

Using Hermeneutics to Understand Burnout and Coping Strategies Utilized by Occupational Therapists

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This research article explores the use of the hermeneutic approach in understanding practice challenges for occupational therapists in the contemporary health care arena. It provides insights into factors that lead to therapist burnout and the strategies they utilize to maintain competent practice. In this mixed methods study, hermeneutics was chosen as the qualitative approach to help understand the meanings occupational therapists ascribe to stressful situations at work and how they cope with those situations. Data was collected by conducting focus groups and semi-structured interviews with seven participants. Demands on time, conflict, lack of respect and autonomy emerged as the main practice issues. Maintaining healthy boundaries, importance of workplace and home community, monitoring self for signs of burnout and focusing on satisfying aspects of work emerged as the major coping strategies employed by the participants. Keywords: Occupational Therapist Practice Concerns, Health Care Provider Stress, Stress Mediators, Hermeneutics

Since the 1990's occupational therapists in Canada have continued to practice in an ever-changing landscape. Drastic cutbacks in public health spending have resulted in hospital closures and transfer of services into the community. Health system reforms in the first decade of the 21st century were primarily directed towards cutting costs, gaining efficiencies, integrating new technologies and meeting the needs of a more informed health consumer (von Zweck, 2004). Education requirements for entry-level therapists have changed as well with a move to a professional master's training in 2008 (von Zweck, 2004). While the publicly funded system struggles with providing services, growth areas include 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.

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.

This article reports on the qualitative aspects of a mixed method research study, which sought to expand existing knowledge on the stressors experienced by occupational therapists (OTs) practicing in Ontario, Canada. The study goals included the elucidation of the practice issues the participants face in their work life and the coping strategies they utilize to prevent burnout. The first author, Sangeeta had eleven years of clinical practice as an occupational therapist (OT) when she started her Masters' degree under the supervision of the second author Margo who is a professor in OT at Queen's University. We agreed that it would be helpful to bring two other experts on as advisory committee members, Claudia who is the Executive Director of the Canadian Association of OTs and Rosemary who is a faculty member at Queen's University and also past president of the Ontario Society of OTs.

Literature Review

Madill et al. (1985) surveyed 119 Alberta occupational therapists using the *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. While this study was conducted more than 25 years ago, I believe it is relevant to include it here as a Canadian study. I did wonder if there would be differences in levels of burnout between new graduates and senior occupational therapists.

Rogers and Dodson (1988) surveyed 99 occupational therapists practicing in the southeastern US using the *Maslach Burnout Inventory-Human Services Survey (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. These studies were very helpful in designing the focus group questions for my study and probes I utilized as follow-up to the main questions.

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 a psychiatric occupational therapist, caseload size and amount of overtime were factors impacting the level of burnout. After reading this study, I became curious about the levels of burnout in general occupational therapy practitioner population as compared to the psychiatric occupational therapists in Ontario.

Balogun, Titiloye, Balogun, Oyeyemi, and Katz (2002) surveyed occupational therapists and physiotherapists using the *MBI-HSS* working in hospitals 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 *emotional exhaustion*, 94% experienced high *depersonalization* and 97% reported low *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 *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 *emotional exhaustion*, 75% had low levels of *depersonalization* and 46% had high levels of *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. This study helped me in my questionnaire design for the quantitative data collection (Results reported in Gupta et al., 2012).

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 *emotional exhaustion*, moderate *depersonalization* and high *personal accomplishment*. Their study also corroborated the findings of Balogun et al. (2002) that there was no significant difference between the two disciplines. In reading the studies that compared occupational therapy and other allied health disciplines such as physiotherapy, social work etc., I came to the realization that the burnout rates are fairly similar. This was helpful to me as a clinician.

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.

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.

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.

Method

This study utilized a mixed methods approach to gain a comprehensive view of stressors faced by occupational therapists in their work life 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 utilized the hermeneutic approach first outlined by Paterson and Higgs (2005) and later by von Zweck, Paterson, and Pentland (2008). In using the hermeneutic approach within this concurrent embedded strategy, a questionnaire was utilized to collect quantitative data as the primary source. Interviews and focus groups were conducted with a subset of the sample and were embedded or nested within the predominant quantitative method (Creswell, 2009).

The objectives of the research were to determine the levels of burnout being experienced by a sample of occupational therapists practicing in Ontario, to describe the practice issues faced by participants in their day-to-day work, and the coping strategies they employ to maintain their practice. Quantitative and qualitative data were collected for each objective and the procedures are detailed in Table 1.

