s) you currently have? Please mark your responses with an X or Check
   Primary Employer
   Community (Schools, Community Care, Private Practice etc.):  
   Hospital (Acute Care, General):  
   Chronic (Long Term Care, Rehab, Psychiatric Hospital):  

   Secondary Employer
   Community (Schools, Community Care, Private Practice etc.):  
   Hospital (Acute Care, General):  

101
Chronic (Long Term Care, Rehab, Psychiatric Hospital): ________

7. Please indicate the number of hours worked in a typical week beside the appropriate option (including overtime)

Primary Employer
- 37 hours or more per week: ______
- Less than 37 hours per week: _____ Please specify percentage of full time _____%
- Casual: ________
- Other: ________

Secondary Employer
- 37 hours or more per week: ______
- Less than 37 hours per week: _____ Please specify percentage of full time _____%
- Casual: ________
- Other: ________

8. What type of occupational therapy position do you currently hold with your primary employer? Please mark your response(s) with an X or Check
- Direct Service Provider: ________
- Administration: ________
- Educator: ________
- Researcher: ________
- Consultant: ________
- Other: ________

9. What type of occupational therapy position do you currently hold with your secondary employer? Please mark your response(s) with an X or Check
- Direct Service Provider: ________
- Administration: ________
- Educator: ________
- Researcher: ________
- Consultant: ________
- Other: ________
10. How long have you worked for the primary employer? *Please mark your response with an X or Check.*

<table>
<thead>
<tr>
<th>Time Frame</th>
<th>X or Check</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-6 months</td>
<td></td>
</tr>
<tr>
<td>7-11 months</td>
<td></td>
</tr>
<tr>
<td>1-2 years</td>
<td></td>
</tr>
<tr>
<td>3-5 years</td>
<td></td>
</tr>
<tr>
<td>6-10 years</td>
<td></td>
</tr>
<tr>
<td>11-15 years</td>
<td></td>
</tr>
<tr>
<td>16-20 years</td>
<td></td>
</tr>
<tr>
<td>21+ years</td>
<td></td>
</tr>
</tbody>
</table>

11. How long have you worked for the secondary employer? *Please mark your response with an X or Check.*

<table>
<thead>
<tr>
<th>Time Frame</th>
<th>X or Check</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-6 months</td>
<td></td>
</tr>
<tr>
<td>7-11 months</td>
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<td>1-2 years</td>
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<td>6-10 years</td>
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<td>11-15 years</td>
<td></td>
</tr>
<tr>
<td>16-20 years</td>
<td></td>
</tr>
<tr>
<td>21+ years</td>
<td></td>
</tr>
</tbody>
</table>
Section 3: Coping strategies you employ to maintain your OT practice.

How important:

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>Not</td>
<td>Of Little</td>
<td>Moderately</td>
<td>Important</td>
<td>Very</td>
<td>Extremely</td>
</tr>
<tr>
<td>Important</td>
<td>Importance</td>
<td>Important</td>
<td>Important</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

How important are each of the following strategies to help you function effectively and maintain a positive attitude towards your work?

1 – 7 Statements

1. _______ Take regular vacations.
2. _______ Engage in hobbies.
3. _______ Maintain balance between professional and personal lives.
4. _______ Maintain professional identity/values.
6. _______ Spend time with spouse/partner/family.
7. _______ Maintain sense of control over work responsibilities.
8. _______ Maintain sense of humor.
9. _______ Engage in physical activities.
10. _______ Spend time with friends.
11. _______ Try to maintain therapeutic relationship with clients.
12. _______ Reflect on satisfying experiences of work.
13. _______ Perceive client’s problems as interesting.
14. _______ Have the autonomy to vary work responsibilities.
15. _______ Remain active in professional development.
16. _______ Discuss work frustrations/seek support from colleagues.
17. _______ Seek case consultation.
18. _______ Define my role on the team.
19. _______ Change practice speciality.
20. _______ Discuss work frustrations with spouse/partner/family.
21. _______ Maintain regular contact with referral networks.
22. _______ Turn to spiritual beliefs/activities.
23. _______ Communicate with my managers.
24. _______ Feel like an equal member of the multi-disciplinary team.
Appendix G: Questions for the Focus Group

In order to help make good use of our time, I am including the questions I will be asking you during the focus group.

