Burnout has been described as a "disease of overcommitment" (Cherniss, 1980, p. 16). It is a job-related syndrome characterized by negative affect caused by chronic work stress. Central to the concept of burnout are feelings of emotional exhaustion and depersonalization and a reduced sense of personal accomplishment (Freudenberger, 1975; Maslach & Jackson, 1981a).

Burnout develops when the cumulative effects of chronic job stress cannot be effectively managed through active problem solving. This failure to cope with stress constructively leads to a depletion of the psychological energy required to carry out the job. To cope with the work situation, the employee withdraws emotionally from the work that he or she previously found satisfying. This withdrawal is often accompanied by apathy, cynicism, rigidity, and a loss of concern and empathy for the recipients of one's services as well as for one's co-workers. These changes create a psychological barrier that insulates the individual from further stress and in so doing enables him or her to cope with the stress. These changes may also precipitate dissatisfaction with one's work performance and an attitude that one's work lacks meaning and purpose. While the three aspects of burnout—emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment—are distinct, their effects are accumulative and contribute to the degree of experienced burnout (Cherniss, 1980; Maslach & Jackson, 1981a).

Human service professions such as medicine, social work, nursing, teaching, public safety, child care, and occupational therapy are viewed as high-stress occupations (Cherniss, 1980). Individuals in these professions work intensively, intimately, and continually with people who have serious physical, mental, emotional, and social problems. The stresses associated with processes of helping that involve treating, teaching, counseling, and reprimanding place these professionals at risk for burnout.

Although burnout has been studied extensively in many human service professions, it has received only scant attention in occupational therapy. A study of Australian occupational therapists by Sturgess and Poulsen (1983) found that, compared with their peers working in physical disabilities and pediatrics, therapists working in psychosocial settings had the least job satisfaction and sense of personal accomplishment and the highest exhaustion level. On the other hand, a survey of American therapists working in hospitals in Virginia by Brollier, Bender, Cyranowski, and Velletri (1987) found no statistically significant differences between therapists working in physical disabilities and those working in psychiatric and developmental settings. Their results indicated that therapists experienced a moderate level of burnout and
that therapists who spent the least time with patients experienced more depersonalization. They had previously reported that burnout in this sample was affected by primary job classification, by the type of work setting, and by treating patients included under the Medicare prospective payment system (Brollier, Bender, Cyranowski, & Velletri, 1986).

The Maslach Burnout Inventory (MBI) served as the data collection tool in the above studies. A comparison of the Australian data (Sturgess & Poulsen, 1983) with the MBI norms revealed that the sample scored lower on five of the six subscales. In view of these results, Sturgess and Poulsen recommended that MBI norms be devised specifically for occupational therapists. The developers of the MBI also advocated the use of normative data based on occupational group (Maslach & Jackson, 1981a). The appropriateness of the MBI for occupational therapists was the major question explored in the present study. In addition, the relationship between burnout and selected demographic and descriptive variables was investigated.

The MBI is recognized as a major tool for delineating job-related stress in human service workers (Offermann, 1984). Evidence of its adequate internal consistency and test-retest reliability as well as its convergent and discriminant validity is given in the test manual (Maslach & Jackson, 1981a). MBI norms represent a blend of data obtained from a variety of human service workers: nurses, physicians, agency administrators, teachers, counselors, social workers, mental health workers, police officers, probation officers, and attorneys. As with any instrument, however, application of the MBI to a population must be validated rather than assumed. What constitutes a high level of burnout in one profession may be only moderate in another. Thus, the interpretation of MBI scores is more meaningful if scores are compared with norms generated from the same occupational category. Offermann (1984) emphasized that the most urgent concern limiting use of the MBI was the lack of occupational norms.

Method

Subject Selection

The sample consisted of 250 registered occupational therapists from the southeastern section of the United States (Florida, Georgia, Kentucky, Louisiana, North Carolina, South Carolina, and Virginia) randomly selected from the membership files of the American Occupational Therapy Association. Subject selection was geographically restricted, as suggested by the test authors, to avoid regional idiosyncrasies in burnout variables (Maslach & Jackson, 1981a). One hundred nine therapists returned the survey, yielding a response rate of 44%. Ten of these 109 surveys were eliminated because they were from unemployed therapists or were very incomplete.