Table 1:***Overview of Mixed Methods Research Design***

Objective	Methodology
To determine the levels of burnout being experienced by occupational therapists practicing in Ontario.	Administer Maslach Burnout Inventory-General Survey (Maslach, Jackson & Leiter, 1996). Explore individual perception of burnout in interview/ focus group.
To describe the practice issues faced by participants in their day-to-day work	Administer Areas of Worklife Survey (Leiter & Maslach, 2000) Explore practice issues in interview / focus group
To describe the coping strategies participants employ to maintain their practice	Administer self developed questionnaire regarding coping strategies Explore coping strategies in interview/focus group

Quantitative approaches are located in the post-positivist world-view that seeks universal truths about reality that can be discovered using objective, reductionist, and quantifiable measurements (Creswell, 2009). This approach identifies and measures variables to predict, control, describe, generalize, and test hypothesis and/or cause and effect relationships (Creswell, 2009). 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, the qualitative 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). 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 metaphor, including the hermeneutic circle, dialogue and fusion of horizons. The hermeneutic circle refers to a procedure where the researcher reads and re-reads an 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, p.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. These merge (fusion of horizons) with the new information and create new knowledge and understandings.

Ethical Considerations

Ethical clearance for this study was received from the Queen's University Research Ethics Board. 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 Sangeeta's password protected personal computer. All paper materials were locked into a cabinet held in a locked room. 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.

Participants

Participants were recruited through purposive sampling. Participants were recruited through inclusion of a recruitment letter in the September, 2009 monthly e-newsletter sent by the Ontario Society of Occupational Therapists (OSOT) to its members with a link to the survey stored at another website. The quantitative findings are presented elsewhere (Gupta, Paterson, Lysaght, & von Zweck, 2012)

Once participants completed the survey, they were directed to a Queen's University secure website to enter their name in a 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 for the author to contact them for participation in a focus group. Six individuals declined participation citing work and family reasons. Of the remaining nine individuals, two could not participate due to scheduling and work conflicts. Four individuals had signed on to participate in the first focus group and three for the second focus group. On the day of the actual focus group, less number of individuals signed in. Margo and I chose to go ahead with them and contacted the members who could not make it for individual interviews. Therefore, three individuals participated in one focus group, two participated in a second focus group, and two individuals participated in individual interviews. The inclusion criteria for the study included the following: practicing as an occupational therapist in Ontario, membership in OSOT, and ability to use a computer to access the survey online.

Characteristics of Participants

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.

Table 2:

Characteristics of Focus Group/Interview Participants

ID	Age	Educational Background	Years of Practice	Work Status (Full Time (FT)/Part Time(PT)/Non Practicing (NP)
1	31 Yrs	BScOT	7.5 Yrs	FT

2	34 Yrs	BScOT; MSc (Rehab Science)	8 Yrs	FT
3	41 Yrs	BScOT	19 Yrs	FT
4	40 Yrs	BScOT, MScOT	17.5 Yrs	PT
5	65+ Yrs	Physical/Occupational Therapy Diploma, BScOT	43 Yrs	NP
6	34 Yrs	MScOT	4.5 Yrs	FT
7	53 Yrs	BScOT	33 Yrs	NP

Data Collection

Sangeeta conducted focus groups and interviews to gather information on the personal experiences of stressors in the participants work-life. In addition she wanted to learn about the coping strategies they employ to continue employment in this area.

Focus Groups

Focus groups help explain and explore social phenomenon 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).

Sangeeta utilized a semi-structured interview approach in conducting the focus groups and interviews. She sent the questions (Appendix A) and definition of burnout and coping skills (Appendix B) in advance to help stimulate thinking and use the time together efficiently. The interview protocol had been previously piloted as part of a research methods and design course by conducting a semi-structured interview with an occupational therapist. Sangeeta planned to only conduct focus groups but some of the participants could not attend on the day of the focus group and were interested in participating in the study. Sangeeta chose to interview them individually so that their experiences could be documented and included in the study.

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 allows for audiotaping of the interviews in a digital format as well as provides a transcription referral service. The researcher subscribed to the 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.

Data Analysis

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. A central tenet of hermeneutics is the belief that people are self-interpreting and engage in processes to understand what is important and real to them in order to create their own construction of reality (Koch, 1996). Sangeeta's own experience as a practicing occupational therapist also helped inform the study as this represents a past horizon of the study.

Sangeeta constructed knowledge by repeated readings of the text, which lead to construction of meaning between the text and the researcher (Koch, 1999). Sangeeta initially coded by writing in the margins of each transcript. She then wrote these codes on a large board and looked for patterns or similarities in the practice issues identified. In this way, she generated the major themes reported in this article. Utilizing the hermeneutic circle (Bontekoe, 1996), Sangeeta attempted to understand the whole (the meaning participants ascribe 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 represented 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 Sangeeta'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.