Interview Questions

1. What attracted you to sign up for this focus group?

2. What practice issues in your day to day work life do you find particularly stressful?
   (workload, level of control, equal treatment of employees, congruence of your values with the employer, workplace community, types of rewards)

3. What are the satisfying, dissatisfying aspects of your job(s)?

4. Have you had a personal experience of burnout? How have you coped with it?

5. What coping strategies do you employ to cope with the demands of your job?

6. Do you have a message you want to send policy makers, educators, professional associations and other clinicians about what we have discussed today?
Appendix H: Definition of Burnout and Coping Skills

Definition of burnout

Burnout places the individual experience in a social context and specifically in the world of work. It is characterized by the presence of the following elements: 1) Emotional Exhaustion: the feelings of being emotionally overextended, drained and exhausted by the helping experience; 2) Cynicism Dimension: having negative or inappropriate attitudes towards clients such as feeling irritable, loss of idealism and withdrawal by distancing oneself and pulling away from clients; and 3) Inefficacy Dimension: having feelings of reduced personal accomplishment, productivity, low morale and inability to cope (Maslach & Leiter, 1997).


Definition of coping skills

Lazarus & Folkman (1984) define coping as “constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the sources of the person” (pp. 141).


Pointers to help the conference run smoothly.

1. Please use a landline for dialing into the conference and preferably from a quiet location that is free from distractions. This will make it easier for us to hear each other and make a clearer recording.

2. Please state your name every time you speak as this will help with the transcription of the focus group.

3. Please print off the focus group questions and have them available with you. You are welcome to jot down some points in advance as well.
Appendix I: Ethical Clearance for the Study

QUEEN’S UNIVERSITY HEALTH SCIENCES & AFFILIATED TEACHING HOSPITALS RESEARCH ETHICS BOARD

August 14, 2009

Ms. Sangeeta Gupta
School of Rehabilitation Therapy
Louise D. Acton Building
Queen’s University

Dear Ms. Gupta,

Study Title: Burnout and Coping Strategies Utilized By Occupational Therapists Practicing in Ontario
Co-Investigators: Dr. Margo Paterson

I am writing to acknowledge receipt of your recent ethics submission. We have examined the protocol, survey and consent form for your project (as stated above) and consider it to be ethically acceptable. This approval is valid for one year from the date of the Chair's signature below. This approval will be reported to the Research Ethics Board. Please attend carefully to the following list of ethics requirements you must fulfill over the course of your study.

➢ Reporting of Amendments: If there are any changes to your study (e.g. consent, protocol, study procedures, etc.), you must submit an amendment to the Research Ethics Board for approval. (see http://www.queensu.ca/vpr/reb.htm).

➢ Reporting of Serious Adverse Events: Any unexpected serious adverse event occurring locally must be reported within 2 working days or earlier if required by the study sponsor. All other serious adverse events must be reported within 15 days after becoming aware of the information.

➢ Reporting of Complaints: Any complaints made by participants or persons acting on behalf of participants must be reported to the Research Ethics Board within 7 days of becoming aware of the complaint. Note: All documents supplied to participants must have the contact information for the Research Ethics Board.

➢ Annual Renewal: Prior to the expiration of your approval (which is one year from the date of the Chair's signature below), you will be reminded to submit your renewal form along with any new changes or amendments you wish to make to your study. If there have been no major changes to your protocol, your approval may be renewed for another year.

Yours sincerely,

[Signature]
Chair, Research Ethics Board

Date

ORIGINAL TO INVESTIGATOR - COPY TO DEPARTMENT HEAD - COPY TO HOSPITAL/1) /FOR (If appropriate) - FILE COPY

Study Code: REH-453-09

➢ Investigators please note that if your trial is registered by the sponsor, you must take responsibility to ensure that the registration information is accurate and complete.
Appendix J: Ethical Clearance for Revised Recruitment Letter

September 24, 2009

Ms. Sangeeta Gupta
School of Rehabilitation Therapy
Louise D. Acton Building
Queen’s University

Re: “Burnout and Coping Strategies Utilized by Occupational Therapists Practicing in Ontario” REH-453-09

Dear Ms. Gupta,

I am writing to acknowledge receipt of your letter dated September 10, 2009 which included the following:

- Notification that the recruitment letter/email has been revised
- Provision of a copy of the recruitment
- Confirmation that the letter of information will still be presented on the website when potential participants enter

I have reviewed this revised email and hereby give my approval. Receipt of this will be reported to the Health Sciences Research Ethics Board.

Yours sincerely,

Albert Clark, Ph.D.
Chair
Research Ethics Board

AFC/LR