THE PREVALENCE OF BURNOUT AMONG THERAPY STAFF EMPLOYED IN LIFE HEALTH CARE REHABILITATION UNITS

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DECLARATION

I, Therésa du Plessis, hereby declare that the work on which this assignment is based, is my own original work (except where acknowledgments indicate otherwise) and that neither the whole work nor any part of it has been, is being, or is to be submitted for another degree at this or any other institution or tertiary education institution or examining body.

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ABSTRACT

Rehabilitation therapists are at risk for burnout as a result of their emotionally challenging and stressful jobs. No South African studies could be found that focus on burnout in therapists who work in the field of rehabilitation. This study attempted to determine the prevalence of burnout amongst a select group of therapists in South Africa i.e. therapy staff employed by Life Rehabilitation. In addition, contributing factors to burnout in this environment, current management of the problem and suggestions for future management were explored.

A descriptive design which used both quantitative and qualitative methods was utilised. Forty-nine therapists and seven managers participated in the study. No sampling was done. Quantitative data was collected through a demographic coding sheet and the Maslach Burnout Inventory (MBI). Data were statistically analysed and a p value of < 0.05 was deemed statistically significant. Interview schedules were used to guide the qualitative interviews on participants' understanding of burnout, contributing factors, its impact on the therapists and company as well as management strategies. Qualitative data was analysed according to the inductive method.

Regarding burnout prevalence in each of the subsections of the MBI, 57.14% of the therapy staff had high levels of Emotional Exhaustion (EE), 20.4% reported depersonalisation (DP) and 38.77% had low levels of Personal Accomplishment (PA). The variables associated with high burnout scores were: male gender (p=0.0238) (PA), absence of children (P=0.02994) (EE), (p=0.03895) (PA), ≤ four years tertiary education (p=0.03640) (PA), ≤ R15 000 income (p=0.02262) (PA), not working weekends (p=0.02882) (DP), none or poor coping skills (p=0.03180) (EE), high overwhelming work load (p=0.03972) (EE), (p=0.01227) (DP), overwhelming/too small patient load (p=0.02365) (EE), high administration load (p=0.00302) (PA), seldom achievable deadlines (p=0.03693) (DP), postponed contact with patients (p=0.02023) (DP), (p=0.01164) (PA) and a poor work environment (p=0.02162) (EE), (p=0.04034) (DP). The qualitative data identified the following factors as causes of burnout: relationship challenges, lack of planning and coping skills, personality type, disempowerment, the nature of rehabilitation work, private health care environment, ethical dilemmas, time

pressures, lack of rewards, lack of space and resources, uncertainty/change, lack of support from management and high workload.

The following burnout management strategies emerged from the qualitative data: psycho-social intervention, team building, decrease in workload/increase in staff, adjustment of administrative workload, acknowledgement of staff through salaries and other rewards, adjustment to leave package, improved orientation and induction of staff, “time-out” opportunities, development of staff and managers, improved treatment facilities, feedback from discharged patients as well as implementation of burnout monitoring systems and development of a burnout policy and burnout management system.

Recommendations to Life Rehabilitation focus on practical strategies regarding the detection, prevention and management of burnout in therapists. The groundwork has been done through this research. Successful strategic implementation will depend on the leadership of the organisation and without these key players and all the other role players involved, commitment in terms of time, money and allocation of resources it will remain an academic exercise

KEY TERMS

Burnout; contributing factors; management; prevalence; private health care, rehabilitation; therapists

ABSTRAK

Die gevaar bestaan dat gesondheidswerkers hulle kan “uitbrand” as gevolg van die emosioneel uitmergelende aspekte van hul werk en die kroniese inspanning waaraan hulle blootgestel word. Geen Suid-Afrikaanse studies kon gevind word wat op uitbranding van die terapeut of die terapeut-assistent in die rehabilitasieveld fokus nie. Hierdie studie het die oogmerk om die prevalensie van uitbranding onder ’n selektiewe groep terapeute, die terapeute in diens van Life Rehabilitasie in Suid Afrika, te bepaal. Ter aanvulling van die prevalensie van uitbranding, is die bydraende faktore van uitbranding in hierdie omgewing, die huidige bestuur van die probleem en voorstelle vir toekomstige bestuur ondersoek.

’n Beskrywende studie-ontwerp, wat sowel kwantitatiewe as kwalitatiewe metodes insluit, is vir data-insameling en -ontleding gebruik. ’n Steekproef is nie gebruik nie. Nege-en-veertig terapeute en sewe bestuurders het aan die studie deelgeneem. Die demografiese inligting is met behulp van ’n demografiese kodeblad ingesamel en maak deel uit van die kwantitatiewe data. ’n P waarde van < 0,05 is as statisties beduidend beskou. Daar is van die Maslach Uitbranding-Inventaris (Maslach Burnout Inventory) gebruik gemaak om die prevalensie van uitbranding te bepaal. Onderhoudskedules is gebruik tydens die kwalitatiewe onderhoude waartydens deelnemers se begrip van uitbranding, die bydraende faktore en die impak op die terapeute en maatskappy, asook die bestuurstrategieë te bepaal. Die kwalitatiewe data is volgens die induktiewe metode ontleed.

Aangaande die dimensies van uitbranding, het die studie bevind dat 57,14% van die terapeute hoog getoets het vir emosionele uitputting (EU), 20.4% het in die hoë kategorie vir depersonalisasie (DP) geval en 38,77% het lae vlakke van persoonlike vervulling (PV) gehad. Die veranderlikes wat met hoë uitbranding-tellings verband gehou het, was manlike geslag (p=0.0238) (PV), gebrek aan kinders (p=0.02994) (EU), (p=0.03895) (PV), ≤ vier jaar tersiêre opleiding (p=0.03640) (PV), ≤ R15 000 inkomste (p=0.02262) (PV), geen werk oor naweke (p=0.02882) (DP), geen of min bybly-vermoëns (p=0.03180) (EU), hoë, oorweldigende werklas (p=0.03972) (EU), (p=0.01227) (DP), oorweldigende of ontoereikende pasiënt-belading (p=0.02365) (EU), hoë administratiewe werklas (p=0.00302) (PA), selde bereikbare spertye (p=0.03693) (DP), uitgestelde kontak met

pasiënte (p=0.02023) (DP), (p=0.01164) (PV), ’n swak werksomgewing (p=0.02162) (EU), (p=0.04034) (DP).

Die hoof-oorsake van uitbranding is faktore wat met individue, pasiënt/werk, bestuur en administrasie verband hou. Strategieë is geïdentifiseer wat gebruik kan word om uitbranding konstruktief in hierdie omgewing te bestuur en sluit psigiese-sosiale behandeling, spanverbeteringe, werk/pasiënt aanpassings, erkenning van personeel, verlofaanpassings, vakansietyd-geleenthede, personeelontwikkeling en bestuursverbetering, asook die implementering van moniteringsisteme en beleidsontwikkeling in.

Aanbevelings vir Life Rehabilitation is onder meer praktiese strategieë vir die opsporing, voorkoming en bestuur van uitbranding onder terapeute. Die aanvoorwerk is deur hierdie navorsing gedoen. Suksesvolle implementering van die strategieë sal van die leierskap in die organisasie afhang. Sonder hierdie en ander sleutelfigure, hul toegewydheid ten opsigte van tyd, geld en toewysing van middele sal dit slage akademise waarde hê.

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GLOSSARY OF TERMS

Burnout

Burnout refers to physical and emotional exhaustion caused by "prolonged physical, affective and cognitive strain at work" and results in "disengagement, i.e. distancing oneself from one's work and experiencing negative attitudes towards work" (Fritz & Sonnetag, 2006, p. 936), as well as: the development of a negative self image and decreased concern and empathy with clients (Scutter & Goold, 1995).

Emotional Exhaustion

Emotional exhaustion refers to "the depletion or draining of emotional resources" (Schaufeli, 2007, p. 218).

Depersonalisation

Depersonalisation points to "development of negative, callous, indifferent and cynical attitudes towards the recipients of one's care or service" (Schaufeli, 2006, p. 218).

Independent Counselling and Advisory Services (ICAS)

The Independent Counselling and Advisory Services is an independent external organisation which provides the Life Employee Wellness Programme (Life Healthcare – Life Employee Wellness Programme brochure).

Joint Performance Management (JPM)

According to the Performance Management Policy (2005, p. 1) of Life Healthcare, Joint Performance Management is: "The process of planning and confirming performance objectives with employees, encouraging employees to ensure the achievement of objectives, regularly reviewing performance and career development. It is owned and driven by both the line manager and the employee."

Lack of personal accomplishment

Lack of personal accomplishment is "The tendency to evaluate one's work with one's recipients negatively. It is believed that the objectives are not achieved, which is

accompanied by feelings of insufficiency and poor professional self-esteem" (Schaufeli, 2007, p. 218).

Life Rehabilitation

Life Rehabilitation is a member of the Life Healthcare Group, one of the private hospital groups in South Africa operating rehabilitation units across the country (Life Rehabilitation brochure, n.d.).

Prevalence

"The number of people, who have a particular disease at a specific time" (Katzenellenbogen, Joubert & Karim, 2004, p. 17). For this study prevalence refers to the number of therapy staff members employed by Life Rehabilitation units whose Maslach Burnout Inventory scores indicated that they suffered from burnout at the time of the study.

Rehabilitation

The UN World programme of Action concerning Disabled Persons (2006, p. 3) define rehabilitation as: "A goal-orientated and time-limited process aimed at enabling an impaired person to reach optimum mental, physical and/ or social level, thus providing her or him with the tools to change her or his own life. It can involve measures intended to compensate for a loss of function or a functional limitation (for example by technical aids) and other measures intended to facilitate social adjustment or readjustment."

Therapy staff

Staff can be defined as: "The people who work for a particular company, organisation or institution" (Macmillan Dictionary, no date) and therapist can be defined as: "A person with special skills, obtained through education and experience in one or more areas of healthcare" (The Free Dictionary, no date) and/or as a person "who specialises in the provision of a particular therapy" (The Free Dictionary, no date). For this study therapy staff refers to physiotherapists, occupational therapists, speech therapists, social workers, psychologists, dieticians and their assistants where relevant who collaborate within intra-disciplinary teams, at the different units of Life Rehabilitation to provide rehabilitation services to patients.

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LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
CISD	Critical Incident Stress Debriefing
COR	Conservation of resources
CPD	Continued Professional Development
DP	Depersonalisation
EAP	Employee Assistant Programme
EE	Emotional Exhaustion
HPA	Hypothalamo-pituitary-adrenal
HSE	Health and Safety Executive
ICAS	Independent Counselling and Advisory Services
ICD-10	International Classification of Diseases - 10th revision
ICU	Intensive Care Unit

IOM	Institute of Medicine
LOS	Length of Stay
JPM	Joint Performance Meeting
MBI	Maslach Burnout Inventory
PA	Personal Accomplishment
PHC	Primary Health Care
SADHS	South African Demographic and Health Survey
UK	United Kingdom
USA	United States of America
WHO	World Health Organisation

CHAPTER 1

INTRODUCTION

1.1 Study outline

Chapter One provides an orientation to the study, as well as a discussion on the study problem, the motivation for the study and the significance of the study. In Chapter Two literature findings on burnout are discussed. In Chapter Three the methodology of the study is presented.

In Chapters Four and Five the quantitative and qualitative results of the study are presented. This is followed by a discussion of the results in Chapter Six and recommendations, as well as the conclusion to the study in Chapter Seven.

1.2 The study problem and motivation

The researcher is a social worker employed by New Kensington Clinic (a Life Rehabilitation Unit). She has noticed that staff members often complain and debrief on an informal basis about stress in the workplace. As a social worker she has recognised some of the signs and symptoms that they described, as signs and symptoms of burnout. She has herself also experienced these feelings from time to time and is of the opinion that all health care staff in this environment are at risk for burnout because of the intense nature of the work.

The therapy staff is constantly exposed to the emotional strain of dealing with patients, and the families of patients who are traumatised by disabling conditions, like stroke, traumatic brain injuries and spinal cord injuries. Sometimes these conditions result in the death of a patient with whom the staff has developed a close relationship.

Furthermore the researcher noticed that there is a high staff turnover at the unit where she is employed. According to the literature one of the consequences of burnout is a high staff turnover (Mandy, Sacter & Lucas, 2004). It is therefore possible that burnout is one of the causes of the high staff turnover in this unit.

According to the literature, burnout is acknowledged as a problem in the healthcare industry, but little is done to address this problem (Cohen & Gagin, 2005). From observations the researcher has made and discussions with co-workers this

seems to be the case at Life Rehabilitation Units as well, since no official policy could be found on the detection, prevention and management of burnout in Life Rehabilitation.

Therefore the researcher wants to assess these assumptions and informal opinions through scientific research in order to determine whether the problem of burnout really exists in this setting, and if it does exist, to quantify the problem and to initiate steps towards addressing the problem.

1.3 Study aim

The aims of this study were to determine:

1. The prevalence of burnout among therapy staff employed by Life Rehabilitation Units.
2. The contributing factors to burnout in this environment.
3. Current management of burnout by the study population in the study setting.

1.4 Study objectives

The study objectives were:

1. To establish the prevalence of burnout among therapy staff at Life Rehabilitation Units.
2. To describe the demographic details of the study population and to determine the impact of demographic details on burnout.
3. To describe the employment circumstances of the study population and to determine the impact of employment circumstances on burnout.
4. To determine the understanding both managers and therapy staff have of the concept of burnout.
5. To determine factors contributing to burnout in this environment.
6. To establish how burnout is currently managed at Life Rehabilitation Units by the company, as well as by therapy staff employed by the company.
7. To determine the effects of burnout on the company and therapy staff.
8. To make recommendations on burnout management strategies for Life Rehabilitation, through utilising literature on the subject and study findings.

1.5 Background to the study

The discussion on the background to the study is presented in two separate sections i.e. background to private health care services in South Africa and Life Healthcare specifically and background information on burnout.

1.5.1 Private health care and Life Rehabilitation Units

Health care to South Africans is provided either through the public sector or in the case of a minority, the private sector. Health care is provided along a continuum of care from primary health care which is offered free of charge by the state or at a price by general practitioners to paying patients, to specialist services in tertiary state hospitals, as well as in private sector clinics and hospitals to those who can afford it (SouthAfrica.info, 2008) The private sector draws the majority of the country's health professionals and provides for the high- and middle income groups who tend to be members of medical insurance schemes (SouthAfrica.info, 2008). According to the Council of Medical Schemes' Annual Report 2007-08, the South African private sector was serviced by 122 medical schemes in 2007. The report further stated that there were 3 178 937 principal members and 7 478 040 beneficiaries.

Since 1990, medical insurance contributors were responsible for a shift from public to private hospital utilisation, which resulted in the expansion of the private health sector. The current number of private beds available countrywide is in the region of 27 500. The private hospital industry turnover amounts to approximately R17.5 billion annually (Matsebula & Willie, 2007). Private hospitals are predominately found in the Western Cape, Gauteng, and KwaZulu-Natal and are mainly owned by three major hospital groups i.e. Life Healthcare, Medi-Clinic and Netcare. These three hospital groups own more than three- quarters of all private sector beds and more than 80% of all private sector theatre facilities (Matsebula & Willie, 2007).

The Life Healthcare Group plays an important role in the South African healthcare sector. Their main focus is on acute hospital care. They own and operate 62 acute care facilities in South Africa and Botswana and employ approximately 2,700 doctors and specialists. Life Healthcare's acute facilities are complemented by related healthcare services, including rehabilitation services to provide the full spectrum of medical care (General information, Life Healthcare web page, 2008).

Private rehabilitation treatment centres are a relatively new undertaking in South Africa. Before 1997 there were only a few private rehabilitation units in South Africa. The picture has started to change and currently more private rehabilitation units are available to those members of the public who can afford it. The major role players in private rehabilitation in South Africa are Life Rehabilitation and Netcare (Dr N. Patel, Managing Director, Life Esidimeni, Personal Interview on 4 August 2008).

From 1999 Life Rehabilitation has started to develop rehabilitation facilities in various South African provinces and currently has seven rehabilitation units across the country. These provide acute rehabilitation for patients who suffer from various disabling conditions. These facilities adhere to strict criteria in order to be accredited and licenced by the Board of Healthcare Funders as dedicated rehabilitation facilities. Length of stay for patients in the units is on average between six and eight weeks and an interdisciplinary team work approach is followed (Life Rehabilitation pamphlet - Restoring quality of life, no date, n.d.).

Life Rehabilitation units carry 59 practice numbers which makes it possible to implement global fee structures (Life Rehabilitation pamphlet – Restoring quality of life, no date, n.d.). The global fee ensures that the patient's daily tariff includes all professional services excluding medication/drugs, ward stock and assistive devices, that patients may require (Life Rehabilitation pamphlet - Restoring quality of life, no date, n.d.). This tariff structure benefits both the funder and provider since it eases administration and there are no hidden costs (Life Rehabilitation pamphlet - Restoring quality of life, no date, n.d.). It is beneficial to the rehabilitation process since it includes services like reporting, education to patients and families and team meetings (Life Rehabilitation pamphlet - Restoring quality of life, no date, n.d.). This also means that the therapy staff receives a salary from Life Rehabilitation and does not charge the patients for services rendered. As such their employer Life Health care has a responsibility towards their wellbeing and the prevention of work-related health conditions such as burnout.

1.5.2 Burnout: Preliminary conceptualisation

According to Mandy et al (2004) the concept of "burnout" in relation to health-care professionals was originally suggested by Freudenberger in 1974 to describe physical and emotional exhaustion. Burnout develops when an individual is exposed to chronic work stressors and frustration that exceeds his or her tolerance, and renders his/her coping

mechanisms ineffective (Mandy et al, 2004; Flaherty, 2006). Burnout is characterised by three components i.e. emotional exhaustion (EE), depersonalisation (DP) and lack of a sense of personal accomplishment (PA) (Gilbar, 1998). Burnout presents a serious threat to an employee's health and working ability with a negative impact on an individual's emotional, behavioural, physical and cognitive functioning (Scutter & Goold, 1995; Hätinen, Kinnunen, Pekkonen & Aro, 2004). It is not only related to negative outcomes for the individual but also for the organisation (Hätinen et al, 2004). It is a syndrome that is encountered frequently among health-service workers as a result of the chronic stress and emotionally challenging nature of their work (Mandy et al, 2004; Flaherty, 2006).

A stressful work environment as a result of the following factors can contribute to burnout: lack of recognition and fair competitive remuneration, insufficient staff, watching patients suffer, demands of patients, staff issues, impaired communication with management, racism, no heed of professional value, non-conducive psychological and physical environment, extensive work hours, poor support from supervisors, increased responsibility, increased workload/task overload, staff shortages, increases in number of patients with HIV-related diseases and a lack of resources (Van Wijk, 1997; Hall, 2004; Cohen & Gagin, 2005; Rothmann, van der Colff & Rothmann, 2006).

Therefore, high rates of burnout can be expected in South Africa especially if one takes into consideration factors like:

- High shortages of heath workers and high rates of medical migration
- Difficult and developing diseases which include infectious and non-infectious epidemics e.g. HIV/AIDS, stroke, heart disease and cancer, as well as a continued struggle against childhood diarrhoea and malnutrition and the high incidence of violence and accidents
- An overwhelmed and demoralised public health system and service providers
- The protracted and complex health transition process
- Insufficient leadership in the healthcare system at all levels (Kautzky & Tollman, 2008).

The assumption was confirmed by South African studies among various groups of nurses, which found high levels of burnout (Van Wijk, 1997; Spies, 2004).

Working in a rehabilitation unit as a therapist is particularly stressful and demanding (Schlenz, Guthrie & Dudgeon, 1995) since emotionally taxing interactions with patients and families are intrinsic to the work. Therapists are consistently confronted with emotionally charged situations, the cumulative effects of which can contribute to the development of burnout (Schlenz et al, 1995). In addition, therapists tend to be empathetic, idealistic, committed to assisting those who are disabled and altruistic. These very attributes that are desirable in human service professionals create a level of vulnerability that makes them highly susceptible to burnout (Schlenz et al, 1995).

1.6 Significance of the study

Research on the incidence, prevalence and causes of health care burnout in South Africa is scarce and even fewer studies evaluate interventions aimed at decreasing burnout (Cohen & Gagin, 2005). Furthermore, most of the health care burnout studies done in South Africa focused on nurses practising in acute, public health care settings (Van Wijk, 1997; Spies, 2004) whereas this study will focus on therapists practising rehabilitation in private health care settings. No South African study on burnout in therapists or burnout in rehabilitation workers could be found. Furthermore, none of the international burnout studies which focused on therapists included the therapy assistants (Wandling & Smith 1997).

The current study will thus contribute to the body of knowledge on burnout through providing prevalence figures on burnout in a population which was not assessed previously and also through making recommendations to address the problem in this specific setting. Therefore, this study could be a step towards the development of a stressor profile and management guidelines for burnout rehabilitation among therapists and therapy assistants in South Africa.

On a micro scale this research will be beneficial to the health care staff, the employer, the patients and the medical insurance schemes involved with Life Rehabilitation Units. The employer will have a better understanding of the extent of the problem and factors contributing to the problem and will therefore be able to start investigating and implementing strategies to manage it effectively. Managers of the units will be able to develop burnout prevention and management strategies. They will also be able to alert staff to the nature of burnout and equip them to deal with it. The outcome of these strategies should be healthier and happier staff, who will experience increased job

satisfaction and therefore be able to render a more productive and effective service. This should ensure better patient management and thus increased patient turnover, more admissions and thus benefit the employer financially. The patients will receive better treatment which may result in shorter rehabilitation periods (Turner-Stokes, 2008). This will indirectly have positive benefits for the medical insurance companies, for example shorter stay of patients as well as less claims by health care staff for medical examinations and medication, with resultant decreased costs to these companies.

On a larger scale the results of this research can initiate further research on the subject in other companies as well as government health care services. Recommendations from this study can be adapted according to need and employed by other health care providers as well.

Finally, it will be economically beneficial to the country since the consequences of burnout are costly (e.g. disability and other health costs and loss in productivety) (Goutas, 2008).

1.7 Summary

Burnout is a syndrome that is encountered frequently among health service workers as a result of chronic stress and emotionally challenging aspects of their work. The researcher wants to establish if the therapy staff employed by Life Rehabilitation Units suffer from burnout, because she has noticed some signs and symptoms of burnout in this environment. No South African study on burnout in therapists or burnout in rehabilitation workers could be found. The current study will thus contribute to the body of knowledge on burnout through providing prevalence figures on burnout, contributing factors of burnout in this environment, the effects and management of burnout as well as strategies to address burnout in this population.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

Burnout is a developing phenomenon (Bernier, 1998). One could call it a process rather than an unchanging state (Horiguchi, Kaga, Inagaki, Uno, Lasky & Hecox, 2003). According to Muscatello, Bruno, Carroccio, Cedro, Torre, Rosa & Zoccali (2006, p. 642) burnout represents an "emotional imbalance due to high professional demands and insufficient resources. Burnout is an emotional condition characterized by frustration and demoralisation, worsened by inadequate defence mechanisms and maladaptive behaviours." Burnout involves various dimensions of a person's life, from the personal through the social and the environmental to the physical. The burnout syndrome relates to pessimistic emotions and feelings which are caused by a person's perception of being trapped in hopeless circumstances (Innstrand, Espnes & Mykletun, 2002; Muscatello, et al, 2006).

In order to gain a better understanding of this complex phenomenon, this chapter will provide the reader with an overview of the development of the concept of burnout over the years, the definitions and components of burnout, the risk profile of burnout and the extent of the problem. It also focuses on the causes, effects and prevention of burnout and addresses management and intervention strategies for burnout. Finally Chapter Two covers the recovery process and health promotional aspects related to burnout.

2.2 Burnout

2.2.1 Evolution of the concept

The term burnout was originally coined around 1940 to describe the "cessation of operation of a jet or rocket engine" (Felton, 1998, p. 237). In 1974 Freudenberger related the concept of "burnout" to health-care professionals (Mandy et al, 2004). Freudenberger (1975, p.159) described burnout as: "To fall, wear out, or become exhausted by making excessive demands on energy, strength and resources." In 1976, Christine Maslach expanded on the original work of Freudenburg and developed a more comprehensive description of the syndrome (Anvari, Kalali & Gholipour, 2011). She defined "burnout" with the assistance of three basic dimensions (emotional exhaustion, depersonalisation and

reduced personal accomplishment) which will be further elaborated on in Paragraph 2.2.1 (Smrdel, 2003). Maslach was further of the opinion that the following personal factors can be associated with burnout: low self-esteem, avoidant coping style and low level of endurance (Smrdel, 2003). She also mentioned the occurrence of indifference and disrespect towards an organisation's clients or patients as a result of burnout (Anvari, Kalali & Gholipour, 2011). According to her burnout is a negative emotional reaction to the job and it develops gradually, as a result of long standing and relentless stress (Anvari et al, 2011).

In the 1990s various conceptual models were suggested, which could be divided into the following approaches: organisational, individual and interpersonal (Bernier, 1998). These earlier descriptions of burnout can be grouped under two general headings i.e. emotional deterioration (the deterioration as a result of performing ongoing emotionally challenging tasks over a extended period of time) and emotional conflict (the internal conflict as a result of goals which are not achieved) (Bernier, 1998). However, after years of research there is still no consensus on a definition of burnout (Bernier, 1998).

Maslach and Jackson's research on burnout is regarded as the most influential in the field (Ekstedt & Fagerberg, 2005). In 1986, they identified three elements of burnout which are still used in scientific literature today. These elements are emotional exhaustion, depersonalisation and reduced personal accomplishment in human service professionals (Ekstedt & Fagerberg, 2005).

Other authors argued that burnout could not be limited to individuals working in human service programmes only and that physical symptoms as well as chronic fatigue and cognitive dysfunction should be included in the description of burnout (Innstrand et al, 2002).

2.2.2 The three dimensions of burnout

Since the three dimensions that were identified by Maslach and Jackson are generally accepted by scientists as the most important elements/components of burnout they will be discussed in greater detail:

- **Emotional exhaustion**

  The first phase of burnout is emotional exhaustion (Maru n.d.). Characteristics of this phase include a lack of resources and energy as well as feelings of tension

and frustration (Maru n.d.). Increased feelings of emotional exhaustion lead to the depletion of emotional resources and employees feel drained on a psychological level (Muscatello et al, 2006). When an employee experiences the emotional exhaustion dimension of burnout, he or she may withdraw from patients and persons linked with the work. Workers who are suffering emotional exhaustion are inclined to concentrate their drive at work toward very specific aspects of the work (Halbesleben & Rathert, 2008). Emotional exhaustion is often accompanied by physical exhaustion and signs and symptoms include lacking the energy to work or to treat patients, waking up tired after a night of sleep, psychosomatic symptoms, sickness, increased conflict in marital and family life as well as increased use of drugs and alcohol (Lloyd & King, 2004; Maru n.d.). As a result of these factors deterioration in the quality of care that patients receive may occur (Lloyd & King, 2004).

- **Depersonalisation**

Depersonalisation is the second component of burnout. It normally occurs after emotional exhaustion and tends to be a result of the stressors of the work. It refers to the indifference a person experience with regard to his /her work (Maru n.d). This phase of burnout is characterised by cynical and negative feelings and attitudes about one's patients (Schaufeli, 2007). This unfeeling and dehumanised view of others can lead employees to view their patients as deserving of their problems (Maslach, Jackson & Leiter, 1997). The development of depersonalisation appears to be associated to the experience of emotional exhaustion and these dimensions of burnout should therefore be correlated (Maslach et al, 1997). Depersonalisation could lead to poor patient care, rudeness to and disinterest in patients (Jeanneau & Armelius, 2000). It is different from the other dimensions, in that it measures, reactions to individuals and not internal psychological states (Muscatello et al, 2006).

Depersonalisation among health care workers, in the form of rudeness and uncaring attitudes has been reported to be a problem in South Africa in both the public and private sector according to the South African Demographic and Health Survey (SADHS) (2003) as reported by Day and Gray in the SA Health Review (2008).

- **Reduced personal accomplishment**

Reduced personal accomplishment is the last phase of burnout (Maru n.d.). During this phase the person views himself/herself in a negative light, especially in

relation to his/her patients (Schaufeli, 2007). The people suffering from burnout may be disgruntled with their work achievements, competence and with themselves (Muscatello et al, 2006). They feel that they no longer add value or that their work efforts are useless and/or that they make no difference through their interpersonal relations. This perceived inadequacy has a negative influence on a person's self-efficacy (Maru n.d.).

The relationship between the three dimensions in the development of burnout is unclear. It is not known whether there is a linear progression from one dimension to the next or whether more complex interaction is at play (Innstrand et al, 2002).

2.2.3 The development of burnout

Two theories on the development of burnout have been presented in the literature. The development of burnout is related to stress and that it will depend on how the stress is being addressed whether a situation will lead to burnout or not. It is postulated that burnout develops in three stages. Firstly, an imbalance between resources and demands will occur. The next stage is characterised by instant, temporary emotional stress, fatigue and exhaustion. Lastly, attitudinal and behavioural changes will take place, for example treating patients in a cynical and detached manner (Innstrand et al, 2002).

On the other hand the development of burnout is explained through a model named the conservation of resources (COR) model. It is based on processes which take place on a psychological level and which are related to resources, in particular those aspects which are of importance to individuals. This can include satisfaction with life, family time and meaningful employment. According to this model stress is as a result of one of the following processes:

- Loss of material or psychological resources
- A threat to those resources, or
- Poor acknowledgement of efforts made to maximise material or psychological resources (e.g. a worker who undergoes additional training in the hope of receiving a salary increase but then does not receive the increase). Thus burnout can develop as a result of continual investment in work resources without sufficient return on that investment (Halbesleben & Rathert, 2008).

2.2.4 Disease classification of burnout

It is uncertain from the literature if burnout fulfils the diagnostic criteria for mental disorders (Ahola, 2007). Burnout is also not a formally accepted diagnostic category and as such is not included in the International Classification of Diseases (ICD-10) (Ekstedt, Söderström, Akerstedt, Nilsson, Sondergaard & Aleksander, 2006). The diagnostic category commonly used in the ICD-10 for burnout is Z73.0, in which burnout is broadly defined as "a state of vital exhaustion" (Ekstedt et al, 2006). Recently "exhaustion syndrome" has been established as an ICD-10 diagnosis in the Swedish version (KSH97,#F43.8A) (Ekstedt et al, 2006).

In a 2003 study, the diagnosis of burnout was made (Brenninkmeijer & Yperen, 2003) when a patient could be diagnosed with neurasthenia (ICD-10 classification) and when the medical picture resulted from a long-lasting development of overload. Neurasthenia according to the ICD-10 can be described as "persistent and distressing complaints of either increased fatigue after mental effort or bodily weakness and exhaustion after minimal effort". The patient must in addition suffer from no less than two of the following complaints: muscular pains, faintness, stress headaches, sleeping disturbances, failure to relax, stomach irritation or indigestion. Furthermore, there may be no correspondence in the clinical picture to a more exact ICD-10 disorder (for example, depressive or anxiety disorder). Where work-related complaints and decreased professional qualities were evident it provided additional support for the conclusion of burnout (Brenninkmeijer & Van Yperen, 2003)

The fact that there is no ICD-10 classification for burnout probably creates problems for individuals with regard to medical insurance companies to pay for medical expenses related to burnout, except if it is been treated under the pretext of depression or chronic fatigue syndrome. This is however the opinion of the researcher and the researcher has not found literature to substantiate this.

When work-related stress becomes severe and chronic and results in seriously impaired daily function a formal diagnosis of neurasthenia or adjustment disorder may be made.

Work-related neurasthenia[1] (PsychNet-UK, n.d.), can be considered the psychiatric equivalent of professional burnout (De Vente, Kamphuis & Emmelkamp, 2006).

2.2.5 Distinguishing between burnout and similar disorders

Burnout is not similar to clinical syndromes like anxiety, stress and depression. Stress might contribute to burnout, but burnout and stress are not similar (Espeland, 2006). Stress can be experienced as useful and positive or non useful and negative. Stress can create urgency and energy, while burnout only results in feelings of hopelessness and helplessness (Espeland, 2006).

The fatigue component which overlaps with disorders such as chronic fatigue syndrome, vital exhaustion and depression dominates in burnout (Ekstedt et al, 2006). In these diseases, as in burnout, there is a tendency to treat fatigue in a generic way although the concept has several dimensions, such as affective, muscular, cognitive and physical fatigue (Ekstedt et al, 2006). In addition, the aetiology of burnout and the abovementioned diseases is not the same (Ekstedt et al, 2006). Literature debates whether burnout is in fact more than just work-related fatigue (Leone, Huibers, Knottnerus, Kant, 2008a). More empirical studies will have to be done in order to establish the relationship between long-lasting fatigue and burnout (Leone et al, 2008a). The lack of studies on this subject has a negative effect on the successful treatment of long-lasting fatigue and burnout (Leone, Huibers, Knottnerus & Kant, 2008b), especially if the fatigue aspect and burnout have different prognostic factors. Alternative prevention and intervention options might therefore be required (Leone et al, 2008a). In the successful management of burnout and lingering fatigue, work-related aspects seem to be more significant in burnout, whilst health-related factors seems to be more important in long-standing fatigue (Leone et al, 2008a). There is evidence that severe burnout and fatigue symptoms become entangled with each other and with other psychological and/or somatic complaints, which can also explain a more chronic course (Leone et al, 2008b). Therefore, as burnout and fatigue progress to a more advanced stage, it can negatively affect other areas of wellbeing and start to overlap (Leone et al, 2008b).

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[1] "Neurasthenia is characterised by general lassitude, irritability, lack of concentration, worry, hypochondria, chronic fatigue, anxiety, painful sensations or numbness in parts of the body and fainting"

Adams, Boscarino & Figley (2006) have established that burnout and secondary trauma have common characteristics and that both contribute to psychological distress, although not in similar ways.

Thus while burnout shares risk factors and characteristics with many other mental conditions it should be seen as a separate condition with its own risk factors, aetiology, symptoms and management needs.

2.2.6 Possible aetiology of burnout

A physiological deregulation in burnout is suggested as a result of the severity of exhaustion and its resistance to change as well as its insusceptibility to rest (Sonnenschein, Mommersteeg, Houtveen, Sorbi, Schaufeli, & van Dooren, 2007). The physiological mechanism behind fatigue in burnout has not been identified, but the role of long-term stress suggests that the hypothalamo-pituitary-adrenal (HPA) axis is involved (Ekstedt et al, 2006). As pointed out by Mommersteeg, Heijnen, Verbraak & van Dooren (2006, p. 793) "the HPA-axis is interconnected with other regulatory systems, which are involved in regulating energy balance, mood states, sleep and cognition." A disturbed HPA-axis could therefore have an impact on these systems, causing the array of symptoms as observed in individuals suffering from burnout (Mommersteeg et al, 2006).