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 including positioning of the researcher's preconceived notions or experiences from the beginning of the study. Gadamer (1975) encouraged researchers to acknowledge their biases and preconceived ideas but not to bracket them as hermeneutics is the theory and practice of interpretation. Gadamer (1975) also posited that the hermeneutic circle of interpretation is never closed but ongoing as new knowledge is generated and integrated into existing knowledge. Sangeeta was aware that as an occupational therapy practitioner, she brings "insider" knowledge to this study. She, Margo and the thesis advisory committee saw this as a strength. Additionally, Sangeeta chose to use standardised assessments that are well known in the burnout field to measure burnout quantitatively to enhance rigour of this study.
- Member checking the findings with participants to ensure credibility
- Rich and thick description of quotes that provide 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 Maslach Burnout Inventory-General Survey (Maslach, Jackson & Leiter, 1996) and Areas of Worklife Survey (Leiter & Maslach, 2000): two standardized assessment tools commonly used to measure burnout. Margo attended all except one teleconferenced interview. She attended to provide support to Sangeeta and also because she was interested in hearing participant's experience first hand. Sangeeta conducted the primary analysis of the interview and focus group data with spot checks by Margo. Several participants provided rich, thick quotes, describing the meaning of their experiences, which enhanced the credibility of the emerging themes. Additional review came from the thesis advisory committee. Additionally, the preliminary quantitative results were submitted in poster form to World Federation of Occupational Therapists conference in May 2010 in Chile and defended by Margo. She brought back comments of interest especially around coping strategies to help prevent burnout and build engagement.

Results

This section will present themes identified by the participants regarding the practice issues they encounter in their work-life.. The next section will present qualitative results on coping strategies the practicing occupational therapists employ to sustain their practice.

Practice Issues

Focus groups and interviews with participants revealed commonalities and differences regarding environmental factors that impinge on their day-to-day practice. Overall, four major themes emerged from the focus groups and interviews.

Table 3:***Clusters of Common Themes for day-to-day practice issues***

<p>1. Demands on time</p> <p>a) Burgeoning workload</p> <p>b) Unrealistic demands</p> <p>c) Juggling clinical and non-clinical duties</p> <p>2. Conflict</p> <p>a) Mismatch in values with the organization</p> <p>b) Lack of health care resources</p> <p>3. Lack of respect</p> <p>a) Need to provide constant justification</p> <p>b) Lowered morale over bureaucratic delays</p> <p>4. Lack of autonomy</p> <p>a) Unable to customize practice</p> <p>b) Policies and procedures of the workplace</p> <p>c) Coordinating care</p>	<hr/>
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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 clients and feeling overwhelmed at times with the amount of work required. 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 Inpatient, 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)

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. Dealing with angry parents may be. (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 trying to refer 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)

2. Conflict

Participants identified a mismatch in their values and the organizations they work for. They reported 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 identified feelings of fatigue 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.

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're 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 its 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 a pediatric population until they start school, spoke of feeling conflicted while in 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)

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 pieces are recognizing that you are working hard at times 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 may 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 I guess 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 for 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)

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 meeting about something more procedural, not that that doesn't need to happen, but it certainly is that whole case load management and time to meet everybody's needs. (P3)

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)

Coping Strategies

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 4.

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)

Table 4:

Coping Strategies

<p>1. Boundaries a) Maintain work-home boundary b) Negotiating workload / other commitments</p>
<p>2. Workplace / Home Community a) Supportive family / friends b) Supportive colleagues</p>
<p>3. Monitoring self/maintaining self awareness a) Time management strategies b) Goal setting c) Pacing self d) Physical self care</p>
<p>4. Focus on satisfying aspects of work a) Seeing clients improve b) Participating in program development</p>

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)

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)

Discussion

Findings of this study shed light on the issue of 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 and Pranger (1992), Davis and Bordieri (1998), Laminman (2007), and Moore et al., (2006a, 2006b).

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 et al., 2006) were not reported as highly by the study participants. These are interesting findings and needs to be investigated further.

Limitations associated with the research study

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, too burnt out to respond or the subject matter may not have resonated with them. The participants in this study were volunteers who may be more motivated than non-volunteers. 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 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).

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 study, 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 research is needed about occupational therapists and others 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 & 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. Studies designed to survey these groups and to learn about their practice issues would help elucidate their specific concerns and ways to ameliorate them.

Implications for clinicians, educators, 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. This 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 (Gupta et al., 2012). 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.

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Appendix A

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 B

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: (a) *Emotional Exhaustion*: the feelings of being emotionally overextended, drained and exhausted by the helping experience; (b) *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 (c) *Inefficacy Dimension*: having feelings of reduced personal accomplishment, productivity, low morale and inability to cope (Maslach & Leiter, 1997).

Maslach, C., & Leiter, M. P. (1997). *The truth about burnout*. San Francisco, CA: Jossey-Bass.

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” (p. 141).

Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal and coping*. New York, NY: Springer Publishing Co.

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.

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