Subject Characteristics

Of the 99 individuals in the sample, 97 were women and 65% were married. The average age was 33.3 years and the median 29.6 years (range 22-67). For 62% of the sample, the bachelor's degree was the highest degree attained. Seventeen percent had earned a postbaccalaureate certificate, and 14% a master's degree. The remaining 7% had a doctorate or some course work at a level higher than the master's. Basic professional education had been taken in 60 occupational therapy curricula. The respondents had worked in occupational therapy from 1 to 33 years, with a mean of 9.1 years. Forty percent had been working from 1 to 5 years. The mean number of years spent in the position held at the time of the survey was 3.0 years. Thirty-seven percent had occupied that position for 1 year, 20% for 2 years, and 21% for 3 years. The mean number of years spent in the position that immediately preceded the position held at the time of the survey was 3.7 years.

Seventy percent of the respondents spent the majority of their time in direct patient care, 25% in administration, and 3% in teaching (2% failed to respond). The average number of hours spent per week in direct contact with patients was estimated to be 27.8. Thirty-three percent of the therapists indicated that they worked primarily with children; 5%, with adolescents; 35%, with adults other than the elderly; 20%, with the elderly; and 7%, with mixed age groups. Almost half the subjects, 48%, treated only patients with physical dysfunction. A mere 5% treated only patients with psychosocial impairments.

The majority (n = 90) reported a religious affiliation. Fifty-nine percent were Protestant, 21% Catholic, 6% Jewish, and 3% other denominations. A 7-point scale designed to evaluate the strength of the individual's religious attachment revealed a moderate degree of belief for the sample as a whole. The mean response was 4.5, with 62% falling between 4 and 6.

Thus, the typical subject from this sample of southeastern therapists was female, married, between 30 to 33 years of age, Protestant with moderately strong religious faith, had been employed in occupational therapy for 9 years, and was currently working with children or older adults in direct patient care. Tenure in the present position was about 3 years and in the prior position almost 4. Professional education was achieved at the bachelor’s level.

Instrument

The MBI is a 22-item, self-report questionnaire consisting of three subscales. A high score on the 9-item
Emotional Exhaustion subscale reflects feelings of being emotionally overextended and exhausted by one's work. A high score on the 5-item Depersonalization subscale indicates an unfeeling and impersonal response toward the recipient of one's service. A low score on the 8-item Personal Accomplishment subscale signifies feelings of incompetence and ineffectiveness in one's work. Each subscale yields two scores. The first score indicates the frequency with which feelings occur. The response scale for frequency ranges from 0 (never) to 6 (every day). The second score indicates the intensity of feelings when they occur. This scale ranges from 1 (barely noticeable) to 7 (very strong). Burnout is conceptualized as a continuous variable that ranges in strength from low to high degrees of experienced feeling. A low score on the Emotional Exhaustion and Depersonalization subscales and a high score on the Personal Accomplishment subscale is indicative of low burnout. Subscale internal consistency estimates using Cronbach’s alpha were .90 (frequency) and .87 (intensity) for Emotional Exhaustion; .79 (frequency) and .73 (intensity) for Depersonalization; and .71 (frequency) and .73 (intensity) for Personal Accomplishment. Evidence of validity was derived from correlations between MBI scores and (a) independent ratings of subjects by co-workers or spouses; (b) job characteristics, such as time spent in direct contact with patients; and (c) personal outcomes, such as intent to leave one’s job. Further evidence of the MBI’s reliability and validity is described in Maslach and Jackson (1981a, 1981b) and Offermann (1984). The instrument takes 20 to 30 minutes to complete.

Results

The means and standard deviations for the three MBI subscales for the frequency and intensity dimensions are presented in Table 1. For convenience, the norms provided by Maslach and Jackson (1981a) for the general and college-educated populations are also provided in this table. A comparison of the study data with that of the normative sample revealed a high degree of agreement on the Personal Accomplishment subscales, with means of 36.06 and 36.01 on the frequency dimension and 39.63 and 39.70 on the intensity dimension for the study and normative samples, respectively. However, on the average, these occupational therapists scored 3.78 to 4.31 points lower than the normative sample on the frequency and intensity dimensions of the Emotional Exhaustion and Depersonalization subscales. When the comparison is made between the study sample and the more selective normative sample made up of college graduates, the disparities on the Emotional Exhaustion and Depersonalization subscales widen to a difference of 4.61 to 6.23 points. Scores on the Personal Accomplishment subscales remained comparable, with less than a 2-point difference.

Pearson product-moment correlation coefficients were calculated between the six MBI subscale scores and the following variables: age, educational level, years of work as an occupational therapist, years of work in the present position, average number of hours of direct patient contact per week, and degree of religiosity. The significant correlations highlighted in Table 2 indicate that both increased age and increased education were associated with decreased Emotional Exhaustion and Depersonalization. Career longevity, on the other hand, was associated with increased Depersonalization as well as increased Personal Accomplishment. Years in the present position, however, was related only to increased Personal Accomplishment and was restricted to intensity. The number of hours of direct patient contact was positively correlated with the intensity dimension of Emotional Exhaustion and the frequency dimension of Depersonalization. The highest correlations were obtained between age and Emotional Exhaustion and between years of work as a therapist and Depersonalization. No significant correlations emerged in regard to religiosity.

Discussion

These findings suggest that, on the average, occupational therapists experience less burnout than other human service professionals. This observation con-
The need to develop MEQ norms for occupational therapists. The mean score deviations from the aggregated norms support the need to develop MBI norms for occupational therapists.

Scores on the frequency and intensity dimensions of the MBI subscales are interpreted as low, moderate, or high. These levels are based on score ranges established from data derived from the normative occupational sample. Scores are considered low if they are in the lower third of the normative distribution, moderate if they are in the middle third, and high if they are in the upper third. On the basis of the normative data, the mean scores obtained in this study translate to a moderate level of emotional exhaustion, depersonalization, and personal accomplishment. However, our data and the Australian data indicate that occupational therapists generally score lower than the MBI normative sample on the Emotional Exhaustion and Depersonalization subscales. This implies less burnout, since a high degree of burnout is reflected in high scores on these subscales in conjunction with low scores on the Personal Accomplishment subscale. Thus, when the MBI norms are applied to individual therapists, they may underestimate the degree of stress being experienced. Normative data for occupational therapists seem needed to revise the numerical cutoff points for delineating a low, medium, or high degree of experienced feeling on the subscales.

It is significant that low burnout in our sample was evidenced by lower scores on the Emotional Exhaustion and Depersonalization subscales, with scores on the Personal Accomplishment subscale remaining essentially comparable to that of the normative sample. According to Cherniss (1980), emotional exhaustion and depersonalization are the most salient dimensions of burnout as it is usually presented in the literature. Personal accomplishment is often discussed as being more akin to satisfaction. From this perspective, it has been proposed that tolerance to burnout, as measured by the Emotional Exhaustion and Depersonalization subscales, may be higher than average as long as a sense of personal accomplishment is sustained. These data are consistent with this proposition, which is also supported by findings from studies of community mental health workers (Cherniss, 1980) and hospice workers (Mor & Laliberte, 1984).

In view of the central role emotional exhaustion and depersonalization play in burnout, it is noteworthy that the American sample scored slightly over 2 points lower than their Australian counterparts on both dimensions of the Emotional Exhaustion subscale. Otherwise the average scores of the American and Australian therapists were quite comparable. Thus, cultural variability may favor the Americans in regard to feelings of emotional exhaustion.

The differences between occupational therapists and the normative sample regarding feelings of emotional depletion and dehumanization may relate to the way in which the occupational therapy process is enacted. Most occupational therapy interventions require the active cooperation of the patient. Eliciting this cooperation requires the therapist to interact with the patient as a collaborator in treatment rather than as a passive recipient of care. Often this interaction takes place over a long time. The aspects of collaboration and contact provide the opportunity for more personal interaction than when service is rendered under a more impersonal and episodic model. This may diminish feelings of depersonalization. The occupational therapy process also requires a substantial degree of autonomy and creativity, two qualities whose absence has been linked with feelings of emotional exhaustion (Maslach & Jackson, 1981a). Therapists select activity options appropriate for meeting treatment goals, and the very process of adapting these activities to achieve these goals requires ingenuity. These inherent opportunities for control and creativity may revitalize emotional reserves and shield against emotional depletion.

It may well be that the component of burnout to which occupational therapists are most susceptible is a decreased feeling of personal accomplishment. The perceptions that the occupational therapists shared most with the normative sample were those of a negative self-evaluation associated with a decreased sense...
of competence and effectiveness and a loss of meaning and purpose in one's work. Success in occupational therapy is often marked by small gains followed by lengthy plateaux, maintenance of function, or a retardation or loss of capability. The lack of dramatic improvement may lead one to question one's expertise and this, in turn, may contribute to a buildup of feelings of ineffectiveness.

Investigation of the correlates of burnout was undertaken to provide insight into factors that mediate burnout and, hence, suggestions for future study. Although no specific hypotheses were put forth, certain relationships were expected. For example, the normative data (Maslach & Jackson, 1981a) suggest that one of the benefits of age is lower burnout, an association supported by our findings on the Emotional Exhaustion and Depersonalization subscales. In a study on workers with the developmentally disabled population, Stevens and O'Neill (1983) also found decreases with age on these dimensions. However, these were accompanied by decreases, rather than increases, on Personal Accomplishment. Lowered burnout may arise from the replacement over time of less effective coping strategies with more effective ones.

One potential coping strategy examined in this study, religiosity, emerged as not being related to the burnout variables. Religiosity, or the extent of devotion to religious beliefs, was included for study because of the clinical impression of the prevalence in the South of religious motivation for overcoming difficulties. Since our calculations are based on a very global index of religious motivation, a more comprehensive measure is recommended for future exploration. Moreover, although our findings suggest that education may serve as an insulator for burnout, earlier research has linked education with a greater degree of burnout (Maslach & Jackson, 1981a; Mor & Laliberte, 1984). The inclusion of occupational therapy assistants and aides in future studies may help clarify this relationship for occupational therapy personnel.

Research on the relationship of the intensity of exposure to stress to burnout has generally indicated a positive association (Lewiston, Conley, & Blessing-Moore, 1981; Maslach & Pines, 1977). However, the impact of intensity has emerged as equivocal for occupational therapists, despite the dearth of research on burnout. Data by Brollier et al. (1987) suggest that burnout in occupational therapists is not affected by the amount of direct service, with the exception of therapists who spent less than 50% of their work time with patients reporting more frequent feelings of depersonalization than those who spent more time. Our findings suggest that the frequency of feelings of depersonalization and the intensity of feelings of emotional exhaustion may be exaggerated by increased patient contact. The complexity of the concept of the intensity of exposure to job stress has been highlighted by Sturgeon and Poulsen (1983). Having ascertained that psychosocial therapists experienced greater burnout on the measure of frequency of feelings of personal accomplishment than pediatric and physical rehabilitation therapists, they reasoned that this difference might be attributable to differences in the type and intensity of patient contact experienced by therapists in these three categories. For example, compared with their peers, psychosocial therapists had fewer hours of patient contact, fewer rest breaks, and treated fewer patients individually; but they also treated more patients and carried out more treatments in a group setting. Both the duration and the intensity of exposure to job stress require further study.

It seems logical to expect that the duration of exposure to a stressful situation would increase burnout. Nonetheless, neither the effects of long experience in developmental disabilities (Stevens & O'Neill, 1983) nor the effects of long experience in one position in child care (Maslach & Pines, 1977) were found to support this logic. In our study, duration of exposure, as represented by years of work as an occupational therapist, was linked to feelings of callousness and depersonalization. However, duration of exposure, both in the sense of career longevity and in the sense of length of time in one position, was also associated with an increased sense of job achievement. These results may reflect a change in the meaning of personal accomplishment that comes with experience. Stevens and O'Neill (1983) hypothesized that successful workers protected themselves from burnout by basing personal accomplishment on their own development of expertise rather than on the progress of their patients.

Conclusion

Much has been heard about burnout lately; it is the occupational hazard now in vogue. Unfortunately, its popularity may result in a tendency to neglect to give it the attention it deserves. Burnout can have serious negative consequences for the care receiver, the care provider and his or her family, and the employer. It has been linked with intent to leave one's job, absenteeism, alcoholism, drug use, illness, and family stress (Belcastro, Gold, & Hays, 1983; Jackson & Maslach, 1982; Maslach & Jackson, 1981b; Nowack & Hanson, 1983). Fortunately, its deleterious effects can be mitigated by antiburnout tactics such as improvements in communication and support, feedback on performance, and periodic respite from job pressures (Maslach & Pines, 1977; Stevens & O'Neill, 1983). Since the use of preventive or remedial strategies depends on the timely identification of those at risk of burnout and the factors increasing susceptibility to it, attention
must be directed toward instrumentation to identify burnout and measure its depth. This study points out the need to tailor the MBI norms for application to occupational therapists. Nonetheless, we underscore the tentativeness of our conclusions. Although a random sampling procedure was used, the return rate was less than 50%, and differences between respondents and nonrespondents are unknown. Further research is needed to document the prevalence of burnout among occupational therapists.

References