The connection between burnout and the HPA-axis functioning and burnout have been studied by researchers but the results were inconclusive. The findings of the longitudinal study of Mommersteeg, et al (2006) on complaint reduction and cortisol in burnout, were that recuperation from burnout complaints and basal cortisol production were not connected and that the scientific implications of the finding were limited (Mommersteeg et al, 2006). Cortisol as described by the Wikipedia is *"*a corticosteroid hormone or glucocorticoid produced by the adrenal cortex, which is part of the adrenal gland and is usually referred to as the 'stress hormone' as it is involved in response to stress and anxiety".

Therefore currently the connection between the development and treatment of burnout and the physiologic systems of the body is still unclear. However, the existence of the syndrome and its negative impact on health care delivery cannot be ignored (Munn-Giddings, Hart & Ramon, 2005).

2.2.7 Severity and extent of the problem

Stress, work pressure, lack of control, monotony and high levels of psychological distress result in a loss of an estimated 6.5 million working days per year in the United Kingdom in the workplace. In 2002, it was estimated that 41 million people in Europe were affected by employment related illnesses (Munn-Giddings et al, 2005).

Studies on burnout from around the globe spanning the last 20 years found emotional exhaustion among 8% to 60% of participants, depersonalization among 10% to 29% of participants and decreased personalization amongst 5% to 60% of participants (Donohoe, Nawawl, Wllker, Schindler & Jette, 1993; Schlenz et al, 1995; Scutter & Goold, 1995; Ogiwara, Hayashi, 2002; Pavlakis, Raftopoulos & Theodorou, 2010; Kowalski, Driller, Ernstmann, Alich, Karbach, Ommen, Schulz-Nieswandt & Pfaff, 2010). While certain methodological differences might account for some of the differences it is clear from this that the prevalence of burnout varies widely. The findings and methodologies used in these studies will be discussed in detail under the discussion section of this document and under 2.3.6.

2.2.8 Risk profile and causes of burnout

There is no single factor or biological agent that causes burnout (Mandy et al, 2004). It is rather caused by a combination of risk factors that interact with each other (Mandy et al, 2004). However, it would appear that burnout is strongly influenced by the degree to which an individual feels competent, efficacious and confident as a professional (Mandy et al, 2004).

Montero-Martin, Garcia-Campayo, Fajó-Pascual, Carrasco, Gascón, Gili & Mayoral-Cleries (2011) described three types of employees who are particularly susceptible to burnout:

- The “frenetic” type (ambitious employees who forfeit not only their personal lives but also their health for their work)
- The “underchallenged” type (bored and indifferent employees who unable to develop on a personal level in their jobs)
- The “worn-out” type (neglectful employees who perceive that they are not acknowledged and that they have minimal control over outcomes).

Researchers postulated that burnout can arise from progressive increases in realism, loss of vigour and sense of accomplishment in workers who are mainly employed in service-intensive professions and are not just associated with employment which requires a heightened level of empathy (Felton, 1998; Ekstedt et al, 2006). It is frequently educated, ambitious, young and idealistic professionals who are negatively affected by burnout and therefore several authors believe the imbalance between a person's expectations and realism to be one of the most important causes of burnout (Espeland, 2006)

Tables 2.1 and 2.2 present the most common stressors/risk factors for burnout according to the literature (Schlenz et al, 1995; Yadama & Drake, 1995; Scutter & Goold, 1995; Koeske & Kirk, 1995; Lewall, 1996; Van Wijk, 1997; Wandling & Smith, 1997; Truchot D, Keirsebilck & Meyer, 2000; Jeanneau & Armelius, 2000; Ogiwara & Hayashi, 2002; Horiguchi et al, 2003; Mandy et al, 2004; Hätinen et al, 2004; Crabbe, Bowley, Boffard, Alexander & Klein, 2004; Brachtesende, 2004; Munn-Giddings et al, 2005; Espeland, 2006; Ekstedt et al, 2006; Rothmann et al, 2006; Blust, 2006; Dunwoodie & Auret, 2007; Bell & Breslin, 2008; Girgis, Hansen & Goldstein, 2009). The risk factors are divided into two main categories i.e. those related to the person and those related to employment circumstances.

Table 2.1 Personality, social and situational burnout risk factors

Personality traits
• Dedicated and committed to patients • Empathetic, humane and sensitive • Idealistic • People orientated • Eager to demonstrate professional capability and achievement • Low self-efficacy, confidence and lack of self-competence • Work ambiguity • Altruistic • Over-involvement • Passive, defensive approach to stress and coping • Lack of control over circumstances • Resistance to change • The belief that the environment has more control over life circumstances than the individual does (external locus of control) • A-type personality e.g. competitive and controlling • Young and inexperienced • High expectations in terms of work
Social
• Lower levels of religiousness • Little social support and networks • Higher levels of education • No life-partner
Situational
• Previous stressful life events

Table 2.2 Common employment-related stressors/risks factors of burnout

Management and administration
• Having managerial responsibilities and bureaucratic injustices • Poor or rigid management or administration • Lack of support from supervisors and too few mentors • Management restructuring and insecurity about downsizing • Bureaucratic injustices • Staff shortages and/or poor access to/and staff cover for leave
Work circumstances
• Low level of job/work satisfaction and boredom • High/increased responsibility • Lack of training • Conflict with other staff and role confusion • Poor communication with colleagues • High job demands/perceived demands • Lack of recognition and authority • Low decision latitude and prestige [j] • Compromises in quality • Ethical/moral distress
Time constraints
• Long work hours • Decreased treatment time • Early discharge • Overwork
Working conditions and resources
• Poor work setting/workplace and work conditions • Lack of resources • Inadequate salaries

2.2.9 Symptoms and effects of burnout

The symptoms of burnout are diverse and so are the people who suffer from burnout (Espeland, 2006). It is recognizable through fatigue which is not alleviated by sleep, constant tiredness, sceptical indifference and lack of effectiveness (Espeland, 2006), (Brachtesende, 2004). If not recognized and managed burnout can increase and negatively affect all aspects of a person's functioning. This includes emotional, physical, work-related, identity and relationship problems.

Negative emotions typically start gradually and steadily become chronic (Espeland, 2006). This eventually results in emotional fatigue (Espeland, 2006). Bitterness, negativity about oneself, others and the world, frustration, depression, cynicism and anger are familiar negative emotions (Muscatello et al, 2006).

A decrease in job enthusiasm, productivity and quality is part of the burnout process (Espeland, 2006). Decreased performance includes symptoms of absenteeism, lack of punctuality, feelings of powerlessness to change circumstances, uselessness and perceiving work as a yoke and lack of achievement (Espeland, 2006).

As a means of coping with strain related to work, compulsive activities such as worrying, under-eating or overeating, gambling, excessive shopping, increasing hours at work, chain smoking, using street or prescription drugs and alcohol abuse might occur (Espeland, 2006).

Emotional exhaustion has a negative effect on communication and as a result relationships with friends, colleagues and family may suffer (Espeland, 2006). Symptoms include outbursts, antagonism, mistrust, depersonalization, indifference, withdrawing, losing compassion and inability to work in a team (Espeland, 2006).

Physical symptoms also transpire with burnout as a result of strain and guilt caused by decreased productivity. These are sleeplessness, exhaustion which is not relieved by sleep, colds, lightheadedness or dizziness, headaches, migraines, backaches and other muscle problems (Espeland, 2006).

Furthermore the emotional strain experienced in human service occupations may cause psychological stress which can be reflected in hormonal alterations, such as an increase in the level of prolactin (Ohlson, Söderfeldt, Söderfeldt, Jones and Theorell, 2001). According to Medic8 (2009), prolactin: "…is a peptide hormone primarily associated with lactation". Prolactin plays a role in orgasms, lactation, and stimulating production of oligodendrocyte precursor cells. High prolactin levels have a negative effect on fertility in that it suppresses the ovulatory cycle and it can also contribute to mental health problems (Medic8, 2009).

A mind-set of not having a purpose in life is an additional symptom (Espeland, 2006). Once-enthusiastic individuals start to find work pointless and experience symptoms such as loss of identity, feelings of worthlessness, lack of happiness, loss of self-esteem, decreased sense of worth and despair (Espeland, 2006).

The researcher divided the effects of burnout as discussed in the literature into individual and organisational effects and summarised it (Yadama & Drake, 1995; Scutter & Goold, 1995; Koeske & Kirk, 1995; Wandling & Smith, 1997; Van Wijk, 1997; Felton, 1998; Gilbar, 1998; Bernier, 1998; Blau, Bolus, Carolan, Kramer, Mahoney, Jette & Beal, 2002; Ogiwara & Hayashi, 2002; Crabbe et al, 2004; Brachtesende, 2004; Cohen & Gagin, 2005; Mommersteeg et al, 2006; Espeland, 2006; Dunwoodie & Auret, 2007, Girgis et al, 2009). These are presented in Table 2.3 and Table 2.4.

Table 2.3 The effects of burnout on the organisation

- Reduced quality of care and job performance
- Impaired decision-making and increased errors and adverse events
- Lower productivity and effectiveness
- Staff dissatisfaction
- Increased job turnover
- Staff conflicts
- Requests for transfers
- Postpone contact with patients
- Low morale
- Lack of accomplishment
- Boredom at work
- Clients/patients are negatively affected
- Unfavourable job attitudes
- Thoughts of quitting the job/actual quitting
- Lack of commitment

Table 2.4 The effects of burnout on the individual and his/her relationships

- Depression
- Cynicism and lack of training
- Losing compassion/empathy
- Impatience
- Denial and paranoia
- Loss of humour
- Persistent sense of failure
- Somatic complaints
- Irritability towards co-workers and patients
- See work as a yoke and finding it pointless
- Enthusiasm for the job decreases
- Feelings of powerlessness to change situation
- Ineffectiveness

Table 2.4 (continue)

- Work aversion
- Anger and resentment
- Bitterness
- Apathy and detachment
- Emotional withdrawal
- Frustration
- Feeling stuck/paralysed
- Worrying
- Hostility
- Withdrawing
- Lack of purpose in life
- Feelings of emptiness
- Loss of identity

Although most people experience various symptoms of burnout from time to time, an individual who is experiencing burnout exhibits them with increasing frequency and severity (Ogiwara & Hayashi, 2002). Victims of burnout tend to accentuate the negative rather than the positive aspects of their work (Ogiwara & Hayashi, 2002). It is important that persons are aware of the causes and symptoms of burnout, so that they can take preventative measures in time (Ogiwara & Hayashi, 2002; Espeland, 2006).

2.2.10 Burnout and patient outcomes

Patient outcomes can be influenced by the work environment and the effect it has on health care workers (Halbesleben & Rathert, 2008). One study linked intensive care unit (ICU) nurse burnout with ICU performance. The study found significant relationships between burnout levels and efficiency and perceived effectiveness (Halbesleben & Rathert, 2008).

Burnout is associated with longer patient recovery times. Burnt-out employees may neglect to give extra advice and follow-up treatment that may not be part of the typical treatment but would accelerate recovery. It is suggested that victims of burnout may not fully explain treatment procedures or listen to patients regarding their preferences, thus creating a treatment plan that is ineffective. In addition, the outward manifestation of

burnout by physicians might lead patients to refrain from asking for clarification regarding treatment that might reduce recovery time. Overall, this suggests that physician burnout may lead to lower involvement with patients in their care. Patient involvement has long been shown to improve patient care outcomes (Halbesleben & Rathert, 2008).

Burnout has a negative effect on the emotional states of certain employees. Employees who are burnt out do not feel positive about work. Positive effect plays a constructive role in problem solving, decision-making and higher levels of patient-centredness in health providers. Employees suffering from burn out are probably less cognitively attentive and less likely to go the extra mile to deliver quality care. Thus health care providers who experience burnout might be involved in more preventable adverse medical events (Halbesleben & Rathert, 2008).

2.2.11 Prevention of burnout, intervention and management strategies

It is not easy to differentiate between actions that prevent burnout and efforts taken to address it. If preventative actions are in position, burnout will not take place and if burnout is already evident, similar measures may be used to treat it (Gilbar, 1998). Burnout does not occur overnight. It builds up over time, thus there is an opportunity to identify it early and prevent a full-blown case of burnout (Maslach & Leiter, 2008).

The intervention strategies as discussed below are thus also important ways of preventing burnout.

2.2.11.1 Managerial leadership and support

Burnout will continue to be rife as a work-related illness in health care as long as human resources managers and policy makers overlook human values and effort at work (Flaherty, 2006). “Skillful managers can do much to rise to the leadership challenge that stress presents, but if it is viewed as an individual matter, largely unconnected with organisational issues, then the pressure cooker will continue to operate – harming many people, driving some away and discouraging people from joining in the first place” (Thompson, 2004, p. 35 in Munn-Giddings et al, 2005).

Managers can play an active role in the prevention and management of burnout, but must first recognise the magnitude of the problem. Hospital managers and administrators must value their staff and must take responsibility for poor performance and service delivery as a result of lack of resources and staff shortages. Anti-burnout programmes and

measures may be expensive, but ignoring the dilemma of burnout will result in much higher costs for the employer (Lewiston, Conley & Blessing-Moore, 1981).

A number of specific actions by management can reduce the incidence of burnout and serve as managing strategies.

Early identification of stress factors and impending burnout

Managers must stay attentive in order to be able to recognize the warning signs of burnout (Wood & Killion, 2007). Problems and risks should be identified as soon as possible to ensure a good outcome (Felton, 1998). Managers of health care workers must be knowledgeable regarding the signs and symptoms of burnout and must be alert to the existence of stress through constant communication with employees and patients (Felton, 1998). With the appropriate strategies and actions, managers can decrease burnout among healthcare professionals whilst also promoting productivity and performance (Wood & Killion, 2007).

The manager must be aware of changes in the employee's behaviour as it could be a sign that the employee is experiencing pressure. Although an employee may not verbalise that burnout is a problem, the manager will be able to detect signs of it in the quality of care provided and the therapeutic outcomes achieved. It is important to identify these behaviours (for example, hardening towards patients), not just for the sake of the employee but also for the good of the company (Felton, 1998; Wood & Killian, 2007). These behaviours could be identified by reviewing employees' records regularly to determine patterns in absenteeism, tardiness, excessive use of sick leave, de-motivation to work, wandering from the work station or avoidance of patient contact (Felton, 1998). Other behaviours could include employees who expressed unwillingness to work with a colleague suffering from burnout and non-co-operation. Managers should thoroughly investigate errors by employees when it is raised by patients and not just dismiss it. These grievances should be given a hearing, because it can reveal why the employee is no longer able to provide an effective service, which could include emotional loss and/or behavioural flattening (Felton, 1998; Wood & Killian, 2007).

In addition to the above the regular (at least once every two years) implementation of recognized (validated and standardised) burnout measuring instruments such as the Maslach Burnout Inventory (MBI) to screen for burnout amongst staff is advised. Employees who require special attention in this regard are those who seldom

take enough leave, who require skills training and who are in constant contact with patients as a result of the nature of their jobs (Girgis et al, 2009). Employees must also have opportunities to meet with a development specialist to review job satisfaction and stress experienced at work (Sweency, Nichols & Cormack, 1993).

Orientation of new employees

A formal induction programme for all new staff is essential since a lack of orientation can create role uncertainty and ambiguity about one's responsibility (Lu, 2008). New employees should be properly orientated to their duties with regard to what is expected of them and what they can expect from the job. Although one gains knowledge while working, some official direction is required in explaining to a new employee the vision, goals and operating practices of the institution. This orientation should include information on challenges that the new employee can expect, as well as guidelines (for example, appropriateness of referrals and caseload size). Being prepared for what is expected can dispel several apprehensions experienced on assuming a new position (Gilbar, 1998; Felton, 1998; Sweency et al, 1993).

Training, continued education and professional growth

The literature has explored the impact of training in preparing the professional to cope with job stress and burnout and attention has focused on two different aspects of training, i.e. building prevention into professional training by preparing the individual for the potential demands of the job, and on-the-job training to help employees respond creatively to stressful events or situations (Van Wijk, 1997; Gilbar, 1998; Sweency et al, 1993).

The content of on-the-job training programmes in stress management and burnout should include practical coping strategies as well as an overview of what burnout is and how it affects the individual. It should enable participants to examine their immediate feelings in the context of what others are feeling, as well as what they have experienced in the past and can expect to experience in their future careers. On-the-job training can help employees respond creatively to stressful situations, but a training programme or burnout workshop can only have a short-term effect if it does not result in the formation of continuing peer discussion or support groups (Sweency et al, 1993).

An Israeli study, performed with 25 social workers, indicated that skills development programmes may play a positive role in the increase of personal accomplishment and

reduction of depersonalisation, whereas improvement of poor peer support may be an efficient strategy for decreased emotional exhaustion. Although it is not as effective when peer support is already adequate (Cohen & Gagin, 2005). It is important to ensure that the skills development programmes are aligned with the development needs of participants.

Professional development activities in the workplace may augment feelings of personal accomplishment, increase morale and minimize burnout (Farooq, 2003). It is the responsibility of supervisors and management to initiate professional development through journal clubs, lectures and case presentations (Van Wijk, 1997; Gilbar, 1998; Sweency et al, 1993). To ignore professional growth is to stagnate. Growth opportunities can include: volunteering for new responsibilities, playing a constructive role in problem solving, developing expertise, and parting with knowledge and information or to commence with further studies (Munn-Giddings et al, 2005; Espeland, 2006).

Contact with supervisors

The relationship between manager and employee can have a strong influence on job stress and coping. Supervision in human service programmes is distinctive because it serves two different functions. First, supervisors are responsible to evaluate and monitor the work of employees to ensure conformity and accountability to organisational rules and to communicate important administrative decisions and directives. Secondly, supervisors serve a professional developmental function and there may be strong expectations that supervisors will assist employees to understand and manage their emotional response to the job. Traditionally, staff in health service settings look to their supervisors for support, advice, learning and personal growth, thus in short, mentorship (Sweency et al, 1993).

Therefore supervisors should be accessible in person to staff at least once a week for a prearranged supervision session and should be accessible by phone at other times. Furthermore supervisors should provide constant informal feedback to the therapist on his/her performance and should conduct performance reviews either annually or biannually (Sweency et al, 1993).

Staff meetings

Staff meetings are crucial in that they provide a channel for communication in units. It is important that these meetings provide opportunities for expression of suggestions, complaints, ideas and questions instead of just being an opportunity for the manager to

announce decisions. Participants should be allowed to communicate freely in the presence of the manager without any fear of negative consequences (i.e. vengeance, penalty or delayed promotions). Constructive ideas to address problems should be followed up and implemented by the manager, so that the participants are aware that their inputs are valued (Gilbar, 1998; Felton, 1998). The manager should facilitate the meeting and must be able to tolerate critique of his/her management style (Felton, 1998).

Support systems

Support systems such as support groups, counselling and/or stress management strategies within the hospital system were all found to be valuable tools in coping with impending burnout of staff members both internationally and in South Africa (Felton, 1998; Ogiwara & Hayashi, 2002; Cohen & Gagin, 2005; Rothmann et al, 2006).

Weekly or bi-monthly staff support meetings, to encourage the ventilation of feelings and find solutions to problems have an important role to play and are essential to avert burnout. Therapists can provide support and understanding to each other by actively communicating the feelings generated by intense contact with disabled individuals. Support groups provide a formal forum for the discussion of hostile or taboo feelings and to help therapists explore ways of coping (Sweency et al, 1993; Espeland, 2006). However, even though employee support groups may be helpful in alleviating feelings of burnout, it is important that it should be structured in a way that lessens destructive communication and encourages staff to discuss their concerns in a positive manner (Espeland, 2006). There are five ways through which social support can influence work stressors. These are: catharsis, the provision of technical information and practical advice, the provision of a frame of reference and feedback, the presentation of a united front in situations of conflict and the provision of a stimulating environment (Sweency et al, 1993).

In order to improve the work environment, trust should be establishment between members of healthcare teams. People are more resilient, achieve more and feel more meaningful when their relationships are close and supportive (Espeland, 2006).

Critical Incident Stress Debriefing (CISD) and counseling

Critical Incident stress debriefing (CISD) is an important preventative tool which allows individuals to express their emotions after a traumatic event, like the death of a patient. It

provides an opportunity to address feelings of possible inadequacy, guilt or inefficiency and to assist the individual with resuming duties without lasting reactions or feelings (Felton, 1998, Gilbar, 1998; Wood & Killion, 2007).

Employee assistance programmes (EAP)

According to Munn-Giddings et al (2005: 410), Employee Assistant Programmes (EAP's) "are workplace-based counselling for employees who experience mental distress". Several employers in the UK who offered these programmes were of the opinion that they have a positive effect on both the individual and the organisation in that they resulted in the decrease of stress, and enhanced productivity and performance (Munn-Giddings et al, 2005). Research findings, however, are non-conclusive in this regard and further research is necessary, especially in relation to claims of improved production and reduction of expenses (Munn-Giddings et al, 2005).

Reward and recognition

In a profession like occupational therapy where the individual works with chronic illness and long term impairments, the opportunities for reward and recognition from the patient may be limited. Patients often do not improve and frequently are unable to acknowledge the assistance of the therapist. Extrinsic recognition and rewards for good quality performance must come from other sources in the form of pay, promotion and colleague feedback (Sweency et al, 1993; Ram & Prabhakar, 2011).

Size and type of caseload

A manageable caseload size has been associated with a reduction in burnout (Burns, Yiend, Doll, Fahy, Fiander & Tyrer, 2007). The therapy manager should ensure that each member of staff is assigned only a reasonable number of patients and the most difficult and unrewarding work should be shared equally among staff. Each therapist should be given the opportunity to do some work he/she finds rewarding and managers should help staff members to arrange their schedule so that rewarding and unrewarding tasks can be alternated (Sweency et al, 1993).

Burnout can be prevented when staff have the opportunity to recover from an increased workload and are provided an opportunity to rest, recuperate and reinstate balance. The critical point occurs when staff are not able to recover from high work demands and when this surplus load becomes a chronic job condition. A sustainable caseload

provides opportunities to make use of and improve existing skills and in addition to become efficient in new areas of work (Maslach & Leiter, 2008)

Non-patient-related tasks

Ideally, each therapy staff member should have the opportunity to participate in non-patient-related tasks on a regular basis. These tasks should be allocated according to areas of interest (Sweency et al, 1993).

Resources and demands

Demands that are made on the therapist which are perceived by the therapist to be in excess of her/his resources result in job stress. These excessive demands may in part, result from the shortfall of management to fill vacancies. Staff shortages invariably increase pressure for in-post staff and patient-related responsibilities as well as reduce the opportunity to become involved in other tasks. Administrative responsibilities, continuing education, research and evaluation may be neglected while the therapist is struggling to maintain a clinical service. The therapy manager must take responsibility to help the clinician set realistic treatment goals and set clear guidelines on referrals and optimum caseload size and should teach staff members the skills of time management and prioritising (Sweency et al, 1993).

Autonomy

The therapist's impression of his/her professional worth is related to his/her function and to the sum of consultation and communication within the organisation. Role disagreement and role uncertainty have been found to permeate the jobs of health care professionals. Therapists tend to work closely with other professionals where job boundaries are diffuse and responsibilities overlap. The therapy manager can reduce the potential for ambiguity and conflict by providing explicit frames of reference and by providing immediate and clear feedback to the clinician on his/her performance in the job (Sweency et al, 1993).

Stress can arise when aspects of the job, such as policy and decision-making, are seen to be outside the individual worker's authority and this can give rise to feelings of helplessness and lack of control. When opportunities are lacking in the environment, the worker may feel trapped and may become susceptible to burnout. By not providing clinical therapists with the opportunity to become involved in significant policy planning issues

managers undermine the value of input from clinician level and send therapists a powerful message that their opinion does not count (Sweency et al, 1993).

Granting autonomy to an employee in his/her daily tasks is of the utmost importance in the prevention of burnout (Ramarajan & Barsade, 2006). The increased autonomy contributes to an increase in the purpose of a job and it is no longer seen as only a ritualistic carrying out of functions (Gilbar, 1998; Felton, 1998).

Recruitment, selection and performance programmes

Programmes that improve selection, recruitment, and performance management should be implemented. A study by Koeske and Kirk (1995) suggested that job applicants who show evidence of decreased psychological wellbeing or who have recently had to deal with negative circumstances in their lives are expected to be more discontented with their jobs and if employed, may need appropriate support and supervision. In order to identify these job applicants more than the usual applicant information may have to be collected. Other attributes which will enable the worker to better cope with the demands and stressors are work experience and social support.

2.2.11.2 Management strategies related to the individual

Research on burnout emphasizes that the individual also has a responsibility towards solving the problem (Lewall, 1996; Munn-Giddings et al, 2005). Sweency, et al (1993) suggested the following individual stress managing techniques:

- Create periods of time out during the working day through taking coffee and lunch breaks. Ideally therapists should leave the work environment and patient treatment areas during these breaks
- Programme non-treatment tasks (for example, report writing and service planning) into each day so that short periods throughout the working day are to be free of direct patient contact
- Incorporate a cut-off point at the end of the day (for example, an exercise class or a social activity) to indicate that the work role can be exchanged for the social or domestic role
- Spread “rewarding” (for example, rapidly improving, acute condition patients or

service planning) and “less rewarding” (for example, slow moving, chronically ill patients or keeping statistics) tasks throughout the day and the working week, in an attempt to maximise the versatility and the reward potential of the job

- Acquire and use skills for positive coping in the workplace (for example, time management, prioritising and limit setting)

- Regularly evaluate and redress personal stress balances through an awareness of the signs and symptoms of stress, discussion with colleagues and the use of appropriate coping strategies.

Other suggestions to reduce burnout focus on stress-reduction and include getting a hobby, relax, take time off from work or change jobs. Thus to prevent burnout one has to find out what motivates one and engage in the activities that rejuvenate one intellectually, physically and emotionally (Brachtesende, 2004). Emotional well-being can be achieved by developing a peaceful mentality and focusing on serene thoughts. Examples of this will be listening to quiet music and meditation (Espeland, 2006).

Humour has a positive influence on health and the prevention of burnout. Laughter contributes to the release of endorphins in the body, which have in turn also a positive influence on blood pressure, stress levels, immunity, mood and pain. Humour can be used as a tool in stressful situations and can assist to create a fresh viewpoint on the state of affairs and to avoid burnout (Espeland, 2006).

Good physical health is vital in the prevention of burnout. This can be achieved through healthy eating, participation in sport and taking part in activities, like massages and resting, which have a calming effect (Espeland, 2006). Another key to battle burnout is proper self-care (Wandling & Smith, 1997; Skovholt, Grier & Hanson, 2001). Because burnout erodes self-esteem, it is also important to rebuild one’s confidence (Wandling & Smith, 1997; Zellars, Perrewé & Hochwarter, 2000).

The inability to cope effectively with stress has a negative influence on a person’s energy levels and can lead to performance failures, problems in interpersonal relationships and health problems. Sweency et al (1993), quoted Lazarus and Folkman’s definition of coping as “Constantly changing cognitive and behavioural responses to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person.”

According to the literature, training in stress management skills assists in the reduction of the exhaustion part of burnout, but does not have an effect on the depersonalisation or the personal accomplishment parts (Crabbe et al, 2004).

Not setting boundaries and being assertive at work can lead to burnout. Espeland (2006, p. 181) described assertiveness as a "positive and constructive way of relating to others that respects their needs, wants and rights, as well as one's own needs, wants and rights". An assertive person does not exercise manipulation or threats nor allow himself/herself to be manipulated, threatened or abused. Not to have restrictions prevents individuals from protecting their personal time. This impacts negatively on the quality of their work, their happiness, their family and health (Espeland, 2006).

Unfortunately for some therapists, these solutions may not be enough. The solution might not be in how we change our work surroundings or lifestyle habits, but in how we perceive what is going on around us (Munn-Giddings et al, 2005).

2.2.11.3 The impact of working hours

Working fulltime versus part-time

Mandy et al (2004) found lower levels of burnout than other authors. A possible explanation for these findings might have been the fact that 53% of the sample (physiotherapists) did not work fulltime. There is also evidence that medical general practitioners working part-time experienced lower levels of burnout than those working fulltime (Kirwan and Amstrong, 1995). Kirwan and Amstrong (1995) are of the opinion that it could be surmised that adequate time away from the stressors at work may grant major psychological advantages and thus provide a protective shield against burnout. Lawrence (2007) found in her study on burnout in radiotherapists that part-time staff showed lower levels of EE and higher levels of PA than their fulltime counterparts.

Flexible working hours

Flexible working hours can counteract burnout, especially in our current society where many women have careers and time for family members and work that needs to be juggled (Felton, 1998; Gilbar, 1998). Staff members who do not work with patients can also consider working from home on certain days (Felton, 1998). Introduction of flexible work hours resulted in a smaller number of employees (a decrease from 39% to 28%) reporting burnout in a U.S. study (Flexpaths, 2004).

Leave/vacation

Ozyurt and colleagues established a relation between an increase in number of vacations and lower burnout rates (Girgis et al, 2009). Research by Isikhan and colleagues supports the above with their finding that time restrictions in personal and family life contribute to higher stress levels in the work environment (Girgis et al, 2009). Vacations create an opportunity to build resources and these in turn have a positive effect on burnout. Studies which explored the effects of vacation on burnout established that burnout levels were lower just before until shortly after a vacation (Fritz & Sonnentag, 2006). Vacations, however, only provide temporary relief and the positive effects disappear once the person returns to work (Wandling & Smith, 1997; Gilbar, 1998; Fritz & Sonnentag, 2005; Munn-Giddings et al, 2005).

2.2.11.4 Changing employers

In order to prevent burnout it is sometimes necessary to either resign or secure an alternative position within the company. For some it might even be necessary to find an entirely different work set-up or field (Munn-Giddings et al, 2005; Espeland, 2006).

Implementing the above-mentioned burnout management and intervention strategies can play a major role in the prevention of burnout. Both the employer and employee should take responsibility for this.

2.2.12 Recovery from burnout

Burnout is resistant to natural recovery and burnout sufferers have a poor prognosis for recovery (Sonnenschein, Sorbi, Verbraak, Schaufeli, Maas & van Doornen, 2008). Researchers are not yet sure what causes this persistence (Sonnenschein et al, 2008). Certain studies have shown that burnout levels remained the same over periods of up to eight years (Sonnenschein et al, 2008). Studies on the stability of the burnout syndrome and the responsiveness of burnout to treatment are scarce (Sonnenschein et al, 2008).

Studies where treatment and intervention strategies have been compared are also scarce. One such study which covered mild to severe burnout complaints focused on self-employed people on sick leave. The two intervention strategies included cognitive behavioural therapy and activating intervention. The cognitive behavioural therapy was conducted by psychologists using standardised protocol and activating intervention was based on cognitive behavioural therapy and conducted by labour experts and

focused on graded activity and workplace intervention (Sonnenschein et al, 2008). Intervention did not promote symptom improvement and the results were similar to those of no treatment. In the first four months the exhaustion levels decreased considerably and continued to decrease during the next six months. After ten months the exhaustion levels stopped decreasing and remained above the MBI's clinical cut-off point for burnout (Sonnenschein et al, 2008).

In a similar study, cognitive behavioural therapy was provided to people with clinical burnout. They were no longer suffering from exhaustion after 8.5 months of treatment as measured by the MBI. However, their exhaustion levels were high in comparison with healthy groups. Exhaustion levels did stabilise after six months and further cognitive behavioural therapy (Sonnenschein et al, 2008).

Sleep problems are associated with the burnout process and clinically burnt-out persons recover poorly through sleep. Sleep problems may obstruct the recovery from severe exhaustion in clinical burnout in the long-term (Sonnenschein et al, 2008).

Although psychological treatment has some value in treating burnout, it is not fully effective and the recovery rate of individuals varies (Mommersteeg et al, 2006). Cognitive and physical therapy were responsible, according to a study, for a decrease in burnout related symptoms over a six-month period in 30-35% of a working population (Mommersteeg et al, 2006). Sick leave also plays a role in the treatment of burnout and researchers reported that from a group of fatigued employees, 43% had acceptable levels of fatigue after a period of twelve months and 62% managed to returned to work (Mommersteeg et al, 2006).

In conclusion the question on prognosis remains unanswered due to limited studies on the stability of burnout and on the responsiveness of burnout to treatment (Sonnenschein et al, 2008). Therefore the best way of managing burnout is to prevent it. In order to do that it is important to promote a positive attitude towards developing excellent mental health among employees (Flaherty, 2006). In order for wellbeing support initiatives to be successful, it needs to become embedded in the culture of an organisation (Flaherty, 2006).

2.3 Literature underscoring the study methodology

Various studies on the incidence of and contributing factors to burnout were found in the literature both nationally and internationally. The methodologies of these studies are

presented in Table 2.4. The current study included all types of therapists (including the assistant) and their managers whereas the international studies focused mainly on physiotherapists and occupational therapists. Two of the international studies (Girgis, et al, 2009; Kowalski et al, 2010) included other health care professionals (e.g. nurses, nursing assistants, social workers, disability support workers and health professionals who specialise in the field of oncology). It is uncertain if the disability support workers are similar to the therapy assistant referred to in this study or included the therapy assistant. Only Donohoe et al (1993) and Schlenz et al (1995) focused on inpatient rehabilitation as did the current study. It is uncertain if these units were public or private units.

The participant numbers of these studies varied between 40 and 740 and the number of participants in the current study is thus small in comparison. The researcher did not do sampling for this reason.

Of the thirteen studies, six used a mixed methods design and seven used a quantitative study design. The researcher chose a mixed method design in order to enrich the study findings. Ten studies made use of the MBI or an adapted version of it. That combined with the MBI's proven reliability and validity made it the instrument of choice with which to determine the prevalence of burnout in the current study in spite of it being expensive. By including interview schedules and a qualitative component the researcher was able to not only establish the prevalence of burnout but also to establish the factors which contribute to burnout and possible solutions to the problem in the study setting.

Table 2.5 South African and international burnout studies underscoring the study methodology

Study	Setting	Design	Population	Sampling	Participants	Instruments
South African studies						
Military nurses (Van Wijk, 1997)	1 Military base hospital, sick bays in isolated areas & larger centres	Mixed qualitative and quantitative	94 fulltime nurses	Volunteer	46 Military nurses	Questionnaires & semi-structured interviews
Trauma nurses (Spies, 2004)	Eight trauma units in Pretoria	Quantitative	Nurses employed at level 1 & 2 trauma units (103 questionnaires distributed)	Convenient	53 Trauma unit nurses	MBI, Nursing stress survey & biographical questionnaire
Hospice workers (Sardiwalla, Van den Berg & Esterhuyse, 2007)	Hospices in Bloemfontein & Ladysmith	Quantitative	All available hospice workers in setting (no number given)	Not described	78 Hospice workers	MBI, Biographical questionnaire, Cope Scale, Experience of Work and Life Circumstances questionnaire
International studies						

Pacific Northwest of the USA (Schlenz et al, 1995)	Ten rehabilitation units in Pacific Northwest	Mixed qualitative and quantitative	All Occupational Therapists & physiotherapists that treat patients with head injuries	None	21 Occupational Therapists & 19 physiotherapists 40 in total	MBI & biographical info Survey which included three open-ended questions
Massachusetts (Donohoe et al, 1993)	Seven inpatient rehabilitation hospitals	Mixed qualitative and quantitative	All physiotherapists treating inpatients in the setting	None	129 Physiotherapists	MBI, demographic data questionnaire, Interview schedule
Cypriot (Pavlakis et al, 2010)	Public & private sector	Mixed qualitative and quantitative	383 Physiotherapists doing rehabilitation of head injured patients	Stratified random	172 Physiotherapists	MBI, demographic data questionnaire that included several aspects related to burnout & occupational stress and self image
Germany (Kowalski et al, 2010)	Sheltered workshop and five homes for disabled persons	Quantitative	308 Professionals working in the care of persons with intellectual & physical disabilities	Not described	175 Professionals	MBI-GS & questionnaires which measured variables based on certain scales

Madrid, Spain (Gutiérrez, Rodriguez, Puente, Costa, Recio, Cerro & Cuadros, 2004)	Institutions in Madrid Autonomous Region that offered occupational therapy service	Mixed qualitative and quantitative	Occupational Therapists working in clinical practice (Number not given)	Not described	110 Occupational Therapists	Specific stressors scale & Nursing Professional Burnout Questionnaire
Japan (Ogiwara & Hayashi, 2002)	Physiotherapists employed in Ishikawa Prefecture	Quantitative	243 Physiotherapists		127 Physiotherapists	Demographic questionnaire, MBI (Japanese version)
South Australia (Scutter & Goold, 1995)	Physiotherapists employed in Southern Australia	Quantitative	122 Physiotherapists who graduated in the last five years	None	81 Physiotherapists	MBI & demographic and stressors questionnaire
Norway (Mandy et al, 2004)	Norwegian physiotherapists	Quantitative	Total number not given 200 Questionnaires mailed	Random	127 Physiotherapists	Bergen Inventory, General Self-Efficacy Scale & demographic questionnaire Posted questionnaires
Australia (Girgis et al, 2009)	Multi-disciplinary oncology health professionals in Australia multidisciplinary groups	Mixed qualitative and quantitative	All the members of the Clinical Oncological Society of Australia (1157)	None	740 Health professionals	Demographic questionnaire, MBI, interview schedules and Kessler Psychological Distress Scale

Turkey (Gulalp, Karcioglu, Sari & Koseoglu, 2008)	Three state hospitals in Southern Turkey	Quantitative	All healthcare workers		90 staff members (38 emergency physicians, 40 nurses and 12 nurses' aids)	MBI

2.4 Summary

In this chapter the literature findings on burnout were addressed. The concept of burnout in relation to health-care professionals was first suggested in 1974. After years of research there is no generally agreed-on definition of burnout. However, Maslach and Jackson's research on burnout is regarded as the most influential and their three elements of burnout: emotional exhaustion, development of depersonalization and reduced accomplishment generally form the basis of burnout research.

Burnout is not officially recognised as a mental disorder and is not included in the ICD-10 classification. Burnout has a number of similarities with other emotional disorders but is different from other clinical syndromes such as anxiety, depression and stress. The fatigue component overlaps with disorders such as compassion fatigue, vital exhaustion and depression.

Burnout is caused by a combination of risk factors that interact with each other. Through research a risk profile for burnout has been developed. The symptoms and effects of burnout vary. There has been ample evidence to show that burnout presents a serious threat to an employee's health and working ability and has a harmful influence on an individual's emotional, behavioural, physical and cognitive functioning. It also has a negative effect on the functioning of the organisation. A few studies indicated that burnout has a negative effect on patient outcomes, but more research needs to be done in this regard.

It has been stressed by literature that burnout must be treated in a pro-active and preventative way and the literature discusses various burnout management and intervention strategies in this regard for both the company and the individual. The burnout syndrome is resistant to spontaneous recovery. Health promotion is of increasing importance and must be integrated into the culture of organisations.

The severity and extent of the problem is huge with negative current and future impact on work place finances and staff turnover both in South Africa and internationally.

CHAPTER 3

Methodology

3.1 Introduction

In Chapter Three the methodology of the study is presented. The chapter focuses on the aim, objectives, design, setting, data collection and data analysis procedures used in the study. It also includes information on the study population, the pilot study and the measuring instruments used in the study. Finally ethical issues, as well as the rigour of the data, are explored.

3.2 Study design

The researcher made use of a descriptive study design and used both quantitative and qualitative methods of data collection. The researcher decided to combine the two methods in order to enhance findings. The first aim of the study, i.e. to establish the prevalence of burnout in the study population, calls for a quantitative methodology. However, while quantitative data will provide information towards the following two aims as well, qualitative data provide rich insights into the experiences of the participants (Endacott, 2005). The researcher collected quantitative and qualitative data simultaneously.

It is increasingly common for qualitative and quantitative approaches to be used in the same study (Endacott, 2005). Qualitative and quantitative research strategies should no longer be seen as in conflict, but as synergistic methods which enrich each other (Lempp & Kingsley, 2007; Rusinová, Pochard, Kentish-Barnes, Chaize & Azoulay, 2009). The combination of qualitative and quantitative methods enables researchers to generalise in quantitative terms and understand complexity in qualitative terms (Kroll, Neri & Miller, 2005). The qualitative component can supply answers to “why things work or not” and the quantitative component may measure to what degree a program is working well (Kroll et al, 2005).

As is the case with descriptive studies (Grimes & Schulz, 2002) the researcher wanted to measure and describe the problem of burnout in Life Rehabilitation Units in order to establish the size of the problem, who is affected, where it is found and when it occurs, but

did not intend to intervene in this regard. This study should form the basis for the generation of strategies for intervention and further studies.

3.3 Study setting

Life Rehabilitation consists of seven rehabilitation units: New Kensington Clinic (Johannesburg), Riverfield Lodge (Johannesburg), Eugene Marais Hospital (Pretoria), Little Company of Mary (Pretoria), Pasteur Hospital (Bloemfontein), Entabeni Hospital (Durban) and St Dominic's Hospital (East London). At the time the researcher commenced with the study Life Rehabilitation was in the process of opening the unit in the Eastern Cape. The researcher did not include this unit in this research project, because it was just opening, had just appointed staff and it was unlikely that they would have had burnout issues at this early stage that could be related to working for Life Rehabilitation.

Life Rehabilitation Units provide acute rehabilitation for adults and in some cases children, disabled by traumatic brain injury, stroke, multiple trauma and spinal cord injury amongst others. The aim of this rehabilitation is to facilitate optimal functional independence. The rehabilitation programme focuses on acute, time-restricted involvement early on in the healing process.

Life Rehabilitation Units provide intensive inter-disciplinary rehabilitation on a fulltime basis. The health care team comprised a rehabilitation doctor, rehabilitation nurses and care givers, physiotherapists, occupational therapists and their assistants, psychologists, social workers, speech therapists and a dietician. The treatment programme includes daily intervention by all the appropriate team members to attend to physical, medical, cognitive and psychosocial aspects. The therapists, doctors and nursing representatives meet weekly to discuss each patient's intervention plan and progress and once a week to discuss staff/unit related issues (Life Rehabilitation Pamphlet – Restoring quality of life, no date, n.d.).

Length of stay in a rehabilitation unit depends on the assessment of the patient, team discussion, progress and funding available. The average stay is between six and eight weeks (Life Rehabilitation Brochure).

Some therapists and assistants are employed full day (eight hours a day, or 40 hours a week) while others work four days a week (32 hours a week) and some are employed on a

5/8 (22 hours a week) basis. Therapy is rendered from Mondays to Fridays. Therapy is also available on Saturday mornings and some Public Holidays and the therapists and therapy assistants work on a rotation basis to cover this.

The rehabilitation units are registered to accommodate the following number of patients: Entabeni Hospital (41 beds), Eugene Marais Hospital (21 beds), Little Company of Mary (nine beds), New Kensington Clinic (42 beds), Pasteur Hospital (27 beds) and Riverfield Lodge (41 beds). At the time of the study Life Rehabilitation Units employed 54 permanent therapists (excluding the unit in the Eastern Cape).

The patient – therapist ratios are:

- One physiotherapist for 8 – 10 patients
- One occupational therapist for 8 – 10 patients
- One speech therapist for 12 – 15 patients
- One social worker for 15 – 18 patients
- Psychologist depending on the need for intervention
- One therapy assistant for 10 – 12 patients. This varies between the units
- Dieticians depending on the need for intervention.

There are, however, no guidelines in Life Rehabilitation units policy documents in this regard and staff-patient ratios fluctuate from unit to unit. Each unit uses its own discretion in terms of how many patients are allocated to a therapist or therapy assistant.

Therapists' duties, other than treating patients, include administration, education to patients and families and the attendance of meetings. The therapy staff works to a large extent autonomously i.e. they decide on their own treatment plans for a patient. The therapy team however, reports to the therapy manager and the therapy manager reports to the hospital manager. Life Rehabilitation offers an induction programme and it is the responsibility of management to see that it is implemented. Life Rehabilitation also runs Continuous Professional Development (CPD) programmes and staff are expected to make use of this. Staff are also allowed to attend external CPD events where applicable. In-service training and skills development take place on an informal basis, but the researcher is not aware of formal programmes in this regard.

3.4 Study population

The primary study population consisted of therapists (physiotherapists, occupation therapists, speech therapists, social workers, dieticians, psychologists) and therapy assistants employed by Life Rehabilitation Units at the time of the study. The managers employed by Life Rehabilitation Units at the time of the study formed a secondary study population. The focus was placed on therapists since the study aims to explore the prevalence of burnout amongst them and their experience of the phenomenon. Thus, while the researcher acknowledges that the managers might also experience burnout, their experience of the phenomenon in the current study was limited to information that would clarify burnout as it relate to therapists.

3.4.1 Therapy staff

3.4.1.1 Inclusion criteria

- All therapy staff members who were permanently employed by Life Rehabilitation Units at the time of the study.

3.4.1.2 Exclusion criteria

- All therapy staff members in temporary and locum positions at the time of the study. (These staff members are normally only employed for short periods to assist in certain areas and their input might therefore not contribute to reflect the true picture of burnout at Life Rehabilitation Units).
- The researcher.
- All therapy staff members who were on leave or who were not at the units at the time of the data collection (it was too costly for the researcher to travel to the different units more than once).
- Refusal to participate.

3.4.1.3 Therapist participants

Because the study population was small and consisted of 54 persons, the researcher included the entire population in the study and did not use any sampling procedures. The distribution of therapists who participated in the study according to units is depicted in Table 3.1

Table 3.1 Distribution of therapist-participants according to the units

Name of Rehabilitation Centre	Number of therapists and assistants employed at the unit at the time of the study	Number of therapists and assistants who participated in the study
Entabeni Hospital	10	10
Eugene Marais Hospital	8	7
Little company of Mary	3	2
New Kensington Clinic	14	14
Pasteur Hospital	9	9
Riverfield Lodge	10	7
Total	**54**	**49**

The therapists and therapy assistants were very eager to participate in the study and were interested to ultimately receive feedback on the study results, findings and recommendations. In total only five therapists did not participate in the study; of these five four were on leave and one refused to participate in the study. Thus of the 54 therapists and therapy assistants employed by Life Rehabilitation Units, 49 participated in the study.

3.4.2 Managers

This section of the study population consisted of all the therapy managers, the Human Resources Manager and the Rehabilitation Manager, who were employed at Life Rehabilitation Units at the time of the study.

Again, due to the small size of the study population (eight people), everybody was asked to participate in the study and there were therefore no sampling procedures. The researcher also did not want to select only some of the managers, since there is only one manager in each unit and each of them would therefore be able to provide unit specific information.

Of these eight only one manager did not participate in the study. Although she consented to participate she became very emotional and mentioned that it was too difficult to answer the questions as she herself felt burnout. She was not prepared to discuss the subject any further and the researcher could not suggest intervention strategies to her. Thus in total seven managers participated in the study.

3.5 Instrumentation

3.5.1 Demographic data coding sheet (Appendix 2)

This was used to gather demographic data on the therapists and therapy assistants (demographic data was not gathered from the managers). Data included personal details e.g. gender and age, employment related information e.g. length of employment and seniority, as well as information on social activities.

3.5.2 Maslach Burnout Inventory (MBI) Human Services Survey (Appendix 3)

The prevalence of burnout was established by means of the MBI. The researcher made use of the Human Services Survey and used the subgroup for medical health workers for scoring purposes. The other occupational subgroups included teachers, educators, social service workers, mental health workers and others (Maslach Burnout Inventory Manual - Maslach, Jackson & Leiter, 1996). The researcher felt that the medical health worker subgroup was the most appropriate for this setting, although there are overlaps with some of the other subgroups, for example social workers. The researcher wanted all the therapy staff to be scored according to the same subgroup in order to be able to compare the scores for the different occupational groups in Life Rehabilitation.

Burnout has also been measured by tools such as the Shirom-Melamed Burnout Questionnaire (S-MBQ), the Burnout Measure (BM) and the Bergen Burnout Inventory (BBI) (Innstrand et al, 2002; Mandy et al, 2004; Söderström, Ekstedt, Akerstedt, Nilsson & Axelsson, 2004; Ekstedt & Fagerberg, 2005). Both the S-MBQ and MBI scales emphasise the exhaustion aspects of the condition. In addition the MBI includes aspects involving a sceptical/pessimistic approach toward work or patients and reduced personal worth (Mandy et al, 2004; Söderström et al 2004; Ekstedt & Fagerberg, 2005). The BM assesses the level of burnout with a single score and is not limited to a specific occupation (Innstrand et al, 2002). The validity and dimensionality of the BM have been investigated and the conclusion was that in order to address the issues associated with the multidimensionality of burnout, the BM is not a sound substitute to the MBI (Innstrand et al, 2002).

The MBI can be scored by hand and takes ten to fifteen minutes to complete. Datasheets are included in the test. The MBI has 22 items that are structured on a scale (seven-point)

ranging from zero (never experienced such a feeling) to six (experience such feelings every day). The three subscales measure emotional exhaustion (for example, “I feel like I’m at the end of my rope”), depersonalisation (for example, “I feel I treat some recipients as if they were impersonal objects”), and personal accomplishment (for example, “I feel I’m positively influencing other people’s lives through my work”). The constructs of emotional exhaustion and depersonalisation are understood as separate but related, showing consistently moderate correlations. Accomplishment is negatively linked with both emotional exhaustion and to a lesser extent depersonalisation (Yadama & Drake, 1995). A number of studies which used factor analysis supported the validity of the three-dimension composition of the MBI (Flaherty, 2006). The MBI’s reliability was assessed by the alpha Cronbach coefficient. Cronbach coefficients were above 0.70 (0.930, 0.792 and 0.895) for the dimensions emotional exhaustion, depersonalisation and reduced professional achievement. Therefore, the indicators are reliable (Dos Santos, Alves & Rodrigues, 2009).

The researcher is a social worker and the MBI is an instrument which is only available to psychologists and psychometrists. The researcher appointed a psychologist, Claudia da Roche, to administer and interpret the MBI.

3.5.2.1 Interpretation of MBI scores

According to the Maslach Burnout Inventory Manual “burnout should be conceptualised as a continuous variable, ranging from low to moderate to high degrees of experienced feeling. It should not be viewed as a dichotomous variable, which is either present or absent” (Maslach et al, 1996 p. 5). “Scores are considered high if they are in the upper third of the normative distribution, average if they are in the middle third and low if they are in the lower third” (Maslach et al, 1996 p. 5). The numerical cut-off points for the medical subscale are presented in Table 3.2:

Table 3.2 Categorisation of the MBI Scores

	Range of Experienced Burnout		
MBI Subscales (medicine)	Low (lower third)	Average (middle third)	High (upper third)
Emotional Exhaustion	≤18	19-26	≥27
Depersonalisation	≤5	6-9	≥10
Personal Accomplishment	≥40	39-34	≤33

Results from the MBI can either be reported separately for each dimension or in combination. Both these approaches have advantages and disadvantages (Brenninkmeijer & Yperen, 2003).

The advantages and reasons for using a multidimensional construct and reporting results separately include (Brenninkmeijer & Yperen, 2003):

- Burnout has a multidimensional structure which makes it complicated to combine the components into a unidimensional variable.
- On theoretical grounds it is preferable to regard burnout as multidimensional and to report results individually for each dimension.
- The relations between the dimensions as well as the relations between the dimensions and other variables are complicated. For that reason, combining the dimensions would result in a substantial loss of information.
- The dimensions were developed to be independent from each other.
- It is possible that the role of the dimensions may be different in the developmental process of burnout.
- Researchers who are primarily interested in the burnout dimensions as such may possibly report the results for each dimension individually. This could include studies between the different components of burnout or to investigate the antecedents of burnout e.g. personality types, work and organisation-related attitudes and characteristics and to examine if it is differentially related to the burnout dimensions.
- It will assist researchers who are involved in evaluating burnout-reducing interventions to know which burnout dimension improved or did not improve as a result of the intervention.

Advantages and reasons for combining the different dimensions include (Brenninkmeijer and Yperen, 2003):

- Emotional Exhaustion carries more weight than the other two dimensions.
- Hypothetically, burnout is a job-related syndrome that comprises three burnout dimensions. Similar to other multidimensional syndromes, the multifaceted nature of the burnout syndrome does not imply that one should discard the overall concept of burnout. One should rather study and theorise on it and it

may well assist to increase in depth understanding instead of studies on the different, underlying dimensions. On the whole the effects of burnout are more visible by combining the three dimensions of burnout.

- Researchers may choose to combine burnout dimensions into a single score if they are interested in burnout as a whole and not in the different dimensions.
- A single combined score can be used to study differences between "healthy" individuals and burnt-out individuals.

There is no consensus in the literature on how to combine the MBI dimension scores into a single score. Different ways of combining the burnout dimension scores into a uni-dimensional score indicating burnout is mentioned by Brenninkmeijer & Yperen (2003). These include:

- All three dimensions are present in high levels
- Only one dimension scores high
- Exhaustion + 1

When the "exhaustion + 1" criterion is used where individuals who have high Emotional Exhaustion scores in combination with either high Depersonalisation or low Personal Accomplishment scores it can be regarded as burnt out (Brenninkmeijer & Yperen, 2003. Brenninkmeijer & Yperen (2003) developed this method to ensure high sensitivity together with high specificity. However, while they continuously refer to combining results of the MBI they unfortunately used results from a different, although similar tool, the Utrecht Burnout Scale, which was developed to measure burnout outside human services. While exhaustion is one of the categories the other two have been named distance and competence. The authors maintain that their findings hold true for the MBI as well, but no research could be found to sustain this assumption.

3.5.3 Interview schedules (Appendices 4 & 5)

The first of these (Appendix 4) was used as a guideline during the unstructured interviews with the managers, HR Manager and Rehabilitation Manager to establish their perceptions of burnout, how burnout has been managed in the past at Life Rehabilitation Units and if they had any suggestions for future management.

The second interview schedule (Appendix 5) was used in unstructured interviews with the therapy staff to establish their perceptions of burnout and its contributing factors in the organisation and individual. The researcher used unstructured interviews in order to allow respondents the freedom to express thoughts and opinions.

3.5.4 Instrument design

The data coding sheet and the interview schedules were self-designed as none could be found in the literature that would elicit the information necessary to achieve the aims and objectives of the study. These questionnaires were designed mainly using the literature on the subject as guidance (Schlenz et al, 1995; Scutter & Goold, 1995; Yadama & Drake, 1995; Van Wijk, 1997; Wandling & Smith, 1997; Felton, 1998; Blau et al, 2002; Mandy et al, 2004; Brachtesende, 2004; Crabbe et al, 2004; Munn-Giddings et al, 2005; Rothmann, et al, 2006; Espeland, 2006; Mommersteeg et al, 2006; Dunwoodie & Auret, 2007; Jeanneau & Armelius, 2007) The researcher also consulted with the psychologist who assisted her with the MBI.

The participants were all fluent in English (English is the operating/working language of Life Healthcare). The research therefore was conducted in English and none of the items was translated into any other languages. Some of the participants answered the interview questions in Afrikaans. These answers were translated into English by the researcher.

3.6 Pilot study

The researcher performed a pilot study to determine how long it takes to complete the questionnaires and to determine if questions were clear and easy to understand. All four measuring instruments were piloted and the researcher determined that the data gathered through them could answer the objectives of the study.

The MBI data coding sheet and the interview schedule for therapists and therapy assistants were piloted with three locum therapists employed at New Kensington Clinic. The interview schedule for the managers was piloted with the Nursing Manager and the Hospital Manager employed at New Kensington Clinic. None of the participants in the pilot study formed part of the population for the main study.

The researcher recorded all questions which were not clearly understood as well as questions that required prompting or explanation (See Appendix 1). Any additional input

from the participants on the measuring instruments was also taken into consideration and used to improve them.

The researcher used her office, which is private and quiet, at New Kensington Clinic as an interview venue. She did not experience any problems with this venue and therefore concluded that any venue could be used for data collection as long as it is quiet, private and without any disturbances.

With regard to time it took to complete the questioinnaires, as well as clarity and understandability of questions, it was found:

3.6.1 Maslach Burnout Inventory (MBI)

The researcher determined that it took approximately fifteen minutes to complete the inventory. The participants did not experience difficulty in completing it, except that it needed to be explained that “recipients” would mean patients in this instance.

3.6.2 Data coding sheet

The Researcher determined that it takes approximately fifteen to 20 minutes to complete the Data Coding Sheet. The Researcher changed its appearance to ensure a neater, more professional look. The other changes which were made to this instrument are presented in Appendix 1.

3.6.3 Interviews with managers

The interviews with the managers, including the time to complete the consent form, took approximately 30 minutes. The questions for these interviews were clear and it was not necessary to make any changes to them. The researcher however, added an open question at the end of the interview to provide the managers the opportunity to add anything else on the subject, which were not covered in the interview.

3.6.4 Interviews with therapists

The researcher determined that the interviews took approximately 30 minutes to complete. The questions for these interviews were clear and it was not necessary to make any changes. However, the researcher decided to add the following question; “Are you aware of the new ICAS wellness programme which was recently launched at Life?” The

researcher also wanted to know from the participants whether they know what this programme entails and whether they would make use of it in case of burnout. The researcher added an open question at the end of the interview to give the participant the opportunity to add anything else on the subject which was not covered in the interview.

3.7 Data collection

The data was collected according to the following steps:

- The researcher identified a psychologist, Claudia da Rocha who assisted in obtaining the MBI and who was able to administer it.
- The researcher contacted the therapy managers telephonically and confirmed the discussion by e-mail to explain the study to them, to obtain provisional consent and to determine a venue, date and time to perform the data collection. The therapy managers then explained the above to the participants and arranged interview slots with them and the researcher. A quiet and private venue was identified (normally either a boardroom or an office), which was used for data collection.
- On meeting the participants the researcher again explained the study, answered any questions they had on the study and requested them to sign the consent form. She also requested consent to use a digital recorder during the interview.
- Once written consent had been obtained the participants completed the demographic data form and the researcher assisted where necessary.
- This was followed by the administering of the MBI by the psychologist, Claudia da Rocha who accompanied the researcher on her visits to the different rehabilitation units. The MBIs were completed at each unit by the participants in group format but each worked at it individually. This was done in order to save the psychologist time.
- After the MBIs were completed the researcher conducted the in-depth interviews with each of the participants separately.

3.8 Analysis of data

3.8.1 Quantitative data

The MBI scores were calculated for each participant and were categorised as high, moderate or low on the subscales according to the instructions provided by the MBI manual. The demographic data, as well as data from the MBI were typed onto a spreadsheet to assist with statistical analysis and presentation. Data will be presented through graphs, charts and figures where appropriate. Where statistical analysis was done e.g. where results from the MBI were compared to the demographic data, employment information and social activities p values were determined with the use of the maximum likelihood or chi-squared test. A p value of <0.05 was deemed statistically significant. The statistical analysis was completed by Professor Daan Nel from the University of Stellenbosch (Centre for Statistical Consultation). The analyses were done by using StatSoft Inc. (2008) STATISTICA (data analysis software system), Version 8. www.statsoft.com.

3.8.2 Qualitative data

The data was transcribed by Mrs SJ du Plessis, a professional transcriber. She also signed a confidentiality statement. The researcher read and listened to the data before and during the process of analysis. Data was analysed according to the inductive method in which the researcher allowed themes to emerge and then organised information according to these themes. Data will be presented under these themes and expanded through narrative examples. The researcher made use of literature to guide her in this regard (Rabiee, 2004).

3.9 Rigour

3.9.1 Validity and reliability of quantitative data

Roberts, Priest and Traynor (2006, p. 43) stated that in quantitative research validity describes “the extent to which a measure accurately represents the concepts it claims to measure”. Broad measures of validity are either external or internal (Roberts et al, 2006). External validity describes “the ability to apply with confidence the findings of the study to other people and other situations” (Roberts et al, 2006, p. 43). Samples of participants drawn must be representative of the population at the time of the study (Roberts et al, 2006). These samples should be drawn with reference to relevant variables in the study, such as gender and age (Roberts et al, 2006). The researcher succeeded in this regard in

that the study participants were representative both in numbers and other characteristics of the study population.

“Internal validity addresses the reasons for the outcomes of the study and helps to reduce other, often unanticipated reasons for these outcomes. In order to consider internal validity one can make use of the following approaches: construct validity, criterion-related validity and internal validity” (Roberts et al, 2006, p. 43).

The validity of the MBI was examined in a study by Yadama & Drake in 1995 and their analysis found the MBI to be valid and reliable. They however recommended that further research using a variety of samples and larger samples are needed to establish the instrument’s construct validity. According to them future research should be conducted to confirm the theory behind this inventory rather than to do more exploratory measurement analysis (Yadama & Drake, 1995).

Selection bias was avoided by including all the therapy staff members in the sample. The data collection was consistent in that the procedure which was followed was the same for every group/unit. To minimise response biases the MBI was completed privately by the participants, without their knowing how other participants were answering. Confidentiality was ensured in that the researcher made use of a numbering system (no names on the form) for research purposes. The participants were therefore comfortable to express their true feelings.

Individuals have different views on burnout. In order to minimise these personal viewpoints the participants must not be sensitised to the general issue of burnout and they must not be aware that the MBI is used to determine burnout. It was not possible for the researcher to avoid sensitisation because she had to explain to the participants what the study was about in order for them to consent to the research.

Although the MBI manual states that no specific credentials or actions are required of the individual who is administering the MBI the researcher appointed a psychologist to administer the MBI. She was a neutral person with no direct authority over the participants because this could cause participants to be less candid in their answers. She contributed to minimise response bias by stressing the importance to give honest answers and by reassuring them of the confidentiality of the results. She read the directions aloud while

the participants followed on their inventories. She checked each completed form as it was handed in to make sure that all the items have been answered.

3.9.2 Trustworthiness of qualitative data

“Trustworthiness has been further divided into credibility, which corresponds roughly with the positivist concept of internal validity, dependability, which relates more to reliability, transferability, which is a form of external validity and confirmability, which uses largely an issue of presentation ” (Lincoln & Guba, 1985, as cited in Rolfe, 2006, p. 305).

The researcher employed the following strategies to ensure trustworthiness and credibility:

- Size of the sample – Sample size is determined by the best possible number required to facilitate valid inferences to be made regarding the population. A larger sample size will reduce the probability of a random sampling error (Marshall, 1996). The researcher included the whole population in the sample and therefore all the participants were interviewed, which resulted in a large amount of information and rich themes and subsequent generalisability of the research findings to the population.
- Response rate − A high response rate indicates very credible data collected, because (a) the participants show great interest in the study and (b) In contrast to a group with a low response rate, the data could be regarded as more reliable (Im & Chee, 2006). In this study a response rate of 90.32% was achieved. A large number of themes were identified, these themes were normally mentioned more than once and this provided further verification.
- Confirmability – Through triangulation the researcher compared qualitative and quantitative data to verify findings. A literature review was done and employed to enhance the truth value (credibility) of the study.
- Transferability – Interviews were transcribed verbatim and relevant quotes were included in the results. A clear description of the methodology was also provided.
- Dependability – The research methodology, the transcription of interviews and analysis were described and relevant quotes were provided.

3.10 Ethical considerations

The researcher implemented the following strategies to ensure an ethical approach:

- Registered the research with the committee for human research at the University of Stellenbosch (Project number: N07/10/237).
- Obtained written permission for access to information from Life Rehabilitation Units as well as permission to perform the study (See Appendix 6).
- Obtained written informed consent (See Appendices 7 and 8) from the participants in the study. The aim and objectives of the study were explained to the participants as well as what their participation will involve.
- The participation in the research was voluntary.
- Confidentiality of participants was ensured. This issue was addressed in the informed consent document which was co-signed by the participants and the researcher. Through this document the researcher undertook to guarantee confidentiality at all times and that the participants' identities would not be disclosed to anybody at any time (See Appendices 7 and 8).
- Participants were free to withdraw from the research at any time.
- Informed consent was obtained from all the participants that a digital recorder could be used during the interviews.
- The psychologist, Claudia da Roche, who was appointed to assist with the MBI, signed a document in order to ensure that she would not disclose any information and that all information will be treated confidentially (See appendix 9). The transcriber also signed a confidentiality statement for the same reason (See Appendix 10).
- The researcher provided the participants found to suffer from burnout or are at high risk to develop burnout with the iCas toll free number through which they could access the services of a psychologist without any cost or encourage them to contact a private psychologist of their choice.
- The researcher will make the findings of the research available to Life: Rehabilitation and the participants.
- The researcher will act on the findings of the research and motivate for action.
- Tapes and data will be stored securely by the researcher at the researcher's home. The tapes and data will be destroyed once the research project has been finalised.

- Only the researcher had access to the participants' records.
- Results will be published in relevant scientific journals.
- The ethical guidelines and principles of the international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and Medical Research Council's Ethical Guidelines for Research were taken into consideration when the study was conducted.

3.11 Summary

The researcher aimed to determine the prevalence of burnout among therapy staff employed at Life Rehabilitation Units, the contributing factors to burnout in this environment and how the study population currently manage burnout. In order to achieve this, the researcher identified nine study objectives. The researcher made use of a descriptive mixed method study design. The study setting consisted of six of the seven Life Rehabilitation Units. The study population consisted of the therapists, therapy assistants and their managers employed by Life Rehabilitation Units. In terms of instrumentation the researcher made use of a demographic data coding sheet to gather demographic data, the MBI to measure the prevalence of burnout and interview schedules for both the managers and the therapy staff to establish their perceptions of burnout and its contributing factors in the organisation and individual. The analysis of the quantitative data was completed by statistical calculations according to instructions provided by the MBI manual. The qualitative data was analysed according to the inductive method in which the researcher allowed themes to emerge and then organised information according to these themes. The researcher endeavoured to be as ethical as possible and to ensure trustworthiness of the data.

CHAPTER 4

QUANTITATIVE RESULTS

4.1 Introduction

In this chapter the quantitative results of the study are presented. The quantitative and qualitative results are presented in separate chapters in order to address the different study objectives. Data gathered from the 49 participants will be presented according to the objectives of the study of which one of the most important ones was to determine the prevalence of burnout among therapists employed by Life Rehabilitation units. This is presented second in this chapter after a short demographic introduction to participants. Following that the impact of demographic and employment details of participants on burnout are presented.

4.2 Demographic details of study participants

The study population consisted of seven (14.28%) males and 42 (85.71%) females. Figure 4.1 shows the majority of the therapists (39; 79.59%) in the study population were between the ages 20 and 39 years old, while 11 (22.44%) of the therapists were older than 40 years of age.

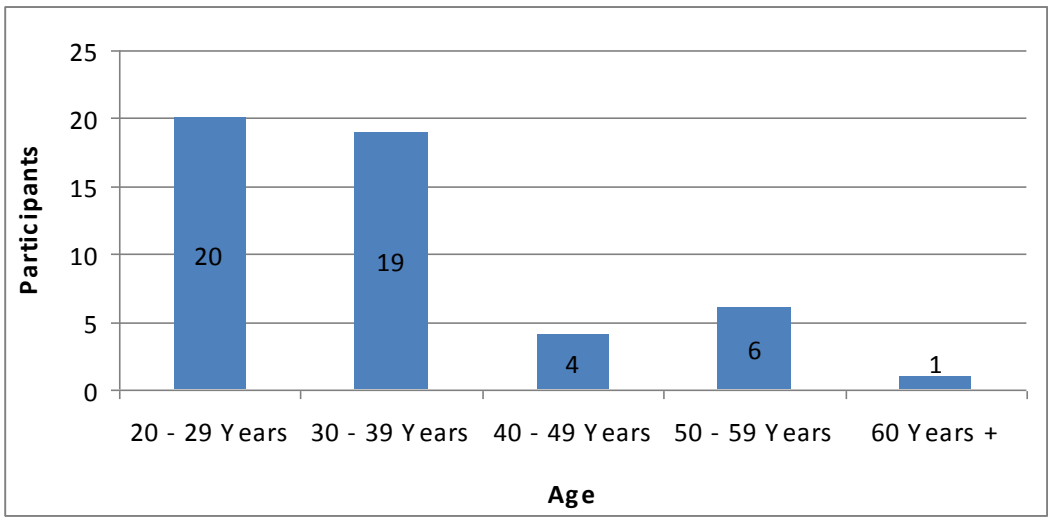

Figure 4.1 Age distribution of study population

A virtually equal number of therapists participating in the study were either never married (21; 42.85%) or married (23; 46.93%). The other five (10.20%) therapists were either divorced or separated.

The majority (31; 63.26%) of the therapists had four years of tertiary education. Of the other 18, five (10.21%) had less then Grade 12, six (12.24%) had 1-3 years tertiary education and seven (14.29%) had a post graduate degree.

Most of the therapists who participated in the study (14; 28.57%) were employed at New Kensington Clinic, while the fewest were employed at Little Company of Mary (2; 4.08%). The Eugene Marais Hospital and Riverfield Lodge employed seven (14.29%) therapists each while Pasteur Hospital employed nine (18.37%) and Entabeni 10 (20.40%).

Figure 4.2 shows the two occupational groups with the highest representation to be occupational therapists (14; 28.86%) and physiotherapists (13; 26.53%). Only one dietician participated in the study.

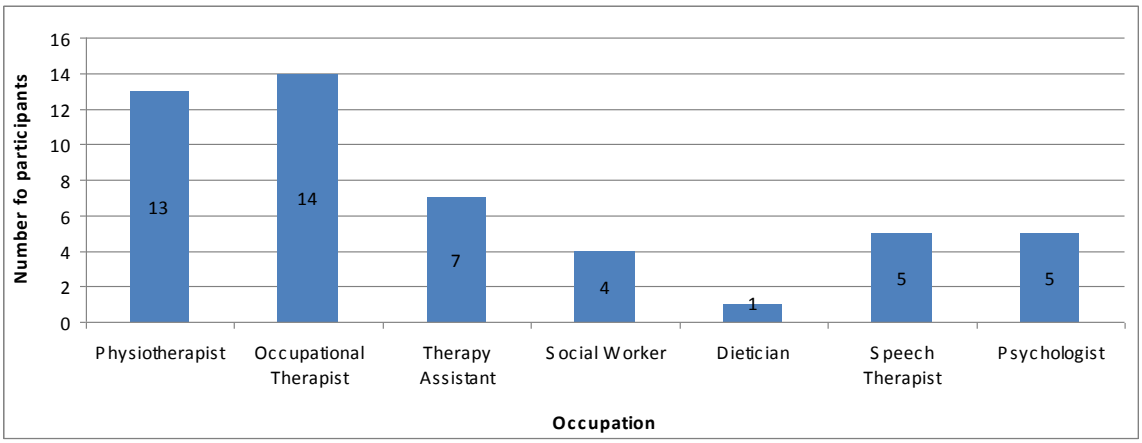

Figure 4.2 Occupation of therapists

4.3 Prevalence of burnout

As discussed in Chapter Three, three formulas can be used to determine a combined burnout score. In this presentation of the results the researcher includes scores for all three of these options (see Table 4.1). However, in further presentation and analysis of results the prevalence of burnout will be presented separately for each of the three MBI dimensions as recommended by the Maslach Burnout Inventory Manual and as scores were presented most often in the literature (Schlenz et al, 1995; Maslach et al, 1996; Liakopoulou, Panarctaki,

Papadakis, Katsika, Sarafidou, Laskari, Anastasopoulos, Vessalas, Bouhoutsou, Papacvangclou, Polychronopoulou & Haidas, 2008; Oyefeso, Clancy & Farmer, 2008; Soler, Yaman, Esteva, Dodds, Spiridonova Asenova, Katić, Ožvačić, Desgrange, Moreau, Lionis, Kotányi, Carelli, Nowak, De Aguiar Sá Azeredo, Marklund, Churchill & Ugan, 2008; Surgenor, Spearing, Horn, Beautrais, Mulder & Chen, 2009; Waldman, Diez, Arazi, Linetzky, Guinjoan & Grancelli, 2009; Bressi, Porcellana, Gambini, Madia, Muffatti, Peirone, Zanini, Erlicher, Scarone & Altamura, 2009; Al-Dubai & Rampal, 2010).

Table 4.1 shows that 41 (83.67%) therapists had high levels of burnout in one of the three dimensions while one therapist (2.04%) had high levels of burnout in all three dimensions and one therapist (2.04%) had low levels in all three dimensions. In the category EE plus 1 there were 13 (26.53%) therapists. Thus one can say that according to the various ways of combining scores to determine a one-dimensional score, at the most 83.67% of therapists suffered from burnout and at best 2.04% of therapists suffered from burnout.

Table 4.1 Number of therapists in various combinations of dimensions

Indicators	N	%
High level of burnout in one dimension	41	83.67%
High level of burnout in two dimensions	19	38.77%
High level of burnout in three dimensions	1	2.04%
Low/average level of burnout in two dimensions	19	38.77%
Low level of burnout in three dimensions	1	2.04%
Emotional Exhaustion + 1	13	26.53%

Figure 4.3 indicates that the dimension in which therapists most often scored high burnout levels were Emotional Exhaustion (EE) where 28 therapists (57.14%) scored ≥27, which indicates a high level of burnout (Maslach et al, 1996).

Figure 4.3 The scores of the participants according to the three MBI subscales

Just more than half of the therapists (25 therapists, 51.02%) had low scores (≥ten) for Depersonalisation (DP), which indicates that they had low burnout levels in this regard (Maslach et al, 1996). Nineteen therapists (the majority), (38. 77%) however, had low scores (≥40) for Personal Accomplishment (PA) which again indicates a high burnout rate in this dimension (Maslach et al, 1996). Emotional exhaustion was most affected while depersonalisation was least affected.

Table 4.2 provides the mean, median and standard deviation for EE, DP and PA and the prevalence rate for each of the dimensions. The means and medians of DP and PA were both within average ranges, while the means and median for EE were in the high range.

Table 4.2 Mean, median, standard deviation and burnout prevalence rate in each of the dimensions

Variable	N	Mean	Median	Std Dev	Prevalence rate
Emotional Exhaustion	49	27.88	30	11.48	57.14%
Depersonalisation	49	6.31	5	4.68	20.40%
Personal Accomplishment	49	37.24	38	7.18	38.77%

4.4 Correlation between demographic details of study participants and MBI scores

4.4.1 Gender

Table 4.3 shows that three (42.86%) males and 25 (59.52%) females presented with high EE scores and one (14.28%) of the males and nine (21.43%) of the females presented with high DP scores. The majority of male therapists (5; 71.43%) had low PA scores, whereas 14 (33.33%) of the females had low scores for PA. This difference was found to be statistically significant (p = .02379). Gender had however no statistically significant impact on EE (p =.50957) and DP (p = .67191).

Table 4.3 Association between EE, DP, PA and gender

Gender				
	Emotional Exhaustion			
	Low	Average	High	Row Total
Male	3	1	3	7
	42.86%	14.28%	42.86%	
Female	9	8	25	42
	21.43%	19.05%	59.52%	
Totals	12	9	28	49
	Depersonalisation			
	Low	Average	High	Row Total
Male	3	3	1	7
	42.86%	42.86%	14.28%	
Female	22	11	9	42
	52.38%	26.19%	21.43%	
Totals	25	14	10	49
	Personal Accomplishment			
	Low	Average	High	Row Total
Male	5	0	2	7
	71.43%	0.00%	28.57%	
Female	14	18	10	42
	33.33%	42.86%	23.81%	
Totals	19	18	12	49

4.4.2 Age

Table 4.4 shows that younger therapists had higher overall, EE scores, with 13 therapists (65.00%) in the 20 – 29 year age group showing high levels of EE with a steady decline as age increases to two therapists (33,33%) from those who are 50 years and older. Generally all age groups scored DP in the lower and average ranges, with only four therapists from the 20 – 29 year group (20.00%), four from the 30 – 39 year group (22.22%) and two from the 50 – 59 year group (33.33%) scoring it as high. Older therapists experienced generally lower levels of PA with six of the seven therapists (85.71%) of the group older than 50 years scoring low in this area (meaning a high level of burnout in this area).

Table 4.4 Association between EE, DP and PA and age

Age				
	Emotional Exhaustion			
	Low	Average	High	Row Total
20-29 yrs	3	4	13	20
	15.00%	20.00%	65.00%	
30-39 yrs	3	4	11	18
	16.67%	22.22%	61.11%	
40-49 yrs	2	0	2	4
	50.00%	0.00%	50.00	
50-59 yrs	3	1	2	6
	50.00%	16.67%	33.33%	
60-65 yrs	1	0	0	1
	100%	0.00%	0.00%	
Totals	12	9	28	49
	Depersonalisation			
	Low	Average	High	Row Total
20-29 yrs	9	7	4	20
	45.00%	35.00%	20.00	
30-39 yrs	8	6	4	18
	44.45%	33.33%	22.22%	
40-49 yrs	4	0	0	4
	100%	0.00%	0.00%	
50-59 yrs	3	1	2	6

	50.00%	16.67%	33.33%	
60-65 yrs	1	0	0	1
	100.00%	0.00%	0.00%	
Totals	25	14	10	49
	Personal Accomplishment			
	Low	**Average**	**High**	**Row Total**
20-29 yrs	6	10	4	20
	30.00%	50.00%	20.00%	
30-39 yrs	5	8	5	18
	27.78%	44.44%	27.78%	
40-49 yrs	2	0	2	4
	50.00%	0.00%	50.00%	
50-59 yrs	5	0	1	6
	83.33%	0.00%	16.67%	
60-65 yrs	1	0	0	1
	100%	0.00%	0.00%	
Totals	19	18	12	49

Statistical analysis revealed that age did not have a statistically significant influence on any of the burnout dimensions. The p values were .35522 (EE), .41083 (DP) and .05749 (PA) respectively. However, a value of .05749 does indicate some level of impact and it would be prudent to keep in mind that according to this finding, older therapists might experience lower levels of PA than their younger counterparts.

4.4.3 Marital status

Table 4.5 shows that a virtually equal number of therapists participating in the study were either never married (21; 42.85%) or married (23; 46.93%). The other five (10.20%) therapists were either divorced or separated. Table 4.5 further shows that amongst the 21 therapists who have never been married 15 (71.43%) had high levels of EE, four (19.05%) presented with high levels of DP and eight (38.10%) showed reduced PA. On the other hand, of the 23 married therapists ten (43.48%) presented with high EE, five (21.74%) showed high levels of DP and nine (39.13%) had reduced PA. Thus according to the percentages noticeably more therapists who were never married showed higher levels of EE compared to

those who are married. With a p value of .28255 the difference is however not statistically significant.

Table 4.5 Association between EE, DP and PA and marital status

Marital status				
	Emotional Exhaustion			
	Low	Average	High	Row Total
Never married	2	4	15	21
	9.52%	19.05%	71.43%	
Married	8	5	10	23
	34.78%	21.74%	43.48%	
Divorced	1	0	1	2
	50.00%	0.00%	50.00%	
Separated	1	0	2	3
	33.33%	0.00%	66.67%	
Totals	12	9	28	49
	Depersonalisation			
	Low	Average	High	Row Total
Never married	10	7	4	21
	47.62%	33.33%	19.05%	
Married	12	6	5	23
	52.17%	26.09%	21.74%	
Divorced	1	1	0	2
	50.00%	50.00%	0.00%	
Separated	2	0	1	3
	66.67%	0.00%	33.33%	
Totals	25	14	10	49
	Personal Accomplishment			
	Low	Average	High	Row Total
Never married	8	8	5	21
	38.10%	38.10%	23.80%	
Married	9	9	5	23
	39.13%	39.13%	21.74%	
Divorced	1	0	1	2
	50.00%	0.00%	50.00%	
Separated	1	1	1	3

	33.33%	33.33%	33.33%	
Totals	19	18	12	49

P-values for DP (.75286) and PA (.90216) indicated that marital status also had no statistically significant impact on these two dimensions. Similarly the number of years married had no statistically significant impact on the dimensions with p values of .06517 (EE), .19270 (DP) and .13863 (reduced PA).

4.4.4 Children

Table 4.6 indicates that 29 (59.18%) of the therapists did not have children. A higher percentage of therapists without children (21; 72.41%) experienced high levels of EE than therapists with children (7; 35.00%). This difference was statistically significant (p = .02994). PA was statistically significantly (p = .03895) impacted on by the absence of children. The scores of twelve (60.00%) of the therapists who did not have children and seven (24.14%) of therapists who had children indicated high levels of reduced PA. DP was not influenced significantly by whether therapists had children or not (p = .07413).

Table 4.6 Association between EE, DP and PA and children

Children				
	Emotional Exhaustion			
	Low	**Average**	**High**	**Row Total**
Yes	7	6	7	20
	35.00%	30.00%	35.00%	
No	5	3	21	29
	17.24%	10.35%	72.41%	
Totals	12	9	28	
	Depersonalisation			
	Low	**Average**	**High**	**Row Total**
Yes	14	3	3	20
	70.00%	15.00%	15.00%	
No	11	11	7	29
	37.93%	37.93%	24.14%	
Totals	25	14	10	49
	Personal Accomplishment			

	Low	Average	High	Row Total
Yes	12	5	3	20
	60.00%	25.00%	15.00%	
No	7	13	9	29
	24.14%	44.83%	31.03%	
Totals	19	18	12	49

The number of children at home did not show any statistically significant impact on EE (p=.26870), DP (p=.32804) or PA (p=.51556).

4.4.5 Educational status

Table 4.7 shows that the majority (31; 63.26%) of the therapists had four years of tertiary education. It further shows that a higher percentage (63.15%) of therapists with four years tertiary education or post graduate degrees scored high on the dimension of EE (respectively 64.52% and 57.14%) than the other two groups whose percentages of high scores in this dimension were respectively 40.00% and 33.33%. The group with 1 – 3 years tertiary education showed the highest percentage of reduced PA (83.33%) per group.

Table 4.7 Association between EE, DP and PA and educational level

Educational level				
	Emotional Exhaustion			
	Low	**Average**	**High**	**Row Total**
<Grade 12	3	0	2	5
	60.00%	0.00%	40.00%	
1-3 years tertiary education	1	3	2	6
	16.67%	50.00%	33.33%	
> 4 years tertiary education	6	5	20	31
	19.35%	16.13%	64.52%	
Post graduate degree	2	1	4	7
	28.57%	14.29%	57.14%	
Totals	12	9	28	49
	Depersonalisation			
	Low	**Average**	**High**	**Row Total**
<Grade 12	3	2	0	5
	60.00%	40.00%	0.00%	

1-3 years tertiary education	3	2	1	6
	50.00%	33.33%	16.67%	
4 years tertiary education	15	9	7	31
	48.39%	29.03%	22.58%	
Post graduate degree	4	1	2	7
	57.14%	14.29%	28.57%	
Totals	25	14	10	49
	Personal Accomplishment			
	Low	**Average**	**High**	**Row Total**
<Grade 12	3	0	2	5
	60.00%	0.00%	40.00%	
1-3 years tertiary education	5	1	0	6
	83.33%	16.67%	0.00%	
4 years tertiary education	8	15	8	31
	25.80%	48.39%	25.81%	
Post graduate degree	3	2	2	7
	42.86%	28.57%	28.57%	
Totals	19	18	12	49

Lower levels of education (but more specifically the 1 – 3 years tertiary category) had a statistically significant impact on burnout prevalence in PA with a p value of .03640, but not on EE (.24719) and DP (p = .75859).

4.4.6 Participation in sport

Table 4.8 shows that 29 (59.18%) of the therapists participated in sport. Table 4.23 further shows that there was not much difference between the EE, DP and PA scores of the therapists who participated in sport and those who did not.

Table 4.8 Association between EE, DP and PA and sport

Sport				
	Emotional Exhaustion			
	Low	**Average**	**High**	**Row Total**
Yes	7	5	17	29
	24.14%	17.24%	58.62%	
No	5	4	11	20
	25.00%	20.00%	55.00%	

Totals	12	9	28	49
	Depersonalisation			
	Low	**Average**	**High**	**Row Total**
Yes	14	8	7	29
	48.27%	27.59%	24.14%	
No	11	6	3	20
	55.00%	30.00%	15.00%	
Totals	25	14	10	49
	Personal Accomplishment			
	Low	**Average**	**High**	**Row Total**
Yes	11	12	6	29
	37.93%	41.38%	20.69%	
No	8	6	6	20
	40.00%	30.00%	30.00%	
Totals	19	18	12	49

Participating in sport had no statistically significant impact on any one of the dimensions with p values of .96103 (EE), .72952 (DP) and .65312 (PA). The amount of hours spent on sport also had no statistical impact on the burnout dimensions: EE (p=.95400), DP (p=.28713) and PA (p=.36919).

4.4.7 Religion

Table 4.9 shows that the majority of therapists (40; 81.63%) are actively involved in religious activities. Table 4.9 further indicates that there was not much difference between the EE, DP and PA scores of the therapists who were actively involved in their religion and those who were not.

Table 4.9 Association between EE, DP and PA and religion

Religion				
	Emotional Exhaustion			
	Low	**Average**	**High**	**Row Total**
Yes	10	8	22	40
	25.00%	20.00%	55.00%	
No	2	1	6	9
	22.22%	11.11%	66.67%	
Totals	12	9	28	49

	Depersonalisation			
	Low	**Average**	**High**	**Row Total**
Yes	22	10	8	40
	55.00%	25.00%	20.00%	
No	3	4	2	9
	33.33%	44.45%	22.22%	
Totals	25	14	10	49
	Personal Accomplishment			
	Low	**Average**	**High**	**Row Total**
Yes	15	15	10	40
	37.50%	37.50%	25.00%	
No	4	3	2	9
	44.45%	33.33%	22.22%	
Totals	19	18	12	49

Participating in religious activities showed no statistically significant impact on the three dimensions with p values of .75992 (EE), .44217 (DP) and .92891(PA).

4.4.8 Leisure activities

According to Table 4.10 the majority of therapists (45; 91.88%) participated in leisure activities. The percentages in Table 4.10 show a positive correlation between participation in leisure activities and decreased scores in the burnout dimensions. The group who did not participate in leisure activities had higher levels of EE (75.00%) than the group who did (56.00%). A lower percentage of the group who did not participate in leisure activities experienced low levels of PA (25.00%) versus those that did participate in leisure activities (40.00%). However, none of these were statistically significant with p values of .41554 (EE), .51523 (DP) and .51286 (PA). Similarly the number of hours spent on leisure activities had no statistical impact on the burnout dimensions: EE (p=.28360), DP (p=.43352) and PA (p=.13458).

Table 4.10 Association between EE, DP and PA and leisure activities

Leisure activities				
	Emotional Exhaustion			
	Low	**Average**	**High**	**Row Total**

Yes	11	9	25	45
	24.44%	20.00%	55.56	
No	1	0	3	4
	25.00%	0.00%	75.00%	
Totals	12	9	28	49
	Depersonalisation			
	Low	**Average**	**High**	**Row Total**
Yes	24	12	9	45
	53.33%	26.67%	20.00%	
No	1	2	1	4
	25.00%	50.00%	25.00%	
Totals	25	14	10	49
	Personal Accomplishment			
	Low	**Average**	**High**	**Row Total**
Yes	18	17	10	45
	40.00%	37.78%	22.22%	
No	1	1	2	4
	25.00%	25.00%	50.00%	
Totals	19	18	12	49

4.4.9 Support system at home

The majority of the therapists (47; 95.91%) felt that they had a fairly good or excellent support system at home.

Table 4.11 indicates that the therapists who had a poor support system at home had high EE and PA scores, with only a small difference in DP scores. Support system at home had no statistically significant impact on any of the dimensions with p values of .13435 (EE), .61110 (DP) and .44110 (PA).

Table 4.11 Association between EE, DP and PA and support system at home

Support system at home				
	Emotional Exhaustion			
	Low	**Average**	**High**	**Row Total**
Poor	0	0	2	2
	0.00%	0.00%	100.00%	
Fairly good	4	7	11	22

	18.18%	31.82%	50.00%	
Excellent	8	2	15	25
	32.00%	8.00%	60.00%	
Totals	12	9	28	49
	Depersonalisation			
	Low	**Average**	**High**	**Row Total**
Poor	1	1	0	2
	50.00%	50.00%	0.00%	
Fairly good	10	8	4	22
	45.45%	36.37%	18.18%	
Excellent	14	5	6	25
	56.00%	20.00%	24.00%	
Totals	25	14	10	49
	Personal Accomplishment			
	Low	**Average**	**High**	**Row Total**
Poor	1	0	1	2
	50.00%	0.00%	50.00%	
Fairly good	8	7	7	22
	36.36%	31.82%	31.82%	
Excellent	10	11	4	25
	40.00%	44.00%	16.00%	
Totals	19	18	12	49

4.5 Employment details of study participants and correlation between employment details and MBI scores

4.5.1 Place of employment

Table 4.12 shows that EE was the burnout dimension that was experienced by the highest percentage of therapists in each of the seven units. Furthermore, more therapists working at Riverfield Lodge (6; 85.71%) experience EE than those working in other units. In the rest of the units, with the exception of Little Company of Mary, from whom only two therapists participated, between 42.00% and 60.00% of therapists experienced high levels of EE.

Riverfield Lodge was also the unit with the highest percentage of therapists who experienced high levels of DP (3; 42.86%). Percentages for the other units varied between 0.00% and 28.00%.

Finally, a higher percentage of therapists working at Eugene Marais experienced reduced PA (4; 57.14%).

Table 4.12 Association between EE, DP and PA and place of employment

Place of employment				
	Emotional Exhaustion			
	Low	Average	High	Row Total
New Kensington Clinic	5	3	6	14
	35.71%	21.43%	42.86%	
Eugene Marais Hospital	3	0	4	7
	42.86%	0.00%	57.14%	
Little Company of Mary	0	0	2	2
	0.00%	0.00%	100.00%	
Riverfield Lodge	1	0	6	7
	14.29%	0.00%	85.71%	
Pasteur Hospital	1	4	4	9
	11.12%	44.44%	44.44%	
Entabeni Hospital	2	2	6	10
	20.00%	20.00%	60.00%	
Totals	12	9	28	49
	Depersonalisation			
	Low	Average	High	Row Total
New Kensington Clinic	4	6	4	14
	28.57%	42.86%	28.57%	
Eugene Marais Hospital	5	1	1	7
	71.42%	14.29%	14.29%	
Little Company of Mary	2	0	0	2
	100.00%	0.00%	0.00%	
Riverfield Lodge	3	1	3	7
	42.86%	14.28%	42.86%	
Pasteur Hospital	4	3	2	9
	44.45%	33.33%	22.22%	

Entabeni Hospital	7	3	0	10
	70.00%	30.00%	0.00%	
Totals	25	14	10	49
	Personal Accomplishment			
	Low	**Average**	**High**	**Row Total**
New Kensington Clinic	5	6	3	14
	35.71%	42.86%	21.43%	
Eugene Marais Hospital	4	3	0	7
	57.14%	42.86%	0.00%	
Little Company of Mary	1	1	0	2
	50.00%	50.00%	0.00%	
Riverfield Lodge	1	1	5	7
	14.29%	14.29%	71.42%	
Pasteur Hospital	4	4	1	9
	44.44%	44.44%	11.12%	
Entabeni Hospital	4	3	3	10
	40.00%	30.00%	30.00%	
Totals	19	18	12	49

The place of employment showed no statistically significant impact on the dimensions with p values of .16305 (EE), .18343 (DP) and .19792 (PA).

4.5.2 Occupation

Table 4.13 shows that the dietician experienced high levels of both EE and DP and average PA. In all the other categories of staff high levels of EE were found. This is especially true for occupational therapists (9; 64.29%), speech therapists (3; 60.00%), psychologists (3; 60.00%) and physiotherapists (7; 53.85%). DP was the dimension to be least negatively affected as scores in Table 4.13 show. Reduced PA at levels indicative of burnout in this dimension was experienced by 71.42% (five) of the assistants, 60.00% (three) of the psychologists and 50.00% (two) of the social workers.

Table 4.13 Association between EE, DP and PA and occupation

Occupation				
	Emotional Exhaustion			
	Low	**Average**	**High**	**Row Total**

Physiotherapist	2	4	7	13
	15.38%	30.77%	53.85%	
Occupational Therapists	5	0	9	14
	35.71%	0.00%	64.29%	
Therapy Assistant	2	2	3	7
	28.57%	28.57%	42.86%	
Social Worker	1	1	2	4
	25.00%	25.00%	50.00%	
Dietician	0	0	1	1
	0.00%	0.00%	100.00%	
Speech Therapist	0	2	3	5
	0.00%	40.00%	60.00%	
Psychologist	2	0	3	5
	40.00%	0.00%	60.00%	
Totals	12	9	28	49
	Depersonalisation			
	Low	**Average**	**High**	**Row Total**
Physiotherapist	6	4	3	13
	46.15%	30.77%	23.08%	
Occupational Therapists	8	4	2	14
	57.14%	28.57%	14.29%	
Therapy Assistant	4	2	1	7
	57.14%	28.57%	14.29%	
Social Worker	2	1	1	4
	50.00%	25.00%	25.00%	
Dietician	0	0	1	1
	0.00%	0.00%	100.00%	
Speech Therapist	2	2	1	5
	40.00%	40.00%	20.00%	
Psychologist	3	1	1	5
	60.00%	20.00%	20.00%	
Totals	25	14	10	49
	Personal Accomplishment			
	Low	**Average**	**High**	**Row Total**
Physiotherapist	4	3	6	13

	30.77%	23.08%	46.15%	
Occupational Therapists	4	8	2	14
	28.57%	57.14%	14.29%	
Therapy Assistant	5	1	1	7
	71.42%	14.29%	14.29%	
Social Worker	2	1	1	4
	50.00%	25.00%	25.00%	
Dietician	0	1	0	1
	0.00%	100.00%	0.00%	
Speech Therapist	1	3	1	5
	20.00%	60.00%	20.00%	
Psychologist	3	1	1	5
	60.00%	20.00%	20.00%	
Totals	19	18	12	49

Occupation showed no statistically significant impact on the dimensions of burnout with p values of .24747 (EE), .97277 (DP) and .36313 (PA).

4.5.3 Total years of work experience

Table 4.14 shows the two groups with the highest representation to be those with more than ten years experience (20; 40.81%) and the group who has between two to four years experience (12; 24.48%). In all the categories of years of work experience high levels of EE were found. The group with the highest percentage of high EE levels were the group who had 5 – 6 years work experience. The groups with the highest percentage of DP were the groups who had between 5 and 8 years experience. The groups with reduced PA were those who had the least and most years experience.

Table 4.14 Association between EE, DP and PA and total years' work experience

Total years work experience				
	Emotional Exhaustion			
	Low	**Average**	**High**	**Row Total**
2 – 4 years	2	2	8	12
	16.67%	16.67%	66.66%	
5 – 6 years	1	0	5	6
	16.67%	0.00%	83.33%	

7 – 8 years	0	4	5	9
	0.00%	44.44%	55.56%	
9 – 10 years	1	0	1	2
	50.00%	0.00%	50.00%	
> 10 years	8	3	9	20
	40.00%	15.00%	45.00%	
Totals	12	9	28	49
	Depersonalisation			
	Low	**Average**	**High**	**Row Total**
2 – 4 years	7	4	1	12
	58.33%	33.33%	8.34%	
5 – 6 years	2	2	2	6
	33.33%	33.33%	33.33%	
7 – 8 years	2	4	3	9
	22.22%	44.45%	33.33%	
9 – 10 years	1	1	0	2
	50.00%	50.00%	0.00%	
> 10 years	13	3	4	20
	65.00%	15.00%	20.00%	
Totals	25	14	10	49
	Personal Accomplishment			
	Low	**Average**	**High**	**Row Total**
2 – 4 years	6	4	2	12
	50.00%	33.33%	16.57%	
5 – 6 years	1	3	2	6
	16.67%	50.00%	33.33%	
7 – 8 years	2	5	2	9
	22.22%	55.56%	22.22%	
9 – 10 years	0	2	0	2
	0.00%	100.00%	0.00%	
> 10 years	10	4	6	20
	50.00%	20.00%	30.00%	
Totals	19	18	12	49

The number of years of experience showed no statistically significant impact on EE (p=.08647), DP (p=.36871) or PA (p=.24386).

4.5.4 Total number of years employed in current position

Table 4.15 shows that the majority of therapists have been in their current positions for zero to four years (35; 71.42%) and only four (8.16%) have been with the company longer than nine years. All the categories experienced high EE levels, except for the 7 – 8 years. For DP the highest representation of the therapists was in the low category, except for the ≥9 years that had equal percentage representation in both the high and low categories.

Table 4.15 Association between EE, DP and PA and number of years in current position

Years experience in current position				
	Emotional Exhaustion			
	Low	Average	High	Row Total
0 – 1 years	4	4	12	20
	20.00%	20.00%	60.00%	
2 – 4 years	6	0	9	15
	40.00%	0.00%	60.00%	
5 – 6 years	0	2	4	6
	0.00%	33.33%	66.67%	
7 – 8 years	1	2	1	4
	25.00%	50.00%	25.00%	
≥ 9 years	1	1	2	4
	25.00%	25.00%	50.00%	
Totals	12	9	28	49
	Depersonalisation			
	Low	Average	High	Row Total
0 – 1 years	9	6	5	20
	45.00%	30.00%	25.00%	
2 – 4 years	8	5	2	15
	53.33%	33.34%	13.33%	
5 – 6 years	4	1	1	6
	66.66%	16.67%	16.67%	
7 – 8 years	2	2	0	4
	50.00%	50.00%	0.00%	
≥ 9 years	2	0	2	4
	50.00%	0.00%	50.00%	

Totals	25	14	10	49
	Personal Accomplishment			
	Low	**Average**	**High**	**Row Total**
0 – 1 years	7	10	3	20
	35.00%	50.00%	15.00%	
2 – 4 years	6	4	5	15
	40.00%	26.67%	33.33%	
5 – 6 years	2	1	3	6
	33.33%	16.67%	50.00%	
7 – 8 years	2	2	0	4
	50.00%	50.00%	0.00%	
≥ 9 years	2	1	1	4
	50.00%	25.00%	25.00%	
Totals	19	18	12	49

The number of years in the current position had no statistically significant impact on EE (p=.10739), DP (p=.51300) or PA (p=.50254).

4.5.5 Hours employed per week

Table 4.16 shows that the majority of therapists (30; 61.22%) had been employed to work between 33 – 40 hours per week.

Table 4.16 Association between EE, DP and PA and number of hours employed

Hours employed				
	Emotional Exhaustion			
	Low	**Average**	**High**	**Row Total**
1 – 8 hours	1	0	1	2
	50.00%	0.00%	50.00%	
9 – 16 hours	0	0	1	1
	0.00%	0.00%	100.00%	
17 – 24 hours	1	0	3	4
	25.00%	0.00%	75.00%	
25 – 32 hours	5	3	4	12
	41.67%	25.00%	33.33%	
33 – 40 hours	5	6	19	30
	16.67%	20.00%	63.33%	

Total	12	9	28	49
	Depersonalisation			
	Low	**Average**	**High**	**Row Total**
1 – 8 hours	2	0	0	2
	100.00%	0.00%	0.00%	
9 – 16 hours	0	1	0	1
	0.00%	100.00%	0.00%	
17 – 24 hours	3	1	0	4
	75.00%	25.00%	0.00%	
25 – 32 hours	7	2	3	12
	58.33%	16.67%	25.00%	
33 – 40 hours	13	10	7	30
	43.33%	33.34%	23.33%	
Total	25	14	10	49
	Personal Accomplishment			
	Low	**Average**	**High**	**Row Total**
1 – 8 hours	1	1	0	2
	50.00%	50.00%	0.00%	
9 – 16 hours	0	1	0	1
	0.00%	100.00%	0.00%	
17 – 24 hours	2	2	0	4
	50.00%	50.00%	0.00%	
25 – 32 hours	5	6	1	12
	41.67%	50.00%	8.33%	
33 – 40 hours	11	8	11	30
	36.66%	26.67%	36.67%	
Total	19	18	12	49

The number of hours employed showed no statistically significant impact on the dimensions with p values of .44461 (EE), .35157 (DP) and .25364 (PA).

4.5.6 Income bracket (gross monthly income)

According to Table 4.17 the largest single proportion (23; 46.93%) of the therapists earn between R10 000 – R15 000 per month, with five (10.2%) earning

less than R5 000.00 per month and five (10.2%) earning more than R15 000.00 per month.

Table 4.17 indicates that 15 (65.22%) members from the R10 001 – R15 000 income group experienced high levels of EE (although not statistically significant with a p value of .51131). Earning less than R15 000 was statistically significantly associated with reduced PA (p = .02262). Income level had no significant impact on DP (p=.73019).

Table 4.17 Association between EE, DP and PA and income

Income				
	Emotional Exhaustion			
	Low	**Average**	**High**	**Row Total**
R0 - R5000	2	0	3	5
	40.00%	0.00%	60.00%	
R5001 - R10 000	5	3	8	16
	31.25%	18.75%	50.00%	
R10 001 - R15 000	3	5	15	23
	13.04%	21.74%	65.22%	
R15 001 – R20 000	2	1	2	5
	40.00%	20.00%	40.00%	
Totals	12	9	28	49
	Depersonalisation			
	Low	**Average**	**High**	**Row Total**
R0 - R5000	2	2	1	5
	40.00%	40.00%	20.00%	
R5001 - R10 000	10	4	2	16
	62.50%	25.00%	12.50%	
R10 001 - R15 000	12	6	5	23
	52.17%	26.09%	21.74%	
R15 001 – R20 000	1	2	2	5
	20.00%	40.00%	40.00%	
Totals	25	14	10	49
	Personal Accomplishment			
	Low	**Average**	**High**	**Row Total**
R0 - R5000	3	0	2	5

	60.00%	0.00%	40.00%	
R5001 - R10 000	7	8	1	16
	43.75%	50.00%	6.25%	
R10 001 - R15 000	6	10	7	23
	26.09%	43.48%	30.43%	
R15 001 – R20 000	3	0	2	5
	60.00%	0.00%	40.00%	
Totals	19	18	12	49

4.5.7 Market-related salary

The majority of the therapists (35; 71.42%) were of the opinion that their salaries were not market-related. Although not statistically significant, Table 4.18 shows that in two of the three categories more therapists who saw their salaries as not market-related score within ranges that are indicative of burnout than therapists who saw their salaries as market-related. Of the fourteen therapists who regarded their salary as market-related seven (50.00%) experienced high EE, two (14.29%) experienced high DP and six (42.85%) experienced reduced PA. Thirty-five therapists regarded their salaries as not market-related, 21 (60%) of them experienced high EE and eight (22.86%) experienced high DP and 13 (37.14%) experienced reduced PA.

Table 4.18 Association between EE, DP and PA and salary (market-related)

Salary (market-related)				
	Emotional Exhaustion			
	Low	**Average**	**High**	**Row Total**
Yes	2	5	7	14
	14.29%	35.71%	50.00%	
No	10	4	21	35
	28.57%	11.43%	60%	
Totals	12	9	28	49
	Depersonalisation			
	Low	**Average**	**High**	**Row Total**
Yes	9	3	2	14
	64.29%	21.43%	14.28%	
No	16	11	8	35

	45.71%	31.43%	22.86%	
Totals	25	14	10	49
	Personal Accomplishment			
	Low	**Average**	**High**	**Row Total**
Yes	6	6	2	14
	42.86%	42.86%	14.28%	
No	13	12	10	35
	37.14%	34.29%	28.57%	
Totals	19	18	12	49

However, statistically there was no significant impact on any of the domains with p values of .13801(EE), .49579 (DP) and .54784 (PA).

4.5.8 Work other than work at Life Rehabilitation

Table 4.19 indicates that of the 49 therapists, 21 (42.85%) were doing additional work to supplement their income. It further indicates that of the 21 therapists who were doing additional work fifteen (71.43%) showed high levels of EE. Of the 28 therapists who were not doing additional work thirteen (46.43%) had high EE. This difference was only just not statistically significant, with a p value of .05866. There were no major differences between DP and reduced PA scores and it was also not statistically significant with p values of .97685 and .71789 respectively.

Table 4.19 Association between EE, DP and PA and additional work

Additional work				
	Emotional Exhaustion			
	Low	**Average**	**High**	**Row Total**
Yes	5	1	15	21
	23.81%	4.76%	71.43%	
No	7	8	13	28
	25.00%	28.57%	46.43%	
Totals	12	9	28	49
	Depersonalisation			
	Low	**Average**	**High**	**Row Total**
Yes	11	6	4	21
	52.38%	28.57%	19.05%	
No	14	8	6	28

	50.00%	28.57%	21.43%	
Totals	25	14	10	49
	Personal Accomplishment			
	Low	**Average**	**High**	**Row Total**
Yes	7	9	5	21
	33.33%	42.86%	23.81%	
No	12	9	7	28
	42.86%	32.14%	25.00%	
Totals	19	18	12	49

4.5.9 Hours spent on additional work

Table 4.20 indicates that of the 21 therapists who did additional work, the highest single proportions spent between zero and five hours (8, 16.32%) and 11 – 15 hours (7; 14, 28%) on additional work per week. The two who worked more than 20 additional hours a week had the highest percentage of EE (100.00%) and DP (50.00%) scores.

Table 4.20 Association between EE, DP and PA and additional hours worked

Additional work hours				
	Emotional Exhaustion			
	Low	**Average**	**High**	**Row Total**
0 – 5 hours	2	1	5	8
	25.00%	12.50%	62.50%	
6 – 10 hours	1	0	2	3
	33.33%	0.00%	66.67%	
11 – 15 hours	1	0	6	7
	14.29%	0.00%	85.71%	
16 – 20 hours	1	0	0	1
	100.00%	0.00%	0.00%	
> 20 hours	0	0	2	2
	0.00%	0.00%	100.00%	
Totals	5	1	15	21
	Depersonalisation			
	Low	**Average**	**High**	**Row Total**
0 – 5 hours	5	3	0	8
	62.50%	37.50%	0.00%	

6 – 10 hours	2	0	1	3
	66.67%	0.00	33.33%	
11 – 15 hours	3	2	2	7
	42.86%	28.57%	28.57%	
16 – 20 hours	1	0	0	1
	100.00%	0.00%	0.00%	
> 20 hours	0	1	1	2
	0.00%	50.00%	50.00%	
Totals	11	6	4	21
	Personal Accomplishment			
	Low	**Average**	**High**	**Row Total**
0 – 5 hours	2	6	0	8
	25.00%	75.00%	0.00%	
6 – 10 hours	1	0	2	3
	33.33%	0.00%	66.67%	
11 – 15 hours	2	2	3	7
	28.57%	28.57%	42.86%	
16 – 20 hours	1	0	0	1
	100.00%	0.00%	0.00%	
> 20 hours	1	1	0	2
	50.00%	50.00%	0.00%	
Totals	7	9	5	21

EE, DP and PA were not influenced statistically significantly by doing additional work with p values of respectively .58374, .24845 and .07458.

4.5.10 Working during weekends and/or on Public Holidays

Table 4.21 indicates that the majority of therapists (45; 91.83%) had to work over weekends and Public Holidays.

Table 4.21 Association between EE, DP and PA and weekend work

Weekend work				
	Emotional Exhaustion			
	Low	**Average**	**High**	**Row Total**
Yes	11	9	25	45
	24.44%	20.00%	55.56%	

No	1	0	3	4
	25.00%	0.00%	75.00%	
Totals	12	9	28	49
	Depersonalisation			
	Low	**Average**	**High**	**Row Total**
Yes	24	14	7	45
	53.33%	31.11%	15.56%	
No	1	0	3	4
	25.00%	0.00%	75.00%	
Totals	25	14	10	49
	Personal Accomplishment			
	Low	**Average**	**High**	**Row Total**
Yes	17	17	11	45
	37.78%	37.78%	24.44%	
No	2	1	1	4
	50.00%	25.00%	25.00%	
Totals	19	18	12	49

Weekend work had no statistically significant impact on EE (p=.41554) and PA (p=.85497), but had statistically significant impact on DP (p=.02882). However, in this case it is the group that is not working over weekends that has the higher burnout prevalence in this category.

4.5.11 Overtime

Table 4.22 indicates that the majority of therapists (31; 63.26%) worked overtime. They work mostly between one and ten hours overtime per month. Working overtime showed no statistically significant impact on the three burnout dimensions with p values of .86166 (EE), .30483 (DP) and .14919 (PA) respectively. The amount of overtime showed no statistically significant impact on EE and DP with p values of .59718 and .10802 respectively. However it did have a statistically significant impact on PA with a p value of .04521.

Table 4.22 Association between EE, DP and PA and the amount of overtime

Hours overtime				
	Emotional Exhaustion			
	Low	**Average**	**High**	**Row Total**

No overtime	4	4	10	18
	22.22%	22.22%	55.56%	
1 – 5 hours	3	2	7	12
	25.00%	16.67%	58.33%	
6 – 10 hours	3	1	7	11
	27.27%	9.09%	63.64%	
11 – 15 hours	0	1	3	4
	0.00%	25.00%	75.00%	
16 – 20 hours	1	0	0	1
	100.00%	0.00%	0.00%	
> 20 hours	1	1	1	3
	33.33%	33.33%	33.33%	
Totals	12	9	28	49
	Depersonalisation			
	Low	**Average**	**High**	**Row Total**
No overtime	10	3	5	18
	55.55%	16.67%	27.78%	
0 – 5 hours	5	5	2	12
	41.66%	41.67%	16.67%	
6 – 10 hours	8	1	2	11
	72.73%	9.09%	18.18%	
11 – 15 hours	0	3	1	4
	0.00%	75.00%	25.00%	
16 – 20 hours	1	0	0	1
	100.00%	0.00%	0.00%	
> 20 hours	1	2	0	3
	33.33%	66.67%	0.00%	
Totals	25	14	10	49
	Personal Accomplishment			
	Low	**Average**	**High**	**Row Total**
No overtime	10	4	4	18
	55.56%	22.22%	22.22%	
0 – 5 hours	5	5	2	12
	41.66%	41.67%	16.67%	
6 – 10 hours	2	3	6	11

	18.18%	27.27%	54.55%	
11 – 15 hours	0	4	0	4
	0.00%	100.00%	0.00%	
16 – 20 hours	1	0	0	1
	100.00%	0.00%	0.00%	
> 20 hours	1	2	0	3
	33.33%	66.67%	0.00%	
Totals	19	18	12	49

4.5.12 Working fewer hours than required by contract

Table 4.23 indicates that ten (20.40%) therapists worked fewer hours than what they were employed to work. The therapists who worked fewer hours than required by contract had a higher percentage of high EE levels than those who did not work fewer hours. Those who did not work fewer hours had higher DP rates, but the percentage representation of therapists who had decreased PA was relatively the same for both those who worked fewer hours and those who did not.

Table 4.23 Association between EE, DP and PA and working fewer hours

Less hours				
	Emotional Exhaustion			
	Low	**Average**	**High**	**Row Total**
Yes	3	0	7	10
	30.00%	0.00%	70.00%	
No	9	9	21	39
	23.07%	23.08%	53.85%	
Totals	12	9	28	49
	Depersonalisation			
	Low	**Average**	**High**	**Row Total**
Yes	5	4	1	10
	50.00%	40.00%	10.00%	
No	20	10	9	39
	51.28%	25.64%	23.08%	
Totals	25	14	10	49
	Personal Accomplishment			

	Low	Average	High	Row Total
Yes	4	4	2	10
	40.00%	40.00%	20.00%	
No	15	14	10	39
	38.46%	35.90%	25.64%	
Totals	19	18	12	49

Working less hours than what their contract stipulates showed no statistically significant impact on burnout with p values of .10016 (EE), .51800 (DP) and .92813 (PA) respectively.

4.5.13 Number of days leave taken during the past twelve months

Table 4.24 indicates that the majority of therapists (32; 65.30%) took between 11 and 20 days annual leave for the year.

Table 4.24 Association between EE, DP and PA and annual leave

Annual leave				
	Emotional Exhaustion			
	Low	**Average**	**High**	**Row Total**
None	2	0	2	4
	50.00%	0.00%	50.00%	
1 – 5 days	0	2	3	5
	0.00%	40.00%	60.00%	
6 – 10 days	2	2	2	6
	33.33%	33.33%	33.33%	
11 – 15 days	2	1	12	15
	13.33%	6.67%	80.00%	
16 – 20 days	5	3	9	17
	29.41%	17.65%	52.94%	
> 20 days	1	1	0	2
	50.00%	50.00%	0.00%	
Totals	12	9	28	49
	Depersonalisation			
	Low	**Average**	**High**	**Row Total**
None	3	0	1	4
	75.00%	0.00%	25.00%	

1 – 5 days	1	3	1	5
	20.00%	60.00%	20.00%	
6 – 10 days	3	2	1	6
	50.00%	33.33%	16.67%	
11 – 15 days	7	5	3	15
	46.67%	33.33%	20.00%	
16 – 20 days	10	3	4	17
	58.82%	17.65%	23.53%	
> 20 days	1	1	0	
	50.00%	50.00%	0.00%	
Totals	25	14	10	49
	Personal Accomplishment			
	Low	**Average**	**High**	**Row Total**
None	2	1	1	4
	50,00%	25.00%	25.00%	
1 – 5 days	0	5	0	5
	0.00%	100.00%	0.00%	
6 – 10 days	2	2	2	6
	33.33%	33.33%	33.33%	
11 – 15 days	7	4	4	15
	46.66%	26.67%	26.67%	
16 – 20 days	7	6	4	17
	41.18%	35.29%	23.53%	
> 20 days	1	0	1	2
	50.00%	0.00%	50.00%	
Totals	19	18	12	49

Number of days of leave taken had no statistically significant impact on EE with a p value of .15339, or on DP with a p value of .65906 or PA with a p value of .21102.

4.5.14 Unpaid leave during the past twelve months

Table 4.25 shows that the majority of therapists (41; 83.67%) did not take unpaid leave during the past year. Although the results are widely spread in this table, it

is noteworthy that all the therapists had high EE scores, no matter whether they took unpaid leave or not or how many days of unpaid leave they took.

Table 4.25 Association between EE, DP and PA and unpaid leave

Unpaid leave				
	Emotional Exhaustion			
	Low	Average	High	Row Total
None	12	8	21	41
	29.27%	19.51%	51.22%	
1 – 5 days	0	1	3	4
	0.00%	25.00%	75.00%	
6 – 10 days	0	0	1	1
	0.00%	0.00%	100.00%	
11 – 15 days	0	0	1	1
	0.00%	0.00%	100.00%	
16 – 20 days	0	0	1	1
	0.00%	0.00%	100.00%	
> 20 days	0	0	1	1
	0.00%	0.00%	100.00%	
Totals	12	9	28	49
	Depersonalisation			
	Low	Average	High	Row Total
None	21	11	9	41
	51.22%	26.83%	21.95%	
1 – 5 days	2	2	0	4
	50.00%	50.00%	0.00%	
6 – 10 days	0	1	0	1
	0.00%	100.00%	0.00%	
11 – 15 days	1	0	0	1
	100.00%	0.00%	0.00%	
16 – 20 days	0	0	1	1
	0.00%	0.00%	100.00%	
> 20 days	1	0	0	1
	100.00%	0.00%	0.00%	
Totals	25	14	10	49
	Personal Accomplishment			

	Low	Average	High	Row Total
None	18	13	10	41
	43.90%	31.71%	24.39%	
1 – 5 days	0	3	1	4
	0.00%	75.00%	25.00%	
6 – 10 days	0	1	0	1
	0.00%	100.00%	0.00%	
11 – 15 days	0	0	1	1
	0.00%	0.00%	100.00%	
16 – 20 days	1	0	0	1
	100.00%	0.00%	0.00%	
> 20 days	0	1	0	1
	0.00%	100.00%	0.00%	
Totals	19	18	12	49

Unpaid leave showed no statistically significant impact on the burnout dimensions with p values of .68970 (EE), .38749 (DP) and .19201 (PA) respectively.

4.5.15 Sick leave during the past twelve months

Table 4.26 shows that the majority of therapists (32; 65.30%) took between one and ten days sick leave, while twelve (24.49%) took no sick leave during the preceding year. The two groups who took the most sick leave (≥16 days) had the highest EE (100%) levels. However, it should be noted that all of the therapists who took sick leave had high EE scores. The groups who took between one and ten days sick leave had the lowest PA (50.00% and 37.50%) scores.

Table 4.26 Association between EE, DP and PA and amount of sick leave taken

Sick leave				
	Emotional Exhaustion			
	Low	**Average**	**High**	**Row Total**
None	6	3	3	12
	50.00%	25.00%	25.00%	
1 – 5 days	4	4	16	24
	16.66%	16.67%	66.67%	
6 – 10 days	1	2	5	8
	12.50%	25.00%	62.50%	

11 – 15 days	1	0	1	2
	50.00%	0.00%	50.00%	
16 – 20 days	0	0	1	1
	0.00%	0.00%	100.00%	
> 20 days	0	0	2	2
	0.00%	0.00%	100.00%	
Totals	12	9	28	49
	Depersonalisation			
	Low	**Average**	**High**	**Row Total**
None	10	1	1	12
	83.34%	8.33%	8.33%	
1 – 5 days	10	7	7	24
	41.66%	29.17%	29.17%	
6 – 10 days	4	3	1	8
	50.00%	37.50%	12.50%	
11 – 15 days	0	2	0	2
	0.00%	100.00%	0.00%	
16 – 20 days	0	1	0	1
	0.00%	100.00%	0.00%	
> 20 days	1	0	1	2
	50.00%	0.00%	50.00%	
Totals	25	14	10	49
	Personal Accomplishment			
	Low	**Average**	**High**	**Row Total**
None	6	3	3	12
	50.00%	25.00%	25.00%	
1 – 5 days	9	10	5	24
	37.50%	41.67%	20.83%	
6 – 10 days	4	2	2	8
	50.00%	25.00%	25.00%	
11 – 15 days	0	1	1	2
	0.00%	50.00%	50.00%	
16 – 20 days	0	1	0	1
	0.00%	100.00%	0.00%	
> 20 days	0	1	1	2

	0.00%	50.00%	50.00%	
Totals	19	18	12	49

Sick leave showed no statistically significant impact on the burnout dimensions with p values of .29633 (EE), .08490 (DP) and .64504 (PA).

4.5.16 Support systems at work

Table 4.27 indicates that the group who felt they had a poor support system at work scored the highest in EE. However, no matter which group the therapists chose they all presented with high EE scores. The group with the highest percentage of DP (27.59%) scores was those who felt they had a fairly good support system. With regard to PA the highest percentage (60.00%) came from the group who felt they had poor support systems at work.

Table 4.27 Association between EE, DP and PA and support system at work

Support system at work				
	Emotional Exhaustion			
	Low	**Average**	**High**	**Row Total**
None	1	0	1	2
	50.00%	0.00%	50.00%	
Poor	1	0	4	5
	20.00%	0.00%	80.00%	
Fairly good	6	8	15	29
	20.69%	27.59%	51.72%	
Excellent	4	1	8	13
	30.77%	7.69%	61.54%	
Totals	12	9	28	49
	Depersonalisation			
	Low	**Average**	**High**	**Row Total**
None	0	2	0	2
	0.00%	100.00%	0.00%	
Poor	3	1	1	5
	60.00%	20.00%	20.00%	
Fairly good	12	9	8	29
	41.38%	31.03%	27.59%	
Excellent	10	2	1	13

	76.92%	15.38%	7.70%	
Totals	25	14	10	49
	Personal Accomplishment			
	Low	**Average**	**High**	**Row Total**
None	0	1	1	2
	0.00%	50.00%	50.00%	
Poor	3	2	0	5
	60.00%	40.00%	0.00%	
Fairly good	10	12	7	29
	34.48%	41.38%	24.14%	
Excellent	6	3	4	13
	46.15%	23.08%	30.77%	
Totals	19	18	12	49

Support system at work showed no statistically significant impact on the dimensions of burnout with p values of .39968 (EE), .11267 (DP) and .37582 (PA).

4.5.17 Coping strategies and skills to deal with stress at work

The majority of the therapists (34; 69.38%) viewed their coping mechanisms and skills at work as fairly good. Table 4.28 shows that the therapists who felt that they had either no or poor coping strategies and skills to deal with stress had the highest EE rate (100.00%) and this was statistically significant (p=.03180). The group that scored the highest in DP (50.00%) were those who felt that they had poor coping strategies. The groups who had the highest percentages of low PA scores were those with fairly good (32.35%) and excellent (75.00%) coping strategies. However it had no statistically significant impact on DP and PA with p values respectively of (p=.44805) and (p=.15304).

Table 4.28 Association between EE, DP and PA and coping strategies

Coping strategies				
	Emotional Exhaustion			
	Low	**Average**	**High**	**Row Total**
None	0	0	1	1
	0.00%	0.00%	100.00%	
Poor	0	0	6	6
	0.00%	0.00%	100.00%	

Fairly good	7	8	19	34
	20.59%	23.53%	55.88%	
Excellent	5	1	2	8
	62.50%	12.50%	25.00%	
Totals	12	9	28	49
	Depersonalisation			
	Low	**Average**	**High**	**Row Total**
None	0	1	0	1
	0.00%	100.00%	0.00%	
Poor	2	1	3	6
	33.33%	16.67%	50.00%	
Fairly good	18	10	6	34
	52.94%	29.41%	17.65%	
Excellent	5	2	1	8
	62.50%	25.00%	12.50%	
Totals	25	14	10	49
	Personal Accomplishment			
	Low	**Average**	**High**	**Row Total**
None	0	1	0	1
	0.00%	100.00%	0.00%	
Poor	2	1	3	6
	33.33%	16.67%	50.00%	
Fairly good	11	15	8	34
	32.35%	44.12%	23.53%	
Excellent	6	1	1	8
	75.00%	12.50%	12.50%	
Totals	19	18	12	49

4.5.18 Job competency

The majority of therapists felt either fairly (17; 34.69%) or very competent (25; 51.02%) in their jobs. Table 4.29 shows that the highest percentage (71.43% and 42.86%) of the group who only sometimes felt competent in their jobs had high EE and DP scores. Those who felt very competent in their job had the highest percentage (52.00%) of low PA.

Table 4.29 Association between EE, DP and PA and job competency

Job competency				
	Emotional Exhaustion			
	Low	Average	High	Row Total
Sometimes	2	0	5	7
	28.57%	0.00%	71.43%	
Fairly competent	3	6	8	17
	17.65%	35.29%	47.06%	
Very competent	7	3	15	25
	28.00%	12.00%	60.00%	
Totals	12	9	28	49
	Depersonalisation			
	Low	Average	High	Row Total
Sometimes	4	0	3	7
	57.14%	0.00%	42.86%	
Fairly competent	8	6	3	17
	47.06%	35.29%	17.65%	
Very competent	13	8	4	25
	52.00%	32.00%	16.00%	
Totals	25	14	10	49
	Personal Accomplishment			
	Low	Average	High	Row Total
Sometimes	2	1	4	7
	28.57%	14.29%	57.14%	
Fairly competent	4	9	4	17
	23.53%	52.94%	23.53%	
Very competent	13	8	4	25
	52.00%	32.00%	16.00%	
Totals	19	18	12	49

Job competency showed no statistically significant impact on any of the dimensions of burnout with p values of .17134 (EE), .19257 (DP) and .09356 (PA).

4.5.19 Job confidence

The majority of the therapists felt either fairly (20; 40.81%) or very confident (22; 44.89%) regarding their jobs. Table 4.30 indicates that the group who only sometimes felt confident in their job had the highest EE (71.43%) and DP (42.86%) scores. However the group who felt very confident had the highest percentage (50.00%) of low PA scores.

Table 4.30 Association between EE, DP and PA and job confidence

Job confidence				
	Emotional Exhaustion			
	Low	Average	High	Row Total
Sometimes	2	0	5	7
	28.57%	0.00%	71.43%	
Fairly confident	4	6	10	20
	20.00%	30.00%	50.00%	
Very confident	6	3	13	22
	27.27%	13.64%	59.09%	
Totals	12	9	28	49
	Depersonalisation			
	Low	Average	High	Row Total
Sometimes	3	1	3	7
	42.85%	14.29%	42.86%	
Fairly confident	10	7	3	20
	50.00%	35.00%	15.00%	
Very confident	12	6	4	22
	54.55%	27.27%	18.18%	
Totals	25	14	10	49
	Personal Accomplishment			
	Low	Average	High	Row Total
Sometimes	2	1	4	7
	28.57%	14.29%	57.14%	
Fairly confident	6	9	5	20
	30.00%	45.00%	25.00%	
Very confident	11	8	3	22
	50.00%	36.36%	13.64%	
Totals	19	18	12	49

Job confidence showed no statistically significant impact on burnout with p values of .30619 (EE), .60396 (DP) and .17347 (PA).

4.5.20 Total workload

The majority of therapists (35; 71.42%) were of the opinion that their workload was either above average (18; 37.73%) or overwhelming (17; 34.69%) (see Table 4.31). The therapist who felt that his/her work load was too small had a high EE score, as did 88.23% (15) of the group who felt their work load was overwhelming. The group who felt that their workload was overwhelming had the highest percentage of high DP scores (29.41%), but 58.33% of the group who felt their workload was sufficient had low PA scores.

Table 4.31 Association between EE, DP and PA and workload

Work load				
	Emotional Exhaustion			
	Low	Average	High	Row Total
Too small	0	0	1	1
	0.00%	0.00%	100.00%	
Sufficient	5	3	4	12
	41.67%	25.00%	33.33%	
Above average	6	5	7	18
	33.33%	27.78%	38.89%	
Overwhelming	1	1	15	17
	5.88%	5.88%	88.24%	
Totals	12	9	27	48
	Depersonalisation			
	Low	Average	High	Row Total
Too small	1	0	0	1
	100.00%	0.00%	0.00%	
Sufficient	10	1	1	12
	83.34%	8.33%	8.33%	
Above average	10	4	4	18
	55.56%	22.22%	22.22%	
Overwhelming	3	9	5	17
	17.65%	52.94%	29.41%	

Totals	24	14	10	48
	Personal Accomplishment			
	Low	**Average**	**High**	**Row Total**
Too small	0	1	0	1
	0.00%	100.00%	0.00%	
Sufficient	7	4	1	12
	58.33%	33.34%	8.33%	
Above average	6	6	6	18
	33.33%	33.33%	33.33%	
Overwhelming	5	7	5	17
	29.41%	41.18	29.41%	
Totals	18	18	12	48

The size of the workload (overwhelmingly high) had a statistically significant impact on EE and DP with p values of .03972 and .01227 respectively. It did not have a statistically significant impact on PA (p = .15474). Workload includes patient load, administration, research, meetings and all other activities of a work day.

4.5.21 Patient load

Twenty-one (43.75%) of the therapists felt that their patient load was above average and 11 (22.91%) felt that their patient load was overwhelming (Table 4.32). The one therapist who felt that his/her patient load was too small scored high in EE, as did all 11 who felt that their patient load was overwhelming. The highest percentage (36.36%) of the group who felt that their patient load was overwhelming scored high in DP. Twelve of the therapists in the group who felt their load was sufficient scored low for DP in comparison with the one therapist who scored high for DP in this category. In contrast 46.67% of those who felt their patient load was sufficient had low PA scores.

Table 4.32 Association between EE, DP and PA and patient load

Patient load				
	Emotional Exhaustion			
	Low	**Average**	**High**	**Row Total**
Too small	0	0	1	1
	0.00%	0.00%	100.00%	

Sufficient	6	4	5	15
	40.00%	26.67%	33.33%	
Above average	6	5	10	21
	28.57%	23.81%	47.62%	
Overwhelming	0	0	11	11
	0.00%	0.00%	100.00%	
Totals	12	9	27	48
	Depersonalisation			
	Low	**Average**	**High**	**Row Total**
Too small	1	0	0	1
	100.00%	0.00%	0.00%	
Sufficient	12	2	1	15
	80.00%	13.33%	6.67%	
Above average	8	8	5	21
	38.10%	38.10%	23.80%	
Overwhelming	3	4	4	11
	27.28%	36.36%	36.36%	
Totals	24	14	10	48
	Personal Accomplishment			
	Low	**Average**	**High**	**Row Total**
Too small	0	1	0	1
	0.00%	100.00%	0.00%	
Sufficient	7	5	3	15
	46.67%	33.33%	20.00%	
Above average	9	6	6	21
	42.86%	28.57%	28.57%	
Overwhelming	2	6	3	11
	18.18%	54.55%	27.27%	
Totals	18	18	12	48

A high patient load showed a statistically significant impact on EE (p = .02365) but not on DP (p = .09762) and PA (p = .11563).

4.5.22 Administrative duties

The majority of the therapists' workload (33; 67.24%) included up to 25% of administrative duties per day (see Table 4.33). The therapists whose administrative

load represents up to 75% of their duties per day, had the highest EE (66.67%) and DP (66.67%) scores. However, there were only three therapy staff members in this category. The majority (19; 57.58%) of the therapists whose administrative load made up 25% of their duties had high EE scores, while the three therapists who had no administrative duties all experienced low levels of PA. Sixty per cent of the thirteen with more than 50.00% of administrative duties also experienced low levels of PA.

Table 4.33 Association between EE, DP and PA and administrative duties

Percentage of administrative duties				
	Emotional Exhaustion			
	Low	Average	High	Row Total
None	1	1	1	3
	33.33%	33.33%	33.33%	
Up to 25%	8	6	19	33
	24.24%	18.18%	57.58%	
Up to 50%	3	1	6	10
	30.00%	10.00%	60.00%	
Up to 75%	0	1	2	3
	0.00%	33.33%	66.67%	
Totals	12	9	28	49
	Depersonalisation			
	Low	Average	High	Row Total
None	2	0	1	3
	66.67%	0.00%	33.33%	
Up to 25%	15	12	6	33
	45.45%	36.36%	18.19%	
Up to 50%	8	1	1	10
	80.00%	10.00%	10.00%	
Up to 75%	0	1	2	3
	0.00%	33.33%	66.67%	
Totals	25	14	10	49
	Personal Accomplishment			
	Low	Average	High	Row Total
None	3	0	0	3
	100.00%	0.00%	0.00%	
Up to 25%	10	16	7	33

	30.30%	48.49%	21.21%	
Up to 50%	6	0	4	10
	60.00%	0.00%	40.00%	
Up to 75%	0	2	1	3
	0.00%	66.67%	33.33%	
Totals	19	18	12	49

More administrative duties per day showed a statistically significant impact on PA with a p value of .00302 but not on EE and DP with p values of .79251 and .06898 respectively.

4.5.23 Reachable deadlines in work

The majority of therapists (29; 59.18%) were of the opinion that they often have achievable/reachable deadlines (see Table 4.34). The two therapists, who were of the opinion that they never had reachable deadlines in their work, both scored high in EE. In all the groups except for those who "always" had reachable deadlines the highest percentage of therapists had high EE scores. The highest percentage (50.00%) of the group who felt they seldom had reachable deadlines scored high in DP (50.00%), while 70.00% of the group who felt they always have reachable deadlines scored low in PA.

Table 4.34 Association between EE, DP and PA and reachable deadlines

Reachable deadlines				
	Emotional Exhaustion			
	Low	**Average**	**High**	**Row Total**
Never	0	0	2	2
	0.00%	0.00%	100.00%	
Seldom	0	2	6	8
	0.00%	25.00%	75.00%	
Often	7	6	16	29
	24.14%	20.69%	55.17%	
Always	5	1	4	10
	50.00%	10.00%	40.00%	
Totals	12	9	28	49
	Depersonalisation			
	Low	**Average**	**High**	**Row Total**
Never	2	0	0	2

	100.00%	0.00%	0.00%	
Seldom	1	3	4	8
	12.50%	37.50%	50.00%	
Often	15	8	6	29
	51.72%	27.59%	20.69%	
Always	7	3	0	10
	70.00%	30.00%	0.00%	
Totals	25	14	10	49
	Personal Accomplishment			
	Low	**Average**	**High**	**Row Total**
Never	0	1	1	2
	0.00%	50.00%	50.00%	
Seldom	2	3	3	8
	25.00%	37.50%	37.50%	
Often	10	13	6	29
	34.48%	44.83%	20.69%	
Always	7	1	2	10
	70.00%	10.00%	20.00%	
Totals	19	18	12	49

Deadlines which are seldom achieved showed a statistically significant impact on DP with a p value of .03693 but not on EE and PA with p values of .12866 and .19532 respectively.

4.5.24 Role uncertainty in team

As shown in Table 4.35 the majority of therapists (21; 42.85%) never or seldom (16; 32.65%) felt uncertain about their role in the team. The highest percentage (62.50%) of the group who seldom experienced role uncertainty in the team had high EE scores. Of those who were never unsure of their role in the team 57.14% scored low in DP.

Table 4.35 Association between EE, DP and PA and role uncertainty in team

Role uncertainty in team				
	Emotional Exhaustion			
	Low	**Average**	**High**	**Row Total**
Never	5	4	12	21

	23.81%	19.05%	57.14%	
Seldom	3	3	10	16
	18.75%	18.75%	62.50%	
Often	2	1	2	5
	40.00%	20.00%	40.00%	
Always	2	1	4	7
	28.57%	14.29%	57.14%	
Totals	12	9	28	49
	Depersonalisation			
	Low	**Average**	**High**	**Row Total**
Never	12	5	4	21
	57.14%	23.81%	19.05%	
Seldom	9	4	3	16
	56.25%	25.00%	18.75%	
Often	2	1	2	5
	40.00%	20.00%	40.00%	
Always	2	4	1	7
	28.57%	57.14%	14.29%	
Totals	25	14	10	49
	Personal Accomplishment			
	Low	**Average**	**High**	**Row Total**
Never	7	10	4	21
	33.33%	47.62%	19.05%	
Seldom	6	7	3	16
	37.50%	43.75%	18.75%	
Often	2	0	3	5
	40.00%	0.00%	60.00%	
Always	4	1	2	7
	57.14%	14.29%	28.57%	
Totals	19	18	12	49

Role uncertainty showed no statistically significant impact on the dimensions of burnout with p values of .97961 (EE), .67098 (DP) and .18301 (PA).

4.5.25 Conflict with colleagues

Table 4.36 reveals that the majority of therapists (28; 57.14%) seldom experienced conflict with their colleagues. Of the eight therapists who often experienced conflict with their colleagues 87.50% (7) had high EE scores.

Table 4.36 Association between EE, DP and PA and conflict with colleagues

Conflict with colleagues				
	Emotional Exhaustion			
	Low	Average	High	Row Total
Never	4	2	6	12
	33.33%	16.67%	50.00%	
Seldom	6	7	15	28
	21.43%	25.00%	53.57%	
Often	1	0	7	8
	12.50%	0.00%	87.50%	
Always	1	0	0	1
	100.00%	0.00%	0.00%	
Totals	12	9	28	49
	Depersonalisation			
	Low	Average	High	Row Total
Never	6	4	2	12
	50.00%	33.33%	16.67%	
Seldom	15	8	5	28
	53.57%	28.57%	17.86%	
Often	3	2	3	8
	37.50%	25.00%	37.50%	
Always	1	0	0	1
	100.00%	0.00%	0.00%	
Totals	25	14	10	49
	Personal Accomplishment			
	Low	Average	High	Row Total
Never	7	3	2	12
	58.33%	25.00%	16.67%	
Seldom	10	10	8	28
	35.71%	35.71%	28.58%	

Often	2	5	1	8
	25.00%	62.50%	12.50%	
Always	0	0	1	1
	0.00%	0.00%	100.00%	
Totals	19	18	12	49

Conflict with colleagues showed no statistically significant impact on the three dimensions of burnout with p values of .19197 (EE), .81833 (DP) and .30678 (PA) respectively.

4.5.26 Conflict with patients

The majority of therapists (46; 93.87%) never or seldom experienced conflict with patients, as Table 4.37 shows. The two therapists who often experienced conflict with their patients both had scores indicative of high levels of EE and one of them had a score indicative of high levels of DP as well. The majority of participants in the groups who never (10; 55.56%) and seldom (16; 57.14%) experienced conflict with patients also had high EE scores. The group in which the highest percentage (42.86%) had low PA scores was the group who seldom experienced conflict with patients.

Table 4.37 Association between EE, DP and PA and conflict with patients

Conflict with patients				
	Emotional Exhaustion			
	Low	**Average**	**High**	**Row Total**
Never	3	5	10	18
	16.66%	27.78%	55.56%	
Seldom	8	4	16	28
	28.57%	14.29%	57.14%	
Often	0	0	2	2
	0.00%	0.00%	100.00%	
Always	1	0	0	1
	100.00%	0.00%	0.00%	
Totals	12	9	28	49
	Depersonalisation			
	Low	**Average**	**High**	**Row Total**
Never	8	5	5	18
	44.44%	27.78%	27.78%	

Seldom	15	9	4	28
	53.57%	32.14%	14.29%	
Often	1	0	1	2
	50.00%	0.00%	50.00%	
Always	1	0	0	1
	100.00%	0.00%	0.00%	
Totals	25	14	10	49
	Personal Accomplishment			
	Low	**Average**	**High**	**Row Total**
Never	6	8	4	18
	33.33%	44.45%	22.22%	
Seldom	12	10	6	28
	42.86%	35.71%	21.43%	
Often	1	0	1	2
	50.00%	0.00%	50.00%	
Always	0	0	1	1
	0.00%	0.00%	100.00%	
Totals	19	18	12	49

Therapists having conflict with patients, showed no statistically significant impact on burnout with a p value of .34243 (EE), .61982 (DP) and .48847 (PA) respectively.

4.5.27 Authority to make decisions regarding work

Table 4.38 shows that the majority of therapists (28; 57.14%) felt often they had the authority to make decisions at work. The one therapist who felt she/he never had the authority to make decisions regarding her/his work had the highest EE and DP scores as well as a low PA score.

Table 4.38 Association between EE, DP and PA and authority to make decisions

Authority to make decisions				
	Emotional Exhaustion			
	Low	**Average**	**High**	**Row Total**
Never	0	0	1	1
	0.00%	0.00%	100.00%	
Seldom	0	2	4	6

	0.00%	33.33%	66.67%	
Often	8	5	15	28
	28.57%	17.86%	53.57%	
Always	4	2	8	14
	28.57%	14.29%	57.14%	
Totals	12	9	28	49
	Depersonalisation			
	Low	**Average**	**High**	**Row Total**
Never	0	0	1	1
	0.00%	0.00%	100.00%	
Seldom	5	0	1	6
	83.33%	0.00%	16.67%	
Often	11	10	7	28
	39.29%	35.71%	25.00%	
Always	9	4	1	14
	64.29%	28.57%	7.14%	
Totals	25	14	10	49
	Personal Accomplishment			
	Low	**Average**	**High**	**Row Total**
Never	1	0	0	1
	100.00%	0.00%	0.00%	
Seldom	2	2	2	6
	33.33%	33.33%	33.33%	
Often	9	11	8	28
	32.14%	39.29%	28.57%	
Always	7	5	2	14
	50.00%	35.71%	14.29%	
Totals	19	18	12	49

Authority to make decisions showed no statistically significant impact on any of the burnout dimensions with p values of .51682 (EE), .07971 (DP) and .70066 (PA).

4.5.28 Professional prestige

Table 4.39 indicates varied feelings from therapists on how prestigious their professions are, with 27 (50.10%) viewing their professions as never or seldom

prestigious and 22 (44.90%) viewing their professions as often or always prestigious. The highest percentage of the group who were of the opinion that their profession is never seen as prestigious had high EE (85.71%) and DP (28.57%) scores. On the other hand eight (80.00%) of the 10 who see their professions as always prestigious had low PA scores.

Table 4.39 Association between EE, DP and PA and prestige of job/profession

Prestige of job/profession				
	Emotional Exhaustion			
	Low	Average	High	Row Total
Never	1	0	6	7
	14.29	0.00%	85.71%	
Seldom	4	6	10	20
	20.00%	30.00%	50.00%	
Often	4	2	6	12
	33.33%	16.67%	50.00%	
Always	3	1	6	10
	30.00%	10.00%	60.00%	
Totals	12	9	28	49
	Depersonalisation			
	Low	Average	High	Row Total
Never	2	3	2	7
	28.57%	42.86%	28.57%	
Seldom	10	5	5	20
	50.00%	25.00%	25.00%	
Often	7	3	2	12
	58.33%	25.00%	16.67%	
Always	6	3	1	10
	60.00%	30.00%	10.00%	
Totals	25	14	10	49
	Personal Accomplishment			
	Low	Average	High	Row Total
Never	1	4	2	7
	14.29%	57.14%	28.57%	
Seldom	5	8	7	20
	25.00%	40.00%	35.00%	

Often	5	5	2	12
	41.66%	41.67%	16.67%	
Always	8	1	1	10
	80.00%	10.00%	10.00%	
Totals	19	18	12	49

Perceived professional prestige showed no statistically significant impact on any of the burnout dimensions with p values of .37505 (EE), .83048 (DP) and .06754 (PA).

4.5.29 Job satisfaction

More than half of the therapists (26; 53.06%) often experience job satisfaction and another 24.48% (12) always experience job satisfaction. The therapists who seldom experience job satisfaction had the highest percentage of EE (72.73%) and DP (36.36%) scores as shown in Table 4.40. In contrast the highest percentage of those who always experience job satisfaction experience low PA.

Table 4.40 Association between EE, DP and PA and job satisfaction

Job satisfaction				
	Emotional Exhaustion			
	Low	**Average**	**High**	**Row Total**
Seldom	2	1	8	11
	18.18%	9.09%	72.73%	
Often	4	6	16	26
	15.38%	23.08%	61.54%	
Always	6	2	4	12
	50.00%	16.67%	33.33%	
Totals	12	9	28	49
	Depersonalisation			
	Low	**Average**	**High**	**Row Total**
Seldom	4	3	4	11
	36.36%	27.28%	36.36%	
Often	13	8	5	26
	50.00%	30.77%	19.23%	
Always	8	3	1	12
	66.67%	25.00%	8.33%	

Totals	25	14	10	49
	Personal Accomplishment			
	Low	**Average**	**High**	**Row Total**
Seldom	3	4	4	11
	27.28%	36.36%	36.36%	
Often	9	11	6	26
	34.61%	42.31%	23.08%	
Always	7	3	2	12
	58.33%	25.00%	16.67%	
Totals	19	18	12	49

Job satisfaction showed no statistically significant impact on any of the burnout dimensions with p values of .16375 (EE), .49542 (DP) and .52650 (PA).

4.5.30 Postponed treatment of patients

As shown in Table 4.41 the overwhelming majority of therapists (87.75%) never or seldom postpone contact with patients. All six therapists who often delayed treatment of their patients had high EE scores and four of them had high DP scores. Low PA was experienced by nine (45.00%) therapists who never postpone treatment and ten (43.48%) therapists who seldom postpone treatment.

Table 4.41 Association between EE, DP and PA and delayed treatment of patients

Postpone treatment of patients				
	Emotional Exhaustion			
	Low	**Average**	**High**	**Row Total**
Never	6	3	11	20
	30.00%	15.00%	55.00%	
Seldom	6	6	11	23
	26.09%	26.09%	47.82%	
Often	0	0	6	6
	0.00%	0.00%	100.00%	
Totals	12	9	28	49
	Depersonalisation			
	Low	**Average**	**High**	**Row Total**
Never	11	6	3	20
	55.00%	30.00%	15.00%	

Seldom	14	6	3	23
	60.87%	26.09%	13.04%	
Often	0	2	4	6
	0.00%	33.33%	66.67%	
Totals	25	14	10	49
	Personal Accomplishment			
	Low	**Average**	**High**	**Row Total**
Never	9	7	4	20
	45.00%	35.00%	20.00%	
Seldom	10	10	3	23
	43.48%	43.48%	13.04%	
Often	0	1	5	6
	0.00%	16.67%	83.33%	
Totals	19	18	12	49

Postponing contact with patients had a statistically significant impact on both DP (p= .02023) and PA (p= .01164), but not on EE (p = .08633).

4.5.31 Sufficient time to treat patients

Table 4.42 indicates that 27 therapists (55.10%) felt that they have seldom or never enough time to treat their patients while 22 (44.90%) felt that they often or always have sufficient time to treat their patients. From the groups who felt that they never or seldom had enough time to treat their patients 20 (74.00%) had high EE scores. However, 62.50% of the group who felt that they always had enough time had low PA scores.

Table 4.42 Association between EE, DP and PA and sufficient time to treat patients

Sufficient time to treat patients				
	Emotional Exhaustion			
	Low	**Average**	**High**	**Row Total**
Never	0	1	5	6
	0.00%	16.67%	83.33%	
Seldom	3	3	15	21
	14.29%	14.29%	71.42%	
Often	5	3	6	14
	35.71	21.43%	42.86%	
Always	4	2	2	8

	50.00%	25.00%	25.00%	
Totals	12	9	28	49
	Depersonalisation			
	Low	**Average**	**High**	**Row Total**
Never	1	3	2	6
	16.67%	50.00%	33.33%	
Seldom	9	7	5	21
	42.86%	33.33%	23.81%	
Often	9	4	1	14
	64.29%	28.57%	7.14%	
Always	6	0	2	8
	75.00%	0.00%	25.00%	
Totals	25	14	10	49
	Personal Accomplishment			
	Low	**Average**	**High**	**Row Total**
Never	2	2	2	6
	33.33%	33.33%	33.33%	
Seldom	7	7	7	21
	33.33%	33.33%	33.33%	
Often	5	7	2	14
	35.71%	50.00%	14.29%	
Always	5	2	1	8
	62.50%	25.00%	12.50%	
Totals	19	18	12	49

Sufficient time to treat patients showed no statistically significant impact on any of the burnout dimensions with p values of .10830 (EE), .08418 (DP) and .63541 (PA).

4.5.32 Job commitment

Table 4.43 shows that 33 therapists are highly committed to their jobs and 12 (24.49%) think they are overcommitted to their jobs. The three who had low commitment to their jobs all had high EE scores and two of them had high DP scores.

Table 4.43 Association between EE, DP and PA and job commitment

Job commitment				
	Emotional Exhaustion			
	Low	Average	High	Row Total
Low commitment	0	0	3	3
	0.00%	0.00%	100.00%	
High commitment	9	8	16	33
	27.27%	24.24%	48.49%	
Over commitment	3	1	8	12
	25.00%	8.33%	66.67%	
Totals	12	9	27	48
	Depersonalisation			
	Low	Average	High	Row Total
Low commitment	0	1	2	3
	0.00%	33.33%	66.67%	
High commitment	19	9	5	33
	57.58%	27.27%	15.15%	
Over commitment	6	3	3	12
	54.55%	27.27%	18.18%	
Totals	25	13	10	48
	Personal Accomplishment			
	Low	Average	High	Row Total
Low commitment	1	1	1	3
	33.33%	33.33%	33.33%	
High commitment	13	11	9	33
	39.40%	33.33%	27.27%	
Over commitment	5	5	2	12
	41.67%	41.67%	16.66%	
Totals	19	17	12	48

Job commitment showed no statistically significant impact on any of the burnout dimensions with p values of .38753 (EE), .17318 (DP) and .56373 (PA).

4.5.33 Work environment rating

Table 4.44 indicates that the majority of therapists felt that their work environment was either fair (23; 46.98%) or good (19; 38.77%). The three therapists who rated

their work environment as poor had high EE scores, as did 18 of the 23 (78.26%) who rated the work environment as fair. Low DP scores were found for 16 (66.66%) of the 24 therapists who rated their work environment as good or excellent.

Table 4.44 Association between EE, DP and PA and work environment

Work environment				
	Emotional Exhaustion			
	Low	Average	High	Row Total
Poor	0	0	3	3
	0.00%	0.00%	100.00%	
Fair	3	2	18	23
	13.04%	8.70%	78.26%	
Good	7	6	6	19
	36.84%	31.58%	31.58	
Excellent	2	1	1	4
	50.00%	25.00%	25.00%	
Totals	12	9	28	49
	Depersonalisation			
	Low	Average	High	Row Total
Poor	0	2	1	3
	0.00%	66.67%	33.33%	
Fair	9	6	8	23
	39.13%	26.09%	34.78%	
Good	13	5	1	19
	68.42%	26.32%	5.26%	
Excellent	3	1	0	4
	75.00%	25.00%	0.00%	
Totals	25	14	10	49
	Personal Accomplishment			
	Low	Average	High	Row Total
Poor	1	2	0	3
	33.33%	66.67%	0.00%	
Fair	7	8	8	23
	30.44%	34.78%	34.78%	
Good	8	8	3	19
	42.11%	42.11%	15.78%	

Excellent	3	0	1	4
	75.00%	0.00%	25.00%	
Totals	19	18	12	49

A poorer work environment had statistically significant impact on EE (p = .02162 (EE) and DP (p = .04034), but not on PA (p = .21708).

4.5.34 Support from line management

The majority of therapists (34; 69.39%) felt that they received good or excellent support from their line managers. Table 4.45 indicates that the four therapists who felt that their support from their line managers was poor, had high EE scores as did eight (72.73%) of the 11 who felt support was fair and 13 (61.90%) of the 21 who felt support was good. DP scores show that 20 (58.82%) of the 34 therapists who rated support from line management as good or excellent had low levels of DP. On the other hand, eight (61.54%) of the 13, who felt that support was excellent had low PA scores.

Table 4.45 Association between EE, DP and PA and line management support

Line management support				
	Emotional Exhaustion			
	Low	**Average**	**High**	**Row Total**
Poor	0	0	4	4
	0.00%	0.00%	100.00%	
Fair	2	1	8	11
	18.18%	9.09%	72.73%	
Good	4	4	13	21
	19.05%	19.05%	61.90%	
Excellent	6	4	3	13
	46.15%	30.77%	23.08%	
Totals	12	9	28	49
	Depersonalisation			
	Low	**Average**	**High**	**Row Total**
Poor	1	1	2	4
	25.00%	25.00%	50.00%	
Fair	4	2	5	11
	36.36%	18.18%	45.46%	
Good	12	6	3	21

	57.14%	28.57%	14.29%	
Excellent	8	5	0	13
	61.54%	38.46%	0.00%	
Totals	25	14	10	49
	Personal Accomplishment			
	Low	**Average**	**High**	**Row Total**
Poor	1	1	2	4
	25.00%	25.00%	50.00%	
Fair	4	3	4	11
	36.36%	27.28%	36.36%	
Good	6	11	4	21
	28.57%	52.38%	19.05%	
Excellent	8	3	2	13
	61.54%	23.08%	15.38%	
Totals	19	18	12	40

Although support from line management showed no statistically significant impact on any of the burnout dimensions with p values of .05380 (EE), .06350 (DP) and .32631 (PA), both EE and DP were close to the cut-off point of being statistically significant.

4.5.35 Sufficient resources to do job

Almost half of the therapists (23; 46.94%) felt that they never or seldom had sufficient resources while the other half (26; 53.06%) felt that they often or always had sufficient resources (see Table 4.46).

Table 4.46 Association between EE, DP and PA and resources

Resources				
	Emotional Exhaustion			
	Low	**Average**	**High**	**Row Total**
Never	0	1	3	4
	0.00%	25.00%	75.00%	
Seldom	6	1	12	19
	31.58%	5.26%	63.16%	
Often	3	6	11	20
	15.00%	30.00%	55.00%	

Always	3	1	2	6
	50.00%	16.67%	33.33%	
Totals	12	9	28	49
	Depersonalisation			
	Low	**Average**	**High**	**Row Total**
Never	2	1	1	4
	50.00%	25.00%	25.00%	
Seldom	8	5	6	19
	42.10%	26.32%	31.58%	
Often	11	6	3	20
	55.00%	30.00%	15.00%	
Always	4	2	0	6
	66.67%	33.33%	0.00%	
Totals	25	14	10	49
	Personal Accomplishment			
	Low	**Average**	**High**	**Row Total**
Never	1	2	1	4
	25.00%	50.00%	25.00%	
Seldom	8	6	5	19
	42.10%	31.58%	26.32%	
Often	7	8	5	20
	35.00%	40.00%	25.00%	
Always	3	2	1	6
	50.00%	33.33%	16.67%	
Totals	19	18	12	49

The availability of sufficient resources showed no statistically significant impact on any of the burnout dimensions with p values of .16059 (EE), .60289 (DP) and .98062 (PA).

4.5.36 Lack of training

The majority of therapists (37; 75.51%) felt that they never or seldom lack training. Table 4.47 shows that eight (66.66%) of the twelve therapists who felt that they always or often lacked the training to do their jobs effectively had high EE scores.

Table 4.47 Association between EE, DP and PA and lack of training

Lack of training				
	Emotional Exhaustion			
	Low	Average	High	Row Total
Never	4	2	5	11
	36.36%	18.18%	45.46%	
Seldom	6	5	15	26
	23.08%	19.23%	57.69%	
Often	1	2	5	8
	12.50%	25.00%	62.50%	
Always	1	0	3	4
	25.00%	0.00%	75.00%	
Totals	12	9	28	49
	Depersonalisation			
	Low	Average	High	Row Total
Never	4	3	4	11
	36.36%	27.28%	36.36%	
Seldom	14	8	4	26
	53.85%	30.77%	15.38%	
Often	6	1	1	8
	75.00%	12.50%	12.50%	
Always	1	2	1	4
	25.00%	50.00%	25.00%	
Totals	25	14	10	49
	Personal Accomplishment			
	Low	Average	High	Row Total
Never	6	2	3	11
	54.55%	18.18%	27.27%	
Seldom	8	12	6	26
	30.77%	46.15%	23.08%	
Often	2	4	2	8
	25.00%	50.00%	25.00%	

Always	3	0	1	4
	75.00%	0.00%	25.00%	
Totals	19	18	12	49

Lack of training showed no statistically significant impact on any of the burnout dimensions with p values of .76722 (EE), .50915 (DP) and .25430 (PA).

4.6 Symptoms experienced by therapists on a weekly basis

Figure 4.4 shows the percentage of burnout related symptoms the therapists indicated they experience on a weekly basis. The following symptoms were experienced by more than 50% of the therapists on a weekly basis: exhaustion (73.47%), increased irritability (67.27%), impatience (61.22%), headaches (57.14%) and decreased motivation (51.02%).

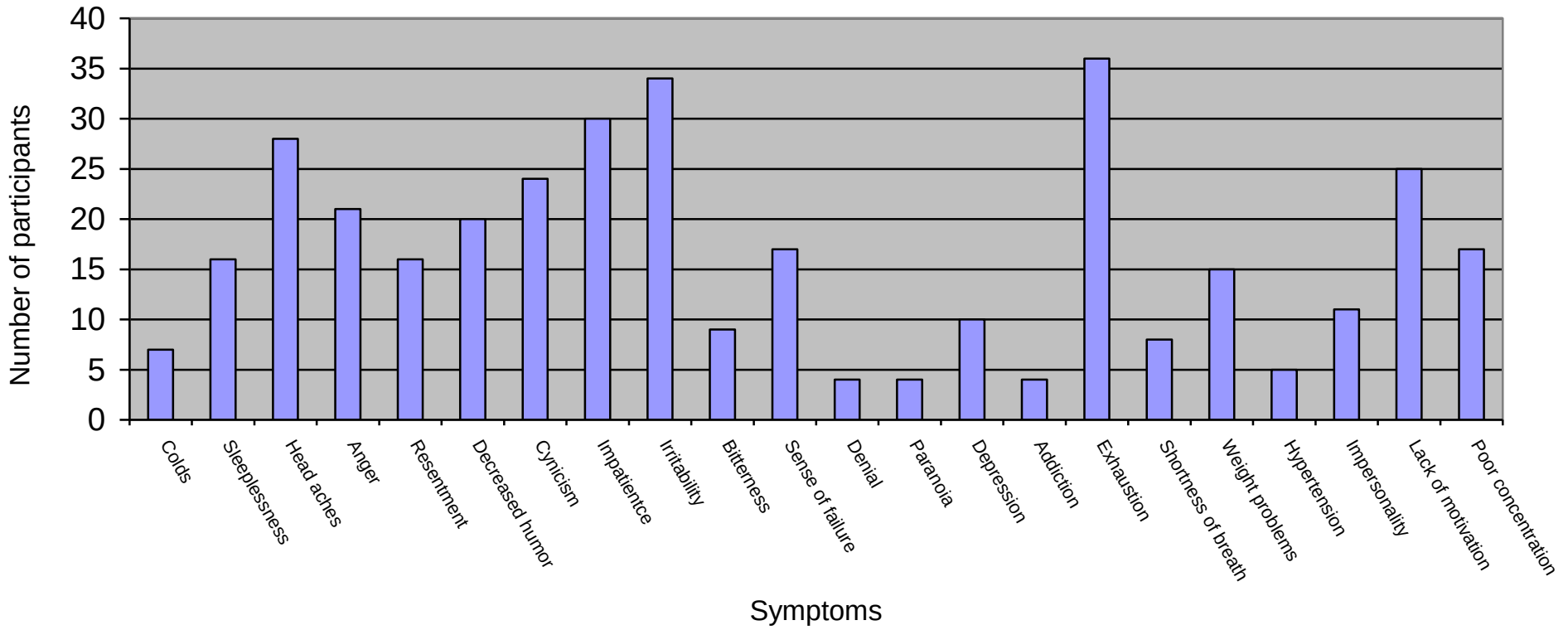

Figure 4.4 Symptoms experienced by therapists on a weekly basis

4.7 Summary

In terms of burnout, 57.14% of therapists scored high for EE, 20.4% for DP and 38.77% had low levels of PA, with one (2.04%) having scores indicative of burnout in all three dimensions and one (2.04%) not scoring high for burnout in any dimension.

The study population consisted of seven males and 42 females. The majority of the therapists were between the ages of 20 and 39 and had more than three years' tertiary education. Most of the therapists who participated in the study were employed at the New Kensington Clinic, while the fewest were employed at Little Company of Mary. The two occupational groups with the highest representation were occupational therapists and physiotherapists.

Therapists mostly earned between R10 000 and R15 000 per month and were of the opinion that their salaries were not market-related. Almost half of them were doing additional work to supplement their income. Most therapists worked overtime, with ten working fewer hours than they were employed to. They took between 11 and 20 days annual leave and six to ten days sick leave, but hardly any unpaid leave.

Therapists viewed their workload and patient load as very high and felt that they often did not have enough time to treat their patients. However, the majority of the therapists were of the opinion that they often have achievable deadlines. They were confident, competent and certain of their roles in the team and seldom experienced conflict with their colleagues or patients. Most therapists experienced job satisfaction and did not postpone contact with patients.

The majority of therapists felt that they received good or excellent support from their line managers but almost half of the therapists felt that they never or seldom had sufficient resources. Most of therapists felt that they never or seldom lack training.

Table 4.48 provides a summary of variables which were found to have a statistically significant impact on the presence of burnout in one or more of the dimensions.

Table 4.48 Summary of variables associated with high burnout scores

Variable	EE (p value)	DP (p value)	PA (p value)
Male gender			0.0238
Absence of children	0.02994		0.03895
≤4 yrs Tertiary education			0.03640
≤R15 000 Income			0.02262
Not working weekends		0.02882	
None or poor coping skills	0.03180		
High overwhelming work load	0.03972	0.01227	
Overwhelming / too small patient load	0.02365		
High administration load			0.00302
Seldom achievable deadlines		0.03693	
Postpone contact with patients		0.02023	0.01164
Poor work environment	0.02162	0.04034	

CHAPTER 5

QUALITATIVE RESULTS

5.1 Introduction

In this chapter the qualitative results of the study are presented. The data gathered through interviews with the 49 therapy staff members and seven managers will be presented according to the objectives of the study, with the focus on how participants understood burnout, what they see as contributing factors to burnout in this environment and to determine how the study population currently manage burnout.

5.2 Understanding of burnout

Both managers and therapists showed a good understanding of burnout. The following narrative examples provide insight into how managers expressed their understanding of the condition:

> *"…It is when you do not have any more strategies in place, when it comes to handle your day, your day program, your load and your priorities."* (p. 14, age 36, female)

> *"Burnout is pretty much related to your work and it's a feeling of getting to a stage where you actually can't do your job to the best of your ability any more, because your are feeling overwhelmed pretty much by your job and probably from the outside as well, but a lot of time it's well, it is related specifically to your work and not being able to do your job because you are tired and you don't have that drive to do it anymore."* (p. 81, age 35, female)

> *"…you don't feel like working anymore…you experience symptoms of depression …your energy levels are low…you are negative…you don't give what you are suppose to give."* (p.40, 33 years, female)

Therapy staff talked a lot about overload, physical and emotional exhaustion, feelings of emptiness, a sense of uselessness of the work, losing enjoyment in work, deterioration of relationships and experiencing physical symptoms. They express these feelings in the following ways:

> *"When you feel that you can't any more, your workload is too much, you can't get up in the morning, your work is an obstacle, don't look forward to your work anymore, everything is too difficult and too much and your relationships with your colleagues and patients are not optimal anymore."* (p. 17, age 25, female)

> *"…being emotionally exhausted and also physically exhausted…a feeling of not being excited about your job, not really wanting to do it, being very confused about it, indifferent may be sometimes".* (p. 43, age 30, female)

> *"I think that when you have to drive yourself every day to come to work, although you are doing a work which you love, that you chose to do, which you have been doing for a very long time, you don't want to do it, you are tired to battle, because it is feeling like you are hitting a brick wall and you don't feel like you are achieving anything and you ask why am I doing it whilst it is bad for my health and that is where I feel I am at the moment."* (p. 67, age 49, female)

> *"I think it is a holistic concept of physical manifestation, emotional feelings and also cognitive symptoms, directly related to your incapacity for whatever reason to deal with the stresses at work, maybe not related to the content of your job, but related to your people around you the people who employ you, your employer in direct terms."* (p. 73, age 51, female)

5.3 Factors contributing to burnout at Life Rehabilitation units according to study participants

All seven therapy managers and all but two therapists interviewed were of the opinion that therapy staff employed at Life Health Care is at risk for burnout. It was also mentioned that younger therapy staff and full-day therapy staff are more at risk. When questioning them about specific factors contributing to burnout in Life Rehabilitation the themes as presented in Table 5.1 emerged:

Table 5.1 Factors causing burnout according to the qualitative data

Core concepts	Themes	Codes
Individual factors	Personal factors	• Family • Financial • Medical • Legal
	Relationships	• Poor relationships (colleagues and patients) • Racism • Gender issues
	Lack of skills	• Lack of coping skills and mechanisms • Poor planning skills • Poor management of workload • Inexperienced • Lack of continued education and development opportunities • Lack of training amongst nursing staff
	Personality type	• Type A personality • Want to do well • Driven • High expectations • Intense • Perfectionists • Want to prove self • Over-committed
	Disempowerment	• Inability to change circumstances • Lack of work satisfaction • Feelings of disempowerment • Feelings of helplessness • Feelings of incompetence • Lack of control over what type of patients are admitted • Frustrated
	Other	• Dislike uniform
Patient/work-related factors	Nature of rehabilitation work	• Emotionally strenuous • Physically strenuous • Patients do not always improve • Repetitious • Patients' entire lives changed • Severely impaired patients • Lack of feedback regarding ex-patients
	Private health care environment	• Profit driven • Medical insurance restraints • Limited medical insurance authorisation
	High expectations of staff	• Company expects a lot • Requires high levels of patient satisfaction
	Ethical dilemmas	• Copyright issues • Confidentiality issues

		• Too high a patient load to treat all patients effectively • Medical insurance money not always optimally utilised • Patients admitted who will not benefit from therapy
	Time pressures	• Inability to take leave regularly • Shortage of staff • Patient load too high • Too much administrative work • Lack of locums • High workloads • Can not meet deadlines
	Lack of rewards	• Underpaid • Salary not market-related • Financial stress • No other perks or shows of appreciation
	Lack of space and resources	• Poor infrastructure • Lack of equipment • Computers old and slow • Water supply • Electricity supply • Too little gym space • Too little office or private space • No tea room
	Uncertainty/change	• Constant change in the units • Quiet units/uncertainty of future • Constant staff turnover
Management-related factors	Lack of support from management	• Poor management • Managers not knowing their teams well enough • Lack of debriefing • Use of social workers for debriefing • Managers with poor management skills
Administrative factors		• High administrative load • Extra projects (unit development) • Changes in time back policy • Owing hours to the company

Themes were organised into four core concepts i.e. individual factors, patient/work-related factors, managerial factors and administrative factors.

5.3.1 Individual factors

- **Personal factors**

Both managers and therapists felt that external factors such as family issues, relationships, financial, legal and medical stress as well as deaths and divorces can play a role in the development burnout. In the words of one participant:

> *"It can also be what is happening in your life outside work, because say, for example, you're going through a divorce or something it is going to have an influence and you won't be able to concentrate on your work and then your boss will say to you well, you are not coping with the work. Then*

everything will fall apart. So it is a spiral effect." (p. 19, age unknown, female)

- **Relationships**

Stressful relationships or conflict between colleagues were seen as a contributing factor to burnout for example:

"…staff undermining each other". (p. 60, age 46, female)

A male therapy assistant expressed a need for more male colleagues as females do not always understand the male psyche and way of releasing stress.

"*…we men sometimes become naughty (laugh) and we need some people that understand that, that's man. And as a man, to relieve much stress, you need to just talk, talk, laugh and do, and talk about the naughty stuff and all those things, so when we meet up with a woman they are not the same…and they get cross, whilst they don't really know what men are. They don't understand men so it is hard for me*". (p. 30, age 36, male)

Some staff experienced racism as a contributing factor to burnout:

"We do have discriminatory family members. When they see you as a black social worker they end up undermining you and do whatever they want to do. Even if that question is social worker related things, because they end up saying they want to see a doctor or they want to see the unit manager and at the end the very same problem it comes to the social worker…. they feel comfortable with the doctor because the doctor is white…" (p. 42, age 46, female)

- **Lack of skills**

Lack of skills referred to planning and coping related skills as well as professional development.

Some managers felt that therapists have an inability to prioritise tasks and therefore struggled to cope with their workload. Both managers and therapists identified a

lack of coping skills as a cause of burnout in this environment, as the following quotes shows:

> "*…some are more prone to it…they can't cope as well as others*". (p. 82, age unknown, female)

> "*…it's your ability or inability to cope with stress you've got and understanding what mechanisms you can use to make a plan, be it that you plan a holiday or interact with colleagues*." (p. 72, 50 years, female)

In addition it was felt that a lack of experience might lead to unrealistic expectations:

> "*…your less experienced therapists, they are still very idealistic, and they don't realise that there are certain things that you can't do and there are certain things that are just not within your scope. You can't solve the world's problems…there is also a lot of guilt around feeling like they are discharging a patient, having done more than, I mean everything that they can possibly do for a patient, but still feeling that there are massive gaps and those gaps might cause the patient to regress, or sometimes even to pass away*". (p. 55, age 29, female)

Therapy assistants in particular felt that there is limited development opportunities for them as one of them stated:

> "*I am not trained as a physiotherapist but I am basically doing the work of a physiotherapist, but I am not receiving the salary of a physio, financially I am standing still. There are no growth opportunities*." (p. 16, age 28, male)

Some of the therapists also felt that Continued Professional Development (CPD) opportunities are mainly applicable to physiotherapists and occupational therapists and that not enough provision is made for the other professions.

- **Personality type**

Managers felt that therapists are often driven, dynamic people and when they fail to reach their own high standards it causes stress that can lead to burnout. One manager explains:

> *"…I think the business attracts a very specific personality type, which is often the A-personality type who want(s) to prove themselves and who want(s) to do well…I thought it will be a good thing to introduce other personality types to the team, hoping that it will bring balance, but it resulted in more frustration, in that the very driven persons became very frustrated with the very laid back persons, who made everything run a bit slower and they saw it almost as a weaker link instead of an asset and it results rather in frustration and conflict, instead of creating a peaceful atmosphere in the team."* (p. 14, age 37, female)

Another manager explained it as:

> *"…dealing with very intense personalities, that is the group of A-type personalities interacting with each other, who all feel very internally driven to give their best at their own expense, often and obviously also having to get on with each other, because of the (inter)disciplinary model, so, agree on goals, agree on treatment…and also in an environment where they can observe what each other is doing, and the wanting to obviously share knowledge and to get agreement on what they are doing, so I think it is just a very intense atmosphere".* (p. 55, age 29, female)

Therapists concurred with these opinions:

> *"…it always felt to me, that we are people with specific personalities and we are all sort of perfectionists and we always just want to do better and better".* (p. 18, 33 years, female)

> *"…it is only me who can do it and you don't trust your colleagues…"* (p. 18, 33 years, female)

Consequently therapists set very high expectations and standards for themselves:

> *"…being driven to perfection, wanting to fix everything, make your patients' lives easier or better and taking responsibility for things that go wrong rather than things that go right".* (p. 52, age unknown, female)

- **Disempowerment**

The staff felt that the same things are addressed over and over again without any results and that they keep on coming up and it feels to them that it is "*like hitting a brick wall*" (p. 68, age 25, female), and it makes them very despondent. They felt that the problem is very much related to external factors which they don't have control over, for example staff shortages. In addition some therapists mentioned feeling incompetent. They ascribe these feelings to the negative effect that not being in control has on their self-confidence and to the restrictions medical insurance companies place on their ability to offer therapy and assistance:

> "*…the medical aid is exhausted, this patient goes home without you seeing any improvement in this patient, is very hard. You feel like you failed the patient.*" (p. 30, age 36, male)

- **Other**

Therapy staff felt that wearing the uniform does not make them feel proud and happy:

> *"It is very de-motivating…the quality of it is horrible, it is very cheap and even just the style, you feel horrible wearing it…I won't go to the shops after work. I change here at work to go somewhere else…I think it adds just to the feeling of being inferior…"* (p. 61, age 34, female)

5.3.2 Patient/work-related factors

- **Nature of rehabilitation work**

Both managers and therapists felt that working in rehabilitation is emotionally and physically strenuous. The physical nature of the work is exhausting. This is exacerbated by not having support staff such as porters to assist with transfers:

> "*You are expected to get patients in and out of bed, especially to transfer patients that are physically demanding. You're expected to help out – for instance feeding that's – in government I've never fed patients. I can't be standing or, if it's lunch-time I'm expected to feed patients."* (p. 37, age 24, female)

> "*In government if I want a patient, I phone the porters, and they bring the patient to me. And with Life you're expected to take patients out in the morning: after lunch you take them back to bed. Immediately after you come from your lunch, you take them back to therapy. It is physically demanding and it's emotionally frustrating*." (p. 37, age 24, female)

This opinion was also shared by the male therapy assistants:

> "*I think myself as a man, you work with woman, and they want you to be there with them every time, especially when you come to the big patients. And they call you all over the place. So it is very hard for me. At the end of the day you are tired.*" (p. 30, age 36, male)

On emotional exhaustion the managers said:

> "…*emotionally draining job and people might not be that good in channelling the frustrations that they experience".* (p. 64, age unknown, female)

> *"…you can't work for six to eight to 12 weeks with a patient without being personally affected by what that person is going through, because you get to know them…"* (p. 27, age 25, female)

Just how much the nature of the work and type of patients affects therapists became clear when one looks at what they had to say on the subject:

> *"Patients die…They are here for such a long time and you really build a nice relationship with them and then they go away, um (sad). It is difficult when you're involved with someone over such a long period, to keep your therapeutic distance. It is very difficult. One gets attached to your patients…one constantly wonders, how they are doing, are they coping …"* (p. 34, 38 years, female)

> *"…we are dealing with people who is (sic) going through so much trauma, because each person who is admitted, is going through a life-changing experience and nothing in his life will ever be same and they burden us with their grieving and I think this is what makes us so exhausted and we can also associate with a lot of these things…when you see a patient crack up it touches you".* (p. 26, age unknown, female)

> *"…they need the emotional support, because every patient that is in here, has gone through a major life change. And you can't treat them as if they haven't. You have to be there and be available to listen and to answer questions and to help them through the difficult times."* (p. 46, age 27, female)

> *"…It is a child, if you touch her she screams, and we all have to cope with this screaming for weeks on end and you can just see how it pulls everybody's moods down. The therapists come to a point where they just don't know – I don't know if they're actually making a difference (you know). And this is only one patient; we have so many difficult patients."* (p. 28, age 43, female)

> *"…we walk a distance with these patients. You really become like friends and you become close to them and I think it also makes it difficult because you feel so much more with them and then it becomes difficult to draw the line between sympathy and empathy…"* (p. 26, age unknown, female)

Furthermore, patients do not always improve and that can cause feelings of helplessness and add to stress as these quotes show:

> *"If you have a very frustrating patient that you are not getting the results that you want to with the patient...you try all the tricks in the books and you get advice, and you don't get that, you become stuck as to which way to go and, you know when you have to just see that patient tomorrow it's like 'oe, what do I do?' On top of that you have pressure from the family, very demanding families."* (p. 37, age 24, female)

> *"… a very young patient, just to look at the patient, or to know if it's a head injury, someone who's been at varsity and now his second year they're not going back because of the head injury, it is not going to fully recover, like, (you know) there's no future there, so it is emotionally draining".* (p. 37, age 24, female)

> "*And what's more frustrating for me is when the patient asks me 'Am I going to be able to walk?'. Even if it's been discussed, they have been told before (you know), they keep on denying and you have to repeatedly try and have a very understanding and comforting attitude, but at the end of the day it's one thing 'You're not going to be able to walk'…those things they work on you – ah, believe me, it works upon you."* (p. 37, age 24, female)

Therapists and managers mentioned the repetitious nature of the work as an added stressor that can lead to burnout: *"…you are seeing almost similar patients every day."* (p. 78, age 38, male)

Another issue was when patients have additional problems that they cannot deal with:

> *"Say for example I've noticed somebody who has got mouth problems. Now they've got more issues about how they look in the mirror and they cry in front of you, because they're not used to how they're looking and then they feel rejected by their family and it's a whole, you can see the whole picture of that person that is not just what you're helping with. It's also*

> *some other things, and if you don't have care for people, I mean if you have that care for people, you're going to see it and actually want to cry all the time, because every single person comes in here having more than one issue and I've got a tendency of putting myself in those people's shoes and seeing how would they feel or, and then you can't help but take it home with you and worry about it and think about it".*(p. 19, age unknown, female)

Therapists experience patients as being dependent on them, which increases their sense of responsibility towards patients:

> *"It is a very difficult type of work to begin with. It is very satisfying, I must say. It is not bad for me but, the patients are a high load physically and emotionally … and you carry the whole load of the patient…They are dependent on each therapist and what makes it difficult is that they can not function normally anymore, where in an outside practice the person is still functional…he comes out of his life to you, you help him and he goes back to his life, where here he brings his whole life to you…"* (p. 25 age 32, female)

Unco-operative patients were identified as a stress factor:

> *"If you have uncooperative patients, people that you need to beg and nag them for therapy, they're not so willing; they are not working with you…"* (p. 37, age 24, female)

Furthermore, stressors regarding the type of work which was mentioned included patients who show inappropriate behaviour or communication problems as a result of their impairments.

While therapists empathise with the trauma the patients are going through it is difficult because they:

> *"take their feelings out on therapists"* (p.49, 54 years, female)

After discharge patients are not followed up at the units, thus therapists do not know how they progress at home:

> *"…you have no reward in seeing how patients are coping a year or two down the line"* (p. 34, age 38 years, female)

Private health care environment

- **Profit driven**

Private rehabilitation is first and foremost a business that must pay its own way. This is often in conflict with the values of therapists and can cause major stress in therapists as explained by one manager:

> *"We are trained as clinicians and this is our biggest priority, but a lot of times, in the private sector there is this additional sideshow as well, of the unit must always be full, the financial pressure, the pressure with regards to quality, you must carry a high workload but you are not allowed to neglect on quality, there is (sic) certain standards that have to be in place…the work set up asks very much in terms of clinical standards, business standards and also in terms of personality standards, you must have a lot of skills, which is (sic) sometimes also conflicting in a way…"* (p. 14, age 36, female)

Where bed occupancy is low, numbers of staff members are accordingly low. However, an upsurge in bed occupancy does not lead to an immediate increase in staff numbers as the following quote shows:

> *"The financial pressure that they don't feel directly, but they are exposed to, indirectly...that the staffing numbers are low because occupancy has been low. Therefore when there is a sudden upsurge in occupancy then the staffing numbers are still low and you have to be (you know) consistently full for up to a year before they…(will approve more staff) and I think that exposes therapists to often working in, kind of variable*

> *situations of workload and variable situations of resources and I think the constant fluctuation is a big stressor."* (p. 55, age 29, female)

Another manager mentioned that the consistently high occupancy in the unit in which she works contributes to burnout. A therapist had the following to say on the subject:

> *"…the unit is not staffed for full bed occupancy. So when the unit is full it can result in a lot of pressure…So you are pressurised and then, even the nurse who comes to take the blood pressure is then a source of frustration, because I only have three days with this patient and now you steal an additional ten minutes to take the blood pressure. So this even can lead to conflict. I think the fact that they are so driven to occupy the beds and the quick turnover and or to keep the beds occupied, results in a lot of frustration."* (p. 35, age 34, female)

Related to the profit-driven environment are medical insurance restraints. These relate both to patients being discharged, because funding has run out, while therapists felt they could still have benefited from therapy and more adequate provision for assistive devices:

> *"…private setting the pressure put on us by the medical aids is huge. We don't often get enough time with our patients, so we have to cram so much into such little time; or you're told you only have R1000 for a patient's equipment when you need R10000 and the pressure…is huge because you feel that you have to try and do something for the patients ..You've got to in a short amount of time with very little money try and sort something out for your patients and it's hard.*" (p. 80, age 28, female)

- **Company expectations**

The high expectations that therapists have for themselves are exacerbated by high expectations from the employer through pressure from management to

achieve high levels of satisfaction, while also dealing with a huge administrative load:

> "*…the company itself expects more of you and it is almost as if the more they see you can do, the more they give to you, which is not always bad, because a challenge is good, but one can only up to a point…*" (p. 18, age 33, female)

> "*High expectations…our patient satisfaction has to be 97% all the time…*" (p. 52, age unknown, female) (The patient satisfaction questionnaire is completed by patients and family members at discharge and forms part of the Life Rehabilitation standard policy that focuses on quality).

- **Ethical dilemmas**

Managers felt that since your personal values relate to the essence of your being it is very demoralising if your values are being questioned. However, they did not expand on how or why this questioning of values might occur.

Therapists provided more insight into this stressor as, according to them, they have to make unlawful copies of test material, are unsure if confidential patient notes are treated confidentially, are being forced to treat more patients during a day than they know they can treat optimally and people are admitted who will either not benefit from treatment or whose funds are limited and might have been better utilised in a different way. The following statements expand on these issues:

> *"They don't give me test material (standardised test material), which means I have to make photocopies, which is against the law and that creates stress for me. Also, I must file my notes and tests, everything that is confidential…I now place it in a closed envelope, but I still don't know how safe it is, but for me it is this auditing of your clinical notes, which is against my professional specifications to let this documentation lie around."* (p. 15, age unknown, male)

> *"It is often about the bed which must be occupied…is it ethical to bring this patient in…to use the little bit of money, which is available in terms of their medical aid?"* (p. 73, age 51, female)

> *"…you are placed in an ethical dilemma almost on a daily basis…I understand that they're a business, they have to make money otherwise I won't get money at the end of the month – but they bring in as many patients as they are able and we are ethically then bound to treat those patients, but you don't have the capacity in terms of your work-hours or your energy or your emotional ability to cope with that number of patients, and yet you are ethically and morally placed in a position where you cannot say 'no' and my feeling is that the employer* knows that and they abuse that." (p. 73, age 51, female)

Managers and therapists indicated that patients might be admitted inappropriately in some instances. This issue is clearly explained by the following quote:

> *"…lack of control over which patients are getting into the unit, so they might get a patient… that they feel that they can't actually benefit in any way, yet they are obligated to spend time with that patient, feeling like they are not getting that internal reward or that satisfaction from a therapeutic session because they are then kind of forced to see a patient."* (p. 55, age 29, female)

Therapists also felt that the case managers create unrealistic expectations as the following shows:

> "*Case managers sell a service which the therapists can't render and therapists are then the ones to suffer, for example that a patient will be seen for so many hours a day which is impossible due to staff shortage*." (p. 67, age 54, female)

- **Time pressure**

Time pressure was mentioned by almost every therapist. This relates to the patient: therapist ratios and administrative tasks.

The therapist:patient ratio is one of the factors mentioned most often by therapy staff and was also mentioned by managers. In the words of one therapist:

> *"…the company's ratio for a therapist, I feel it is ridiculous, because 'how can you see eight to ten patients in seven hours?' Because we still have a meeting every day, 'so how must you do it and still expect individual therapy?' And even if you do groups, you just can't group some people together…I just feel the expectation is already unrealistic...We have seen up to eleven patients a day. You can't! ...when I was a locum I had an hour to treat a patient and that was manageable."* (p. 26, age unknown, female)

> *"…we are actually expected to do more than what's possible in a day…at the moment I've got sixteen patients on my case load, so if I had to spent an hour with each of them, that's sixteen hours…and then there is (sic) still team meetings and family meetings."* (p. 46, age 27, female)

This led to a feeling of not treating patients as they should be treated:

> *"…it feels that you can't give each of them sufficient therapy".* (p. 17, age 25, female)

Due to the high workload and time restraints therapists are unable to implement certain aspects in therapy which will make the treatment more enjoyable for themselves and for the patients:

> "*I can't run some of the groups that I want to do because I am just putting fires out…so it is also a job satisfaction thing (you know) that if I don't have time I can't go and run a group that I like to do which will give me more*

> *fulfilment in the job and it will also be good for the patients…*" (p. 80, age 28, female)

Administrative tasks and the amount of paper work were seen as too much as the following quotes by therapists show:

> *"Too little time and they always find new stuff which must be attended to with these protocols and forms that must be completed and reports that must be written...It feels like you have to do the same thing over and over again…and you have to fit it in with the treatment of your patients. Extra time is not provided for paperwork…"* (p. 49, age unknown, female)

> *"…there's just never enough time to get everything done and you're just always having to rush, rush, rush, rush and then try and attend to the patients as well as get the administrative things done. Like it's just very difficult to time manage because there's (sic) so many factors affecting your time management like…it's just very…ja, very busy, very hectic."* (p. 59, age 25, female)

Time pressures were exacerbated by a lack of locums which results in an inability to take time off or to go on leave. Managers feel they are unable to give staff who might benefit from it time off due to a lack of locums. This was confirmed by therapists who said that you need to find your own locum in order to take time off and that due to the shortage of locums you do not take time off in the end:

> "*If you want to take leave you have to find a replacement for yourself, if you can't you can't take leave. It is almost impossible to find a replacement…*" (p. 17, age 25, female)

> "*…because you are short staffed and this (sic) high patient loads, you maybe don't take leave as regularly as you should…but you can't take leave because then we will be even more short-staffed and then…there is the guilt of putting extra responsibility on your colleagues, so, you then have to work for longer periods…and then you start feeling resentful…you start thinking, well why*

should I be here. It is not like there are great financial rewards at the end of the day." (p. 46, age 27, female)

- **Lack of rewards − financial and other**

The theme of salaries not being market-related kept cropping up in interviews with therapists. They interpret this as a lack of recognition from the company. The following quotes show their feelings on the subject:

> *"It is the irritation and the anger that they (management) are paid huge amounts of money – we are grossly underpaid in my opinion in terms of market-related salaries for what we do and what I know I can earn out there, what I know what I'm worth and what other people consider I'm worth."*

> *"Prices go up but your salary stays the same. So, it is that stress of 'how am I going to pay all my stuff at the end of the month, how am I going to cope with everything', my income is the same, so now you start to do extra work, and you work after-hours and over weekends because you have stuff to pay…and it spills over, because now you wake up in the morning and you are tired, because you worked eighteen hours the previous day."* (p. 65, age 29, female)

Therapists also felt that the company did not show appreciation for their work as the following quotes explains:

> *"You don't feel that you are important in this place. Even if you do well, nobody sees, nobody cares."* (p. 42, age 46, female)

> *"I mean we do get benefits as being part of a private company, and we get a thirteenth cheque, but what about smaller things? 'What about taking us out mid-year, because we've done well?' Or giving us incentive bonuses – if you see so many patients in this amount of time (you know) in a month, a bonus of some sort. It doesn't always have to be cash. It can be any kind of reward. I think, people always say you've*

> *done a good job, but that's – that's not good enough. People want to see something else for their hard work."* (p. 80, age 28, female)

Managers also acknowledged that there is unhappiness about salaries amongst therapists:

> *"For some people I think financially it's a problem, although I would believe that the way people are paid in rehab is much better than it was a few years ago and then there are a lot of reasons why and how our packages are structured."* (p. 82, age unknown, female)

- **Lack of space and resources**

Both managers and therapists mentioned having to make do with infrastructure and equipment that is available instead of being able to get what is needed as a possible cause of burnout. While managers did not provide specific examples therapists mentioned computers, psychometric tests, problems with phones, water supply and power supply. One therapist said: *"I bring my own laptop to work."* (p. 15, age unknown, male)

This lack of resources results in a further stressor through patient and family complaints as the following quote shows:

> *"The patients pay a lot to have these facilities, the families complain and you feel guilty and it is not your fault, you receive the complaints and it has a effect on you."* (p. 35, age 34, female)

A further problem identified by therapists is a lack of resources in the community which, according to them, will just cause the patient to deteriorate once discharged as one explained:

> *"Also lack of social resources in the community, so we know that no matter what we do here or how good we get the patient, it is just going to fall flat on discharge, very demoralising."* (p. 58, age 37, female)

Managers felt therapists need more work − and private space as is expressed here:

> *"I think it is lack of space, both obviously for treating patients, but also for people to have their own personal time, so you constantly have people in your environment, you don't have a moment out where you can just be on your own at all."*

This opinion was confirmed by therapists who said:

> *"…we don't have enough space to accommodate 26 patients and twelve therapists; we are stepping on each others' feet."* (p. 49, age unknown, female)

- **Lack of training amongst nursing staff**

The therapy staff felt that the nursing staff contributes to their stress in that the nurses are not properly trained and that the therapy staff are also punished as a result of the nurses' mistakes:

> "*…we battle a lot with nursing, nursing is in a crisis, a lot of hidings come back to the therapists, or the therapists sit in the family meetings and you feel like you failed and it is not really the therapist who failed but the* whole *system and it is because the people who are 24 hours a day on duty did something wrong, then the little bit (sic) of therapy hours are not considered on the end of the day, you don't get a thank you and you don't get encouragement but you get scolding and hidings the whole time and that affects you after a while*." (p. 67, age 54, female)

- **Uncertainty and change**

The constant adjustment, change and development in the units are seen as risk factors for burnout. As is high staff turnover because there is always an influx of new people and new systems. New people have to be trained and that takes a lot of time. Furthermore therapists have to constantly adapt to working with new colleagues, each with their own personality.

Staff in smaller, quieter units experienced a different kind of stress. They were worried about the future of the units and possible retrenchments: "*Everybody who is resigning and leaving is making me very nervous.*" (p. 42, age 46 female) years, female)

5.3.3 Management-related factors

Some of the therapists felt that the managers contribute to the development of burnout in the units. They complained for example that they receive poor support from management:

> *"I would go to the ends of the earth for my patients…if you don't have that support system from the powers that be or you have the perception that they don't, are not giving you that support, then your attitude towards patients becomes affected and you think 'well, what the hell'…as long as it all looks good on paper and this irritates me intensely, as long as everything on paper is in place, in other words labour hours are recorded as being 'correct' (in inverted commas) whereas we all know that they are not…as long as everything looks good on paper at head-office as if everything is running smoothly, meantime underneath the surface there's a boiling morass of chaos amongst the staff. And that is what I mean by they don't listen...they come occasionally and they say 'well, what can we do to help you?' 'What can we do to stop the burnout?' and then promises are made and they are never kept. With the result is that I just don't believe them anymore. And you are forced to seek help elsewhere."* (p. 73, age 51, female)

A lot of therapy staff were of the opinion that some managers were lacking managerial skills and that they are unable to address the problems in the units. They also felt that it creates frustration when they are managed by a nurse (not a therapy related profession) who does not necessarily have insight into therapeutic issues. Therapists felt that inconsistency of management with regard to decision-making contributes to stress and that management don't listen to them:

> *"Management don't actually listen to our suggestions. So here at X we have all the resources available – we have a pool, we have a house that could be used for patients to determine their independence on their own or for families to stay at if they come from far or a different country. We have a basketball court, tennis court, volleyball court that we can't access because they are not prepared to put a path down there…So although we've got everything available, we can't get it developed or access it because of lack of, so-called lack of funds.*" (p. 66, age 36, female)

Poor understanding of higher management of what therapists do was another contributing factor:

> *"I was shocked the other day when one of the people at head-office said 'well, what is an X? (profession withheld to prevent identification of the therapist). After years of giving everything they still don't know what I do and I think that that was very demeaning, I was very angry about that…and it's their constant…not listening."* (p. 54, age 51, female)

Another frustration was the rigidity of management:

> *"…the huge gap between management and staff, in that they say they understand where we are coming from, but company policy dictates only so many therapists and there is a sense of well if head office say we can not change our formula for how staff is allocated then there is nothing we can do, sorry there is nothing we can do."* (p. 71, age 48, female)

The therapy staff also felt that managers should not keep information from them in order not to upset them because staff quickly sense if there is something wrong and that creates stress. Therapy staff should rather be involved in finding solutions.

Managers who don't know their staff, will not have a profile in their heads about their staff members and will then not be able to pick up on the physical, psychological and cognitive signs of burnout and thus be able to prevent or address it.

In addition therapy staff felt that the lack of debriefing contributes to burnout in this environment and it creates a need for informal debriefing which then often becomes the responsibility of the social worker, which adds to her/his stress.

Therapists also felt that the case managers had unrealistic expectations as the following shows:

> "*Case managers sell a service which the therapists can't render and therapists are then the ones who suffer, for example that a patient will be seen for so many hours a day which is impossible due to staff shortage.*" (p. 67, age 54, female)

5.3.4 Administrative factors

Extra administrative projects create further time challenges and add to stress:

> *"We all have a high workload and with the Joint Performance Management (JPM) we are pressurised to do extra work as well. It is not only all the patients you have to see. You must improve on your performance. What was good enough last year is not good enough this year and then you have to do extra projects and you feel that you don't necessarily have enough time for it."* (p. 23, age unknown, female)

> *"…the clinical load is manageable according to me, but now Life gives you extra work and you have a JPM project which you must do and you have a lot of admin to do…and you just can't fit all of that in eight hours. There is just not time for it."* (p. 25, age 32, female)

To save costs therapy staff in some units do not get extra credit for the time which they work over weekends and public holidays like they used to anymore. For instance, weekend hours were changed from time-and-a-half to time for time. On the other hand one unit was very quiet, which resulted in insufficient work and therapists leaving early and now they owe the company a lot of time which is impossible to work back and this resulted in a lot of pressure:

> *"Patient loads were low and then they end up telling us that we shouldn't stand around and hang out and do nothing, so we must just take our bags…and go home and then it came to a point where I was owing a lot of hours and really it frustrates me because the patients' load is not my problem. It's not my fault that the patients' thing it's low and then, now it becomes your fault that you owe these hours…so had I been delegated something else to do to keep me here for those hours, I would be more than happy to do anything as long as at the end of the day I don't owe anything. So it is difficult to catch up with those hours and now every time you have to go to a point that you even feel guilty to come and say 'can I please go to a bank for an hour or so' and you no longer have half-days because everything that you try and work for, you've got fourteen or 25 hours to work back"* (p. 31, age 28, female)

In conclusion

Managers and therapists were clear on the issue that burnout is usually caused by a combination of the factors referred to above and not by one single factor only, as the following example indicates:

> "*I think there are lots of different causes and I mean you can look at what are internal work causes and then external personality and your own life causes, because I do think that while we all deal with, we all have stress, we all deal with it in a different way and we all have other things happening in our lives (you know) that influence the way you deal with your stress.*" (p. 81, age 35, female)

5.4 Current management of burnout at Life Health Care: Rehabilitation Units

5.4.1 Introduction

This objective was addressed through several steps. Firstly the researcher determined whether and what burnout policies existed. Then she explored the

company's attitude towards burnout, how managers would identify burnout in staff members, and the current management strategies. Following that, it was established who is currently responsible for the management of burnout in this company.

5.4.2 Company attitude towards burnout

The views regarding the company's attitude towards burnout varied. Some managers and therapists were of the opinion that there is recognition of the problem and that the company wants to prevent it. They felt the introduction of the ICAS programme is an indication of this. However, more needs to be done regarding ICAS, if it is really going to be useful: *"It needs to be marketed and its usefulness to be tested."* (p. 55, age 29, female) Furthermore certain aspects must first be addressed before management of burnout will be effective: *"…I think they are supportive. I just don't think that there's a lot of acknowledgement of the problem and I think they could do a little bit more…they just expect you to get on with your work and they do not really acknowledge that it might have like a really serious emotional effect on people."* (p. 43, age 30, female)

Others felt uncertain and indicated that they did not know what the company's attitude on burnout was.

Then there was the majority group who felt that the company does not acknowledge the problem at all. One manager said: *"…Burnout does not get identified until the person resigns and an exit interview is done, but nothing further. This information is not used to identify trends. So my feeling is that the company does not do much."* (p. 40, age 33, female) This was also the opinion of another manager who said (amused): *"I don't think it is something that is fully acknowledged and I think it is seen as something that we as unit managers have to cope with. Everything I have done has been initiated by myself, except the wellness program."* (p. 55, age 29, female)

Therapy staff used the following phrases to describe the company's attitude: *"they are totally ignorant", "they could not care less", "there are no strategies in place and*

it is a case of 'do or die' " (p. 17, age 36, female) and *"not interested".* (p. 73, age 51, female)

Some of the therapy staff expressed their feelings as:

> *"Sometimes I feel their attitude is just to get on with the job, but from a top management point of view. I feel our direct managers and our direct support from Head Office is more supportive and they have a better understanding of burnout. Maybe we have a poor perception of top management, because it feels that they are not approachable … I do believe that they realise the negative effects for the company*." (p. 35, age 34, female)
>
> *"No, I don't think they have a good attitude. Then there would have been things in place and at least acknowledgement of the issue. I mean when you work for a place and request debriefing and it does not happen, and then they obviously don't think it is a problem. Except if they see it as a luxury, no you have to work, no nonsense talk. We don't pay for your psychological sessions…"* (p. 34, age 38, female)
>
> *"I've seen it over the years and I think I can talk from experience…they don't acknowledge it. If a staff member says 'well, I'm burnt out'…there is no respite; there is no offer of tangible help…they just replace you with someone else. It remains your problem and once again you are reinforced with this feeling…that management actually don't care."* (p. 73, age 51, female)
>
> *"I don't know if they really think that it exists, I know when X was in such a bad way, it was kind of like, there is no such thing as burnout leave, you either go to the doctor and get booked off sick or you leave and, ja, it just feels like we cry out to them but they are not listening."* (p. 68, age 25, female)

Another therapist also felt that management has not got enough insight into what is happening on the ground level:

"So it will be nice to invite them in and for them to see what we do, so that they can understand that when the practice manager goes to them and complains…which angle is she complaining from…" (p. 31, age unknown, female)

5.4.3 Company policies on the management of burnout

Most of the therapy managers and therapy staff were of the opinion that there is no official policy regarding burnout. Others were of the opinion that there is a wellness philosophy, but that it is not a policy and that there might be guidelines to use the support system, ICAS (Independent Counselling and Advisory Services) which was recently put in place.

- **Life Employee Wellness Programme (Life EWP)**

ICAS is an independent external organisation which provides the Life EWP. ICAS provides a confidential 24-hour personal support and information service to permanent employees and their households. The service is confidential, free of charge and is provided by qualified counsellors who offer both telephonic and face-to-face counselling (Life Healthcare – Life Employee Wellness Programme brochure, no date, n.d.).

Eleven of the staff members interviewed were not aware that the ICAS programme exists. Three of the staff members mentioned that they forgot about the existence of ICAS. There was also uncertainty about the function of ICAS as this quote shows: *"…heard of it, what it is and how it works, I don't know."* (p. 34, age 38, female)

There also seems to be confusion about ICAS payment and whether they will address burnout: *"According to someone I know (who has financial problems) she phoned them and they sent someone to her but she was then asked payment and was informed of how much a session cost. I am not sure how true it is…I am not sure if they will address burnout."* (p. 15, age unknown, male)

One therapy staff member could speak of experience and felt positive about ICAS: *"I have already phoned them to assist me with something and I will phone them if I suffer from burnout."* (p. 16, age 28, male)

Ten of the therapists felt that ICAS is a really good idea and that they will probably make use of the services provided. While eighteen of the therapists were of the opinion that they will not make use of ICAS, some of the reasons included having their own social support systems or not being the kind of person to ask for that type of help and are illustrated in the following quotes: *"I doubt that I will make use of it, because I have my family and I feel my support system is strong enough to assist me…it is not part of my personality – it is difficult to talk about it."* (p. 26, age unknown, female)

Some were uncertain: *"Well, I use the, well I get the newsletters that we get; I find them very interesting and very informative. You get a lot of nice information. But you know, in terms of like phoning and speaking to a counsellor, I don't know if I would feel comfortable doing that."* (p. 43, age 30, female)

Some concerns were raised on using ICAS in addressing burnout. The biggest of these seems to be the fact that, according to them, that the contact is telephonic. These concerns might be valid or not, but are the perceptions of the therapy staff: *"You don't know how info is used you don't want it on your record."* (p. 52, age unknown, female)

> *"…as far as I understand about ICAS, you phone them and it's telephonic. This for me is not something that I would probably engage in. I would probably rather talk to somebody at work or sit down with a colleague and go from there and do something more face to face..."* (p. 17, age 25, female)
>
> *"I did read through the pamphlet and I know you call a number and you can discuss a variety of issues with the person on the other side of the line and it's confidential and all of that, but I just don't think I would want to phone someone that I didn't know that doesn't really know anything about me or the situation that I work in. I think it has to be more direct*

on site (you know), someone on site or maybe someone at head-office or someone that we know and we're familiar with or – I don't know or, I'm not sure, but I think phoning someone is not going to help deal with issues of burnout at all." (p. 80, age 28, female)

"We don't have time to go and chat to someone, it does not help to go to them and say, there is not enough time, there is not enough equipment, there is nothing and nothing is being done about it, then it does not mean anything to me. I want to see that they do something about it." (p. 49, age unknown, female)

"I will definitely make use of it. I don't have a problem with the system and I think it is a very good idea., for me it is just you address the symptom, but not the cause…I feel if I feel I am burnt-out and I phone them and someone of ICAS gets back to me and I am going through how many sessions that is (sic) available, then when I am finished with it all, I must still go back to the cause of the problem. The cause of the problem does not get addressed. So you are back in the situation and after a couple of months you are at that point again. But I think it is good idea and a step in the right direction, but I don't think it might be the ultimate solution." (p. 65, age 29, female)

"...think it is good thing, but there is no infrastructure at work where you have the privacy to talk." (p. 67, age 54, female)

5.4.4 Identification of burnout in a staff member

Managers stressed the importance of knowing the therapists who work under them and having an open relationship with them. That way you will know their circumstances and what contributes to stress in each of them, who is vulnerable to change, who you can stretch and who can only do their job. You will also know their value systems and how they feel about things. When you have a profile of someone in your head you can be more sensitive to changes and warning signs of burnout. Furthermore, an open relationship and open channels of communication will encourage sharing and staff will know that they can come to you for assistance when

they are not coping. This will assist you to act pro-actively by eliminating stress factors (if possible) and to identify and address problems which you know can contribute to burnout. Managers said the following signs would make them aware that a person might possibly be suffering from burnout:

- **Physical tiredness**

People might look tired or complain of tiredness: *"When you notice physical signs for example when someone starts to get tired, you notice that they are less enthusiastic, they look tired, and they are not as healthy as they used to be."* (p. 14, age 36, female) They might also verbalise that they are tired or that they are not sleeping well.

- **Health problems and increased use of sick leave**

Managers identified both the amount of sick leave taken, as well as patterns that might emerge as possible indicators of burnout. This was expressed in the following ways:

> *"When they start taking more sick-leave, knowing that, that person isn't the type of person that takes more sick leave*." (p. 81, age 35, female)

- **Sleep disturbances**

Staff who report sleep disturbances.

- **Decreased enthusiasm and motivation as well as poor performance**

Managers said signs would include tasks being performed in *"a slipshod manner"* (p. 14, age 36, female), *"negative talk"* (p. 64, age unknown, female) *"not the same drive as before"* (p. 64, age unknown, female), *"a general flat affect"* (p. 64, age unknown, female) or *"when it takes longer than expected to complete tasks."* (p. 14, age 36, female)

One manager explained it:

"You notice suddenly that they are not quite going that extra mile with the patient where they would possibly normally have done that, so you see them spending more time in the office behind the computer doing reports, where they are supposed to be with their patient and they just can't really face that person. And when you ask them to do something they don't respond to deadlines as they would usually have. Another thing is it that they actually verbalise it. They say I can't cope with work today." (p. 55, age 29, female) *and "…that drive and that passion is what goes first and it becomes a more clockwork kind of day-to-day activity".* (p. 64, age unknown, female)

- **Emotional overreaction**

Reacting unexpectedly emotionally to situations i.e. through crying or anger outbursts was seen as a possible indicator of burnout, for example: *"I found that they become more reactive, so little things trigger them and they become very frustrated and emotional about something I would not anticipate that kind of response about."* (p. 55, age 29, female) and *"Tearfulness at work, more emotional…when people get upset quicker about difficult patients or about not coping with the situation their tolerance for stress is less."* (p. 55, age 29, female)

- **Substance abuse**

Possible signs of substance abuse which are picked up.

5.4.5 Burnout management strategies employed by the managers

Managers acknowledge that they might sometimes suspect that a member of staff is suffering from burnout without addressing the problem. Furthermore, four of the seven managers interviewed reported that they have little experience in the management of burnout. Managers were in agreement that they found it difficult to manage burnout. They said that if one person suffers from it, it has an immediate effect on everybody else in terms of workload, and also since people are working so closely together they influence one another. One manager mentioned that managers

don't necessarily have the time or the understanding to deal with the problem. The same manager reported that burnout has resulted in everybody resigning from a unit and that there were huge problems which were not addressed. She however did not elaborate on the problems. This was followed up with head office who said that the closing was a temporary measurement for refurbishing and expansion. They did not acknowledge the problems that the manager alluded to.

The following themes were identified when managers were asked how they manage burnout:

- **Allowing time off from work**

One manager said:

> *"…allow them the time to take time out from the unit and that doesn't necessarily fix it in itself but if you've given someone permission to take four, six months of unpaid leave or given them permission to take a longer than normal holiday or whatever, it allows them to get a bit of perspective and to analyse and that sort of kind of put those people as to look at what is putting them under stress and see if they can deal with it and then after that time come back with that perspective and see if we can work together from there. So for me it's allowing them the time to take a step back because otherwise you're pretty much sure that you're going to lose that person anyway, so that's how I have dealt with it the time I had to."* (p. 81, age 35, female)

In instances where staff members were given time off from work they were either given unpaid leave or took off the hours the company owed them.

- **Individual and group sessions**

Managers went about these sessions in different ways. Examples include:

  - Arranging for a psychologist to do a group session at a unit regarding burnout and stress management. At the same time the risk factors for burnout in that unit were assessed with the assistance of the psychologist.

The manager also planned to address skills in the next session. She got approval to run a group session at least twice a year.

- Unit staff getting together as a team on a regular basis for a "power hour" when it was found that communication and relationships were strained. This opened communication channels to talk about issues/problems as well as to reset boundaries and general team values.

- Another manager held individual and group sessions with the staff. However, according to the manager the group sessions were not dealt with correctly and therefore more damage than good was done. She however did not explain in which way it was not dealt with correctly, but she mentioned that debriefing should have been done on an external level by a professional person. She investigated and established that ICAS is not contracted to do group debriefing sessions with staff and that is what they needed at that stage. They therefore had individual telephonic sessions with ICAS. She further mentioned that she experienced the intervention with ICAS as positive, but that they needed someone to come in who understood the dynamics in the group. The manager got a quote for a group intervention and evaluation session from an external psychologist, but the unit could not afford it.

- Another manager mentioned that they will discuss stress factors in a group session and share ideas around coping mechanisms and skills.

- **Adaptations to workload**

Managers have adjusted workloads in different ways e.g. one gave a person who was starting to show signs of burnout a bigger administrative load and got a locum in to cover half of her patient load for a month.

- **Referral to ICAS**

5.4.6 Burnout management strategies employed by the therapists

Negative approach

- Unable to recognise burnout: "*You don't recognise burnout, when you have not experienced it before and it is not something which everybody talks about."* (p. 26, age unknown, female)

- Deny it/hide it: *"I would not show anybody that I was not coping and I carried on for a while and then realised that I can not anymore."* (p. 26, age unknown, female)

- Don't know how to manage it.

- Withdrawal: *"I did not manage it very well, because I withdrew from people, I did not participate in activities any more."* (p. 17, age 25, female)

- Compulsive drug addiction: "…*started smoking*." (p. 45, age 30, female)

- Don't manage it/don't manage it well:

> *"I don't manage it. I don't do it at this stage. I don't take leave, there is no time out. I think what makes my situation a bit more complicated is the fact that I am also busy with my M, so if I am not at work, I attend class or I am busy...One works on weekends. You don't have a full weekend off because you work on Saturdays, work on public holidays, I definitely don't manage it at the moment. I am too tired when I get home at night to think …okay, I must go to gym, I must take my boat and go and row to relax, I know it will help and make me feel better, but one just hasn't got the energy."* (p. 34, age 38, female)
>
> *"You know it is going to sound bad, but I am not managing it. I am trying to live with it, I identified it and you know I can't afford it to give up now. You can't afford to go on holiday, so now you just have to move this thing to your sub-conscious level and carry on. I don't have the money to go on*

holiday, I can take time off from work, because you are entitled to your annual leave, but I need the extra work for extra money. If I now go on holiday it means there is two weeks in which I can't do the extra work and I miss out on funds which I must generate." (p. 65, age 29, female)

"I don't think I am managing it very well. I don't think you can manage it by yourself. I think you need the support from the people, like management and stuff like that. I am getting better, I am getting better at it, like separating work from personal life and I am getting better at just seeing my job in perspective,...It's not like everything, it is not all-consuming, it's just a part of my life, not everything." (p. 43, age 30, female)

"Initially not very well…initial reaction is to push even harder, work harder and to try to assert some control, if I work longer I will see another patient I will feel more in control…initially I think it works, your body gives you a lot of signals, it is quite dangerous…I once got, what is it myocardial infarction and I knew it was stress related and I though that is it, it is never going to get to that point again. Where physically I feel like my body is actually going to crack. But I think it really means taking a lot of accountability…" (p. 57, age 27, female)

Positive approach

- **Professional intervention**

Four staff members mentioned that they are seeing external psychologists for debriefing, to share experiences they are going through at work, and to assist with the development of coping skills. All of them are paying privately for these services.

Another therapist mentioned that an internal psychologist assisted her to deal with burnout: *"I denied it for long period; the psychologist at work helped me to work through it, by for me basically admitting that I am depressed. I spoke to one of the doctors and the doctor prescribed an anti-depressant, which I took for a while and I am now trying to cope without it."* (p. 68, age 25, female)

A therapist mentioned that Dr X booked her off from work for three days, after she cried in the doctor's office for three hours – she mentioned that she had a very difficult patient and that the family blamed her for everything that went wrong and that she was totally inexperienced at that stage.

- **Draws strength from religion**

A large number of therapy staff mentioned that they rely strongly on their faith and that they draw strength from it as the following quotes state: *"I talked to my pastor and he helped me to work through it."* (p. 17, age 33, female); *"I go to church."* (p. 19, age unknown, female)

- **Created structures/systems**

Therapy staff felt that creating structures and systems for themselves helped them to be more in control of their situation and assist them to deal with burnout: *"I created structures for myself in which I felt safe, I plan my day in order to utilise it as optimal as possible."* (p. 15, age unknown, male), *"…set new goals for my life."* (p. 78, age 38, male) and *"…try and put systems in place, like time management."* (p. 61, age 34, female)

- **Humour**

Humour was mentioned as another strategy to deal with burnout.

- **Healthy lifestyle**

Some staff members incorporate a healthy life style to deal with the negative effects of burnout:

  - Physical activity: Exercise and going to gym: *"I need to get physically active, otherwise I lose perspective."* (p. 58, age 37, female)

    "I make sure I do Pilates every week: it's one place where I can relax and my body can be stretched and relaxed…I usually feel better after a

Pilates class. I feel like I have a bit more energy and a bit more relaxed and not so tired." (p80, 28 years, female)

- Introduced good eating habits.
- Ensure enough sleep and rest.

- **Talk to people**

A lot of therapists felt that talking to family members, friends and colleagues about what they are going through assisted them: "*By talking about it I realised that I am not the only one in the situation."* (p. 31, age 28, female)

- **Reflection**

There were also staff members who felt that reflection is a useful tool in the management of burnout: *"I reflect on how much better my life is compared to my patients…if I have a problem, then I realise okay, well, their problem is maybe worse than mine. So, and they're coping, so I need to be strong for them. I think it's also finding another person you can be strong for, so that you can help that person and then you don't realise how much, you know, you're actually lacking. You actually appreciate what you have and all that."* (p. 19, age unknown, female)

- **Set borders and keep perspective**

Therapy staff felt that setting borders and keeping perspective assisted them in combating burnout: *"You have to draw a line of how many patients you can see a day and you can not give everything to everybody. You must do your best for a patient up till a point and then he/she must also take responsibility. You care too much at the end of the day, you feel sorry and bad and you give everything of yourself. Then you get home and you have nothing to give to your husband and children and on the end of the day you are just an empty tank who can't anymore."* (p. 25, age 32, female)

"I work hard to keep perspective, to stand back and to evaluate what I am really busy with; what is my problem and what is the patient's problem, and what is out of my control." (p. 28, age 43, female)

- **Took time off/leave**

Some therapists took leave (paid and unpaid) to manage their burnout. However, a lot of them felt that after a certain stage of burnout, that it was not a very effective way to deal with it: *"You must take…leave at regular intervals and go and rest and you must know the signs when you get tired."* (p. 25, age 32, female)

"I took leave for a week, but I think when you come to a certain point…I really felt better but after a week back at work I felt that I was there again, burnt-out." (p. 26, age unknown, female)

"By taking a weekend off a month and that helped for a while, but on the continuum of burnout and this is my personal experience, is that as you go on this continuum, your periods of doing something about it or your way of coping with it, becomes less and less effective and your times of respite in-between your so-called holidays or leave or whatever, become less and less." (p. 73, age 51, female)

"This year I've tried to take more holidays. So I've taken lots of short breaks, but I really don't think that made any difference, because I've had lots of short breaks and they've been great for the five days I was off or the Thursday and the Friday, whatever, and by five, three or four days later I feel just as exhausted as I was before I went. I really don't know that it's that helpful. I think two weeks running is a much better option, but I just haven't really had the opportunity to take that." (p. 80, age 28, female)

- **Balance and planning**

As the following quote states, therapy staff felt that by planning they felt more in control: *"So maybe after work I will take a bit time, to plan my day for the next day, to see what I must do – otherwise I am running around like a chicken without a*

head…To prioritise and to organise, then you feel more in control." (p. 35, age 34, female) They also felt that trying to balance their lives assisted them.

- **Working less hours**

Therapists were of the opinion that it assisted them not to work full day: *"…also makes a difference because I'm a five-eight. So I'm only here in the mornings, so I have my afternoons to regulate myself, but people who are like working fulltime, don't really have that time-out, but in the afternoons I can go shopping and I can spend time with my little girl…it's like a complete switch-off, I don't even think about work, I don't worry about work. I rarely call anyone from work and I get annoyed if someone calls me from work…."* (p. 38, age 29, female)

- **Improved skills**

One therapist mentioned that improving her skills helps her to cope and stay on top of things: *"One should regularly improve/sharpen up on your skills…when you really feel…I don't really know what I am doing, then you must seek training opportunities and go and read up and consult with your team members."* (p. 28, age 43female)

- **Socialising with the family and friends**

Some therapists draw strength from their support system outside work: *"I spend time with friends and family. I come from a very, very close family so I generally go visit my sisters and play with their kids and have a bit of an escape into a six year old's world...(laughing), it is always fun."* (p. 46, age 27, female)

- **Share difficult patients**

One therapist mentioned that they make turns to take difficult patients and in such a way support each other.

- **Leisure activities / do "fun" things**

The therapy staff mentioned that they try to incorporate leisure activities into their lives to take their minds off work-related stuff. These activities include:

"…enjoyable things with family and friends" (p. 52, age unknown, female), *"go to movies"* (p. 70, age unknown female), *"go out for dinners"* (p. 70, age unknown female) and *"go to the spa for a massage."* (p. 76, age 36, female)

"To become involved in leisure activities and to have at least once a week something for the week to look forward to that one enjoy otherwise every week is the same. To have a sanctuary that one can go to for example being involved in crafts." (p. 52, age unknown, female)

"I am very involved in community projects, and it de-stresses me, sports projects especially…that is where I am meeting people, sharing ideas, making decisions…and it is very de-stressing to me." (p. 16, age 28, male)

- **Taking tea breaks**

Some therapists mentioned that it will be beneficial if they could take tea breaks: "*Taking tea breaks or taking a walk to the coffee shop, although it does not appear to be part of the culture of the company*." (p. 57, age 27, female)

5.4.7 Responsibility to address burnout in the company

Managers felt mostly that they and the individual have a combined responsibility towards managing burnout. However, the opinion that it was the responsibility of the company or that of the company and manager was also expressed.

"I think it is a combined approach, individuals must realise that they have a responsibility towards their own emotional management, especially if they do not tell that they have a problem. However companies must realise what the unique challenges are of private health care and that the personnel are the tools that make and sell our products and therefore they should be well looked after. Unit managers must work hard to get to know their staff and to find strategies to make the work environment pleasant." (p. 14, age 36, female)

> *"I don't think anybody is going to address it out of their own; sometimes there must first be a crisis before anyone will respond to it, I would like to believe that Head Office will provide guidelines to therapy co-ordinators how to manage it."* (p. 27, age 25, female)

> *"I mean I don't think you can put the ultimate responsibility on one particular department…The ultimate responsibility for providing the corporate tools to address it from a co-operate point of view probably lie with the HR Dept as it has been. There used to be a wellness director in the company, but I know that that post was done away with, I think probably because they got the external company in. I think the individual has a responsibility to be able to recognise and know even there is a problem but I think that people who get to that point probably don't recognise it, so that is a difficult one. I think it sits at line management and they are the ones that need to be empowered to recognise and to have the tools at their hands, not only the ICAS system."* (p. 81, age 35, female)

Managers are uncertain about what their specific responsibilities are in terms of burnout, what it should entail and where their responsibilities begin and end. Burnout will not be properly addressed until these borders are established.

The therapy staff had a lot of different opinions on where the ultimate responsibility lies to address burnout in the company. Similar to the managers nobody really knew for sure who is responsible for what and this contributes to the problem that burnout is not being addressed properly. None of the therapy staff knew of a specific line/procedure that must be followed in the management of burnout. Some were of the opinion that action to address burnout should start from the top and spiral downwards and others were of the opinion that it should start at the bottom and go up from there. The following themes emerged from the interviews:

- **Management**

Some of the therapy staff felt that management was responsible for addressing burnout but there was no clarification in terms of what level of management are being referred to.

- **The therapy manager/line manager**

Others were of the opinion that the therapy manager is the responsible party: *"I think that directly our therapy manager should be monitoring and trying to influence our levels of stress and our workloads and our support system."* (p. 60, age 46, female) Some felt that she/he must report it to the hospital manager, and others felt that it should go higher. *"The complaints and needs must be voiced on ground level, and then it must follow the channels and Head Office must put something in place."* (p. 25, age 32, female)

Another therapist mentioned that: *"Some of it would come from the immediate managers, but it has to go high, national, I suppose there need to be policies, which we don't make on this level, it will have to be probably be filtered down from the top and it will be kind of ad hoc management at the bottom."* (p. 57, age 27, female)

Some therapy staff was of the opinion that the unit levels have to be allowed to manage it – but that they need support from Head Office: *"The line manager must manage it, but Head Office must empower the line manager to be able to do it and provide her with resources to do it, but this does not happen."* (p. 32, age unknown, female)

- **Top management, Head Office and Human Resources**

Another therapist felt that the therapy manager and HR should team up: *"You know, I suppose the therapy manager to start off, who can identify it in the team, but then I suppose HR, because they are the people responsible to manage human resources."* (p. 28, age 43, female)

Others felt very strongly that Head Office is responsible, but that they don't have a good understanding what is happening on the ground: *"The only people that can do*

something about burnout are Head Office. I don't know if X (manager) is aware of the impact of burnout, she is in another world (amused). She would ask you 'what is burnout?' " (p. 49, age unknown, female) It was also felt that Head Office is better equipped to deal with it than HR: "*Probably Head Office. I would want someone to deal with it that was skilled in the field, I wouldn't want it just to be someone from HR who knows about human resources and who is equipped. I would want it to be someone who can facilitate the program. I think it's an issue that's beyond just human resources, it impacts on more than just human resources."* (p. 74, age 27, female)

"Ultimately it's going to have to be the people at the very, very top in terms of understanding what is…and how that affects their staff productivity. So it starts at the top and it has to be something that is acknowledged all the way down…but it works also in reverse, that if your immediate line manager says for instance X, sees that somebody is, looks as though they might be developing signs of burnout she is in a position to ... say 'Okay, why don't have a day off or go shopping or whatever', without other people jumping in and saying: 'You can't do that'." (p. 72, age 50, female) Another therapist felt that one does not only need the support from the top but also the commitment: *"I think it must come from relatively high up. It doesn't help to try and address it from ground level. One should get the feeling that management is interested in the wellness of their employees. We can bring the suggestions but they must commit."* (p. 34, 38 years, female) It was also felt that top management must provide the financial support: *"Top management, they must filter it down from there, because there is going to be financial implications. It does not help we are making plans and they don't approve it"* (p. 23, age unknown, female) and *"…Head Office and top management for the sake of policy purposes."* (p. 35, age 34, female)

- **Individual's responsibility**

One therapist felt that it starts with the individual and another felt that: *"Therapists have to take responsibility for their own actions or lack of actions towards getting rid of burnout but company must be realistic in what they expect from staff."* (p. 25, age 32, female)

- **Shared responsibility**

Then there were also opinions that it is a mainly a shared responsibility between the line manager/therapy manager and the therapists and again that the therapy manager needs the support from above: *"The line manager, but their load is so high that they don't get time, to a certain extent it is also your responsibility. But I mean if the system is not in place then your line manager can also not do it because they are not allowed to. It goes right through the company."* (p. 26, age unknown, female) and *"I think the supervisor has to be aware. But I also think it is the employee's responsibility to also mention it to their supervisor 'I'm struggling, I need help' as well. So I think it's a sort of two-fold...And then the supervisor obviously if she doesn't have the authority to make certain changes or to allow the person to go off, then it has to be sent up to a higher level."* (p. 70, age 25, female)

In summary various combinations were mentioned, but ultimately the whole company and all the designations need to be involved in addressing it.

5.5 The effect of burnout on staff and the company

When the researcher questioned the managers and therapists about the effect of burnout many themes emerged. The researcher organised them into effects impacting on the company and the work of the therapists and effects impacting on the therapy staff personally. The themes that emerged are presented in Table 5.2:

Table 5.2 The effects of burnout on staff and the company

Core concepts	Themes	Codes
Effects impacting on therapy staff	Exhaustion	• Physically • Emotionally
	Relationship problems	• Poor relationships (family, colleagues and patients) • Increased conflict • Family not understanding what therapists have to deal with every day
	Physical	• Headaches • Tiredness • Muscle pain and spasms • Low immunity – easily getting ill • Cold sores • Fibromyalgia flaring up
	Cognitive	• Loss of focus • Loss of creativity • Inability to prioritise • Lack of flexibility

		• Poor memory
	Psychological	• Depression • Suicide inclinations • Post-traumatic stress disorder symptoms • Paranoia • Abnormal functioning • Change in personality
	Emotional	• Negativity • Loss of emotional control • Overwhelmed • Cynicism • Resentment • Hopelessness • Anger • Frustration • Bitterness
	Behavioural	• Dishonesty • Decreased motivation • Passiveness • Impatient • Rudeness • Irritability • Aggression and short temper
Effects impacting on the company	Decrease in productivity and quality of service	• Increase in patient complaints • Patients not receiving optimal treatment • Staff less empathetic and indifferent towards patients • Staff not giving their best anymore • Patients noticing staff's emotional behaviour • Patients losing confidence in treatment • Making more mistakes • Staff not experimenting with new techniques • Postponing work and tasks • Staff disorganised and inattentive • Poor feedback regarding progress of patients to family members
	High staff turnover	• Negative effect on productivity and finances • Loss of skills and knowledge and expertise • Small pool of therapists interested in rehabilitation • Instability for patients • Loss of confidence in treatment
	Absenteeism and increased sick leave	• More sick often • Taking more time off
	Damage to image of company and public relationships	• Less referrals to LHC • Reputation and name of company jeopardised • Unable to build up proper service • LHC not portrayed as desirable employer
	Increased costs to company	• Loss of productivity • Additional locum costs • Training costs of new staff • Recruitment costs
	Increased conflict in team and poor team work	• All team members affected if one person is affected • Negative situation for patients • Increased stress • Lack of motivation to solve problems • Lack of support between team members

5.5.1 Effects impacting on the therapy staff

- **Physical and emotional exhaustion**

The therapy staff reported they are constantly physically and emotionally exhausted and that it has a negative influence on their lifestyle: *"And even things like trying to go to gym and lead a normal active lifestyle, you are too tired. I know that going to gym will make me feel better but I can't get myself there because I am too tired."* (p. 46, age 27, female)

The exhaustion eventually results in an inability to do anything about the situation: *"…too downtrodden emotionally to do anything to better your situation, you actually end up accepting the situation because you simply do not have the energy to change it."* (p. 73, age 51, female) and *"Sometimes I think people who suffer from burnout, haven't got enough energy to look for another job…they sit in a job and they burnout even more…they actually don't have any reserves anymore and they also don't have the self-confidence to look for a new job."* (p. 28, age 43, female)

- **Relationship problems**

The ability to maintain good relationships with family members, patients and colleagues decrease and results in increased conflict. The therapists felt that their family members do not understand what they go through every day with their patients. They also felt that some therapists don't show the stress that they are experiencing at work, but when they go home: *"They crack at home and they take it out on their family rather than the people here."* (p. 19, age unknown, female)

"…I think when you go home, sometimes it's the worst problem for many people…you're able to be tolerant with your patients, you're able to give them your best, you've given everything, when you get home and then the smallest things make you...(voice fades away). So it's the people you love the most in your life that you're actually taking out all your stress on and sometimes they don't understand where you're coming from, because I don't think anybody can understand, somebody who doesn't do what you do...No one can understand exactly what you have seen, like when you come home and tell people that you live with in the house, your house mates, you tell them "Joe," somebody couldn't swallow today and they'll be like "oh shame...But to see a person not being able to swallow is traumatic and to see a

person not having oxygen and almost dying is traumatic and you come home and you're upset and then they tell you straight don't take it out on me, it's not my fault, but you don't intentionally do it, just you can't cope any more…you just can't tolerate any imperfection, anything that is not perfect…things can fall apart at work…I can be flexible and if this does not work out, I can find a plan, but at home if say for example we're planning to go out and it doesn't materialise, then it's like, it's a tragic...Because I want to go out and that's the thing I've been looking forward to and the little bit of quality in your life is just kind of like where is it now." (p. 19, age unknown, female)

- **Physical effects**

The following negative physical effects were mentioned by therapists and managers: Tiredness, headaches, muscle pain and spasms, low immunity which results in getting ill easily, cold sores, diarree and fibromyalgia, which flares up due to stress.

- **Cognitive effects**

Cognitive effects such as loss of focus, loss of creativity, inability to prioritise, lack of flexibility and poor memory were mentioned. Some of the quotes mentioned are*: "My memory is failing me, I forget the stupidest things"* (p. 34, age 38, female) *"…you're not creative any more."* (p. 45, age 30, female)

- **Psychological effects**

    - **Depression**

      "You can get quite depressed, cynical and unhappy." (p. 43, age 30, female) and *"There is a depression and hopelessness that descend on you, and you are just so tired to live and feel that you cannot carry on."* (p. 65, age 29, female)

    - **Suicide inclinations**

      Indications that life is too much and they do *"… not want to live anymore".* (p. 25, age 32, female)

- **Post-traumatic stress disorder symptoms**

  Another effect is symptoms of post-traumatic stress disorder: *"Often people are starting to show post-traumatic stress symptoms. People also experience strange anxiety reactions or nightmares when they see the effect of these things every day."* (p. 57, age 27, female)

- **Paranoia**

  "…especially the patients that we see, where they're here because of some sort of violent occurrence, like a gunshot or a stab wound, and you hear the story and you see the pain and you work through the pain with them, well that affects me, and it makes you paranoid in your normal life. (You know), people say why are you so paranoid and I say because I am exposed daily to the results of the violence." (p. 46, age 27, female)

- **Abnormal functioning**

  It results in abnormal functioning: *"It can come to a point where a person burns out completely and will not be able to function normally again. Such a person can later on for example only work for three hours a day and then he is exhausted. It can have a permanent effect on your life when you get to that point. They develop stuff like fibromyalgia, depression, anxiety and stuff that they have to deal with for the rest of their lives."* (p. 25, age 32, female) and *"It results in anti-social behaviour."* (p. 42, age 46, female)

- **Change in personality**

  It results in change in personality as one therapist pointed out: *"I think maybe a change in personality that whereas a person was bubbly and full of life, they're actually now less, and they don't talk as much, they don't smile as much. They just, almost reached type of depression point or they snap much quicker than they would before. Like usually they would be able to handle something and say okay well, you know, put it in perspective, whereas (you know), they now just completely burst out and,*

or cry consistently when something happens that's small. So I think it's, it will be a change in personality." (p. 19, age unknown, female)

- **Emotional effects**
  - Negativity:

Both the managers and therapy staff agreed that it results in negativity and resentment of staff members towards the company, patients and other people. The managers said: "*The staff are very loyal towards the company and will always walk the extra mile, but when it feels as if the benchmark is always just a little bit higher, if the pressure is just a little bit more then they start to feel it, and they become negative towards the company, and how the company is treating them…they feel abused by the system. I think one can put very high standards for someone and stretch him past expectancy, if there is proper reward and recognition in place and I think this is one of the biggest gaps in the company. We expect extra miles…but we do not reward enough."* (p. 14, age 36, female)

It also has a negative effect and influence on the team and the working environment: *"…if there is burnout within the staff, the staff members become negative and they all start to rub off on each other and it's not a nice vibe to work in."* (p. 38, age 29, female) and "*I think the effect on staff is terrible. I think that it means that we use each other as debriefing, because it is the only other outlet that we have, so it means that any interaction you have with staff, is a complaining session…which is terrible. It just actually exacerbates the whole thing, because you just get together and bitch about this and that and that means any interaction with staff is in a negative way. There is no positive environment. There is no upliftment. Ja, and although it's great to have those people that you can bitch to and debrief to, it just feels like there is always that sort of interaction and there's never just social chat about unrelated things (you know)."* (p. 46, 27 years, female)

- Loss of emotional control:

  "Just feeling like you can't cope, feeling that emotionally you're on the edge the whole time, you never know when you're going to burst into tears and when you're going to get through the day without bursting into tears…" (p. 80, age 28, female) and *"Issues that really shouldn't be a big issue are often blown out of proportion."* (p. 70, age 25, female)

- Overwhelmed:

  "…at this stage, we don't have a lot of patients, but somehow it feels that I can't get through the day, and I can't understand why. My time management is terrible; it is like I am not on track with what is happening with my patients, it is so out of control." (p. 34, age 38 years, female)

- Cynicism:

  Cynicism starts to develop not just with regards to patients but to management as well: *"I'm tremendously cynical because of all these (you know) promises that have been made."* (p. 73, age 51, female)

- Resentment:

  "I think resentment towards management from the staff, which is very easy to pick up." (p. 66, age 36, female)

  "…and then you start feeling resentful…you start thinking, well why should I be here". (p. 73, age 51, female)

- **Behavioural effects**

  - Dishonesty

    "…excuses for not doing the job and justifying it, and lying about it". (p. 42, age 46, female)

  - Decreased motivation:

Staff members were of the opinion that burnout has a negative effect on motivation for work and it further results in listlessness and a complete lack of desire to get things done: *"It can lead to passiveness, so that motivation, that drive and that creativity are not there anymore, so it is like, It's just get through the day; we just finish with what we started; or I only do what is expected of me, but I am not going to walk the extra mile."* (p. 35, age 34, female)

"…I did not want to go to work, it was a real struggle to get up in the mornings and once you were there it was a real struggle to get out onto the wards and do things." (p. 52, age unknown, female)

- Impatience

  "…you become impatient with your patients." (p. 38, age 29, female)

- Rudeness: *"…rude therapists or people who come late…"* (p. 25, age 32, female)

- Irritability

  "…you can't tolerate as much, so you get irritable…" (p. 15, age unknown, male)

- Aggression and short temper

5.5.2 Effects on the company

- **Lack of productivity and quality service**

The managers and the therapy staff agreed that both productivity and quality of care are negatively affected by burnout. Patients will not receive optimal treatment, which will result in more patient complaints. Staff will also present as less empathetic and indifferent towards their patients. In the case of a business which Life Health Care is, this in turn affects profits negatively.

This was explained in the following ways:

> *"Patients are negatively affected because you can't give your best any more."* (p. 18, age 33, female)

> *"I think initially you wouldn't be able to work as well, because you wouldn't be able to give of your best, not that you didn't want to, but you couldn't give of your best…avoiding strategies, not wanting to see your patients…patient care would go down. The patients might even notice your behaviour that you're always crying in front of them or you (you know) you look untidy with your big bags around the eyes. Then they start losing their confidence in you as a therapist, because they think okay, well, if she is falling apart, but what about me, can she really help me? And then you might start making mistakes. Like if you're a nurse or a doctor, you might start giving the wrong medication accidentally, because you can't focus or maybe get rude to your patients…they put it on the air and they say how bad the hospital is and all of that."* (p. 19, age unknown, female)

It has a negative effect on the name of the company:

> *"They have staff that aren't doing their very best and they are not giving the service that they should be giving, which kind of affects the reputation of the organisation and the integrity of the organisation."* (p. 43, 30 years, female)

The company might be saving by not introducing burnout programmes, but quality is jeopardised:

> *"…whilst they may be saving money in a sense by not doing anything to assist the staff, (you know) they are actually lowering the quality of the service because the patients are not then receiving what they deserve."* (p. 73, age 51, female)

> *"People became less productive, where they might have used a new technique or have done something different with a patient, they just feel, ag, you know what, I don't really make a difference. Life is also exposed to*

risks, the risk that you could be negligent in your work, because you really just don't care." (p. 28, age 43, female)

"Instead of waking up at seven o'clock to come to work you end up telling yourself I'll wake up at nine. Even if, when you arrive on duty you end up postponing. When there are documents to be filled or to be processed, you end up postponing it, I'll see it hanging, all the documents are hanging, even if one of the families contact you telephonically or physically you tell them, okay, fine, I'll do that, and then you end up not doing it and the office is piled with papers…and you become more and more disorganised and then un-attending. When you are supposed to have a meeting, you would always give excuses. When the family wants feedback from how the patient is progressing, then you end up postponing and say I'll contact you or whatever…When the family members phone, enquiring about something or want to clarify something, you don't have answers for them." (p. 40, age 33, female)

- **High staff turnover**

Both managers and therapists felt that burnout causes high staff turnover. This negatively affect productivity and finances since new staff must constantly be trained which takes time as this quote explains: *"…you're training people and they're leaving and there is a shortage of skilled staff, so you're getting in new graduates and you're training them and they're leaving, so financially you got a big cost effect"*. (p. 81, age 35, female)

Furthermore, the company loses therapists with knowledge and experience.

"You lose skilled and passionate staff and find that you are not able to replace them with skilled people, not a lot of therapists are interested in working in rehabilitation …" (p. 31, age unknown, female)

"It results in staff turnover, the targets are increased all the time…but if they want to improve the profits of the company, it is not all about profits, but it is about keeping competent staff by treating them with respect. Staff turnover also has a negative

influence on the stability of the unit and it also has a negative influence on the patients, because the stability creates confidence in patients regarding treatment." (p. 15, age unknown, male)

"So they invested in these people; they sent them for training, possibility to all the CPDs which we attend free of charge, maybe on courses which they paid for. So they lose all that experience, the expertise, that know-how, not only the therapy knowledge, but also of how the unit operates, how the business operates and then they have to train someone from scratch." (p. 35, age 34, female)

- **Absenteeism and increased sick leave**

Both therapists and managers were of the opinion that one of the effects will be an increase in sick leave (when people are suffering from burnout they become sick more often), absenteeism and also people would want to take time off. In turn it will have a negative effect on the productivity of the company and will also result in extra work for the other staff members.

- **Increased costs to company**

Increased cost to the employer is caused in many ways i.e. loss of productivity, additional locum costs, training costs of new staff and their uniforms and recruitment costs.

- **Damage to the image of the company and public relationships**

The image of the company in the community and the relationships with the public and other stakeholders are negatively affected. This can result in less referrals in the future, because it will discourage people from bringing their family members for treatment as these quotes explain:

> *"It has a negative influence on the name of the company, I mean, if a patient leaves and the therapy sucked, they are obviously not going to recommend it to someone else."* (p. 34, age 38, female) and "*When problems are reflected and seen by patients and family members, the*

> *families become unhappy and subsequently the medical aids will withdraw."* (p. 77, age 26, female)

Staff turnover as a result of burnout will also contribute to a poor image:

> "…*the reputation, because in the whole changeover from staff leaving, because they're unhappy and new staff coming in, there's a decrease I would say in your effective treatment time. And I'm sure word gets around between medical aids or between people that 'you know this hospital, you don't get good therapy there' they leave you alone. And that will eventually influence the intake numbers and eventually the budget and all the rest. And if the company has a bad name, not only amongst patients but amongst therapists, in the therapist community, from people leaving here you are not going to attract new staff."* (p. 46, age 27, female)

The company will battle to recruit new staff due to a bad name in the industry:

> *"The more tired people get the more irate they become with the company because they get blamed for the difficulties and there is also a low opinion of the company as an employer and resentment towards management and I think a bad reputation in the end because rehabilitation is a very specialised small area and people always talk and then it gets around that Life Health Care isn't good employers."* (p. 66, age 36, female)

It will also create a bad name for the different professions of the therapists:

> *"…bring down the name of your profession, because there are so few speech therapists around. If I was completely a bad example, then people around would soon know and think that speech therapists are rude or they don't know what they're doing or, and other working staff who work with you, like occupational therapists start thinking oh well, you know, they wouldn't respect your decisions any more, because they would see you're not handling yourself as you should be...it gives a bad impression of the profession and of the person."* (p. 19, age unknown, female)

- **More conflict in team and poor team work**

"Burnout has a negative effect on the team. If it affects one member of the team it will have an influence on all the team members." This was confirmed by another therapist: *"If one person in the team suffers from burnout, the rest of the team must work harder, so you make it difficult for them as well. It also affects you when you see someone in your team is battling."* (p. 26, age unknown, female)

It not only has a negative influence on the team but also on the patients:

> *"When there is more conflict between colleagues, the team work is not optimal any more and this also spills over to the patients who can sense that there is stress between team members."* (p. 17, age 25, female)

> *"Then there's also the lack of motivation to actually try and solve that problem and sort of rifts between staff members can start developing and it just sort of destroys your whole working environment for the rest of the people and I am sure patients pick up on that as well."* (p. 70, age 25, female)

> *"…another trend I've noticed over the years and that is in the beginning there was a much more coherent team…And in a sense that in itself was a support system. At the moment the burnout I think has reached such huge proportions that there is a high staff turnover, so the team is never able to form any form of coherence or any form of support for one another because it's constantly changing. So I think not only do you have to get used to working with new colleagues again, but you've never got a chance to form any sort of a bond as it was in the past. So this to me is a reflection that the burnout problem has actually got worse."* (p. 73, age 51, female)

5.6 Strategies to address burnout according to the study population

It became clear during the interviews that the managers do not feel empowered enough to address burnout or feel that they have enough authority to make decisions

regarding the management of burnout. When asked about future strategies to manage burnout that the company can employ, one of the managers mentioned that:

> *"…it is difficult because everybody deals with burnout in a different way and everybody wants help in a different way. Where one person will deal with their burnout by getting a large increase, someone else will deal with it by getting an extra day's leave a month or something like that. So I think we've got our basic standards and conditions in place, so you've got your leave, sick leave and your salary set as they are. So I don't think those are things that we can change. I think we need to empower managers to be able to make decisions to help their staff without being too regimented. So if you see your person has come to you and they could really do with a 'mental health day' (you know inverted commas) that you've got the ability to say 'look, take the day off and you will be all right', but of course that's open to abuse, you've got to be very careful with that…"* (p. 81, age 35, female)

The therapy managers mentioned the following problems regarding the implementation of some of the strategies:

- Shortage of locums to cover for therapy staff taking time off from work,
- High financial implications (for example:- to employ locums when staff takes time off and cost of external group debriefing programmes),
- Abuse of the system,
- Service delivery might be affected (for example: if staff takes time off and there are no locums to replace them).

Themes as presented in Table 5.3 emerged when participants were asked to discuss strategies to address burnout

Table 5.3 Strategies to address burnout according to the study population

Core concepts	Themes	Codes
Psycho-social intervention	Debriefing	• Individual sessions • Group sessions • To be done with care and skill • Death bereavement when patients pass away
	Counselling	• Regular sessions • Psychologist to visit the units
	ICAS	• Must be marketed • Usefulness be tested
Team-related aspects	Team building	• Once a month • Management to contribute financially • Inter-hospital sport days
	Team support	• Increase team support structure at work • Improve team relationships
	Team dynamics	• Understand team dynamics and team personalities • Assist with management of individuals • Hire staff that can cope with stress
Work/patient load	Decrease in workload/increase in staff	• Manageable workload • Spend quality time on patients • Re-view therapist-patient ratio formula − not a good scale
	Administrative aspects	• Streamline administrative duties
	JPM extra project/ Unit development	• Re-consider as they do not have time for it
	Re-evaluate Saturday work	• Not therapeutically effective for patients • To make use of locums over weekends • Consider double payment
Acknowledgement of staff	Salaries	• Better market-related salaries • Not to have to do additional work
	Reward and recognition	• Acknowledgement of good work, not only focusing on negative • Does not have to have monetary value
Leave	Annual leave	• Increase paid annual leave days • Forced leave • Expand locum pool
	Sabbaticals	• For staff who worked for prolonged period in current environment
Orientation/induction		• More support for new staff • Induction booklet
Time-out opportunities	Lunch breaks	• Set hours for lunch • Lunch times to be enforced
	Time-out room	• Provide opportunity away from work station
	Relaxation activities	• Introduce during lunch times
Staff development	CPD	• Increase budget • More staff to benefit
	Personal development	• Courses i.e. to improve relationships and conflict management
	Career development	• New opportunities for “old” staff
	Formal supervision	• Introduce supervision
Management	Communication	• Regular meetings with staff • Staff to understand business/financial aspects • Staff to be on par with company goals and vision • Management more approachable and visible • Suggestion boxes

	Selection and skills	• More experienced managers • Good managerial skills • Therapists not to have nursing manager
	Sensitivity	• Acknowledge burnout • Aware of therapists needs • Create better working conditions • Provide support and structure • Commitment • Eliminate stress • Pro-active
	Informal sessions	• Opportunity to communicate with manager on monthly basis
	Decision-making	• Include staff
Case managers	Criteria	• Stick to criteria and not to admit high acuity patients with poor prognoses
	Unrealistic expectations	• Not promise unrealistic services
Monitoring system	Staff wellbeing	• Ensuring staff wellbeing
Treatment facilities	Space	• Increase treatment/gym space
	Equipment	• More and improved therapy equipment • More computers
Feedback	Discharged patient	• Positive feedback to be fed through to staff
Burnout policy and management	Workshops	• Introduce policy • Support, knowledge, skills and tools and empowerment to be provided to staff

- **Psychosocial intervention**

A lot of staff felt that debriefing is a very good tool to combat burnout. Opinions on the format of debriefing varied from doing it on an individual basis, through starting with individual sessions, which are followed up by group sessions to only group sessions. Everybody felt that it should happen regularly (suggestions were made for bi-monthly, once a month or every six weeks) and that it should be done by a qualified and professional person. They cautioned that if it is not done with care and skill it can have the opposite effect of what it is intended to do. Some participants had experience of debriefing sessions at two units, which they felt were not done in an optimal way.

> *"Debriefing must be effective. I would like to do debriefing but it is not necessarily everybody's need. You have to look at what the needs of the team are and how you are going to manage it. I think it must be done in a small group, I know it is about the universal aspect as well − I am not the only one with…it must be a group where people trust each other. I don't*

> *want to be with the nurses in such a session, to share freely, three therapists, maximum four therapists…when the group becomes too big, then everybody just sits there with nothing to say and then it is not effective. There are advantages in doing it on an individual basis and in groups."* (p. 34, age 38, female)
>
> *"You can offer team debriefing and that kind of thing, some people will benefit from it and others won't. This can be potentially harmful. It depends on how they do it and what issues actually come to the fore."* (p. 81, age 35, female)

Staff also seems to be particularly affected by the death of patients and debriefing can be utilized to address their feelings: *"A lot of patients die…but nobody ever tells you that they passed away. This is someone who you have worked with intensely for six weeks. I feel it should be acknowledged in some way but the manager here feels that everybody should deal with it in his/her own way. It is very difficult for me every time when someone passes away and no grieving is allowed, we just have to deal with it."* (p. 15, age unknown, male)

The therapy staff expressed the need for regular counselling sessions, for example by a psychologist who visits to the units. Suggestions were made for once a month, twice a year or as needed. In addition the ICAS programme must be marketed and its usefulness tested.

- **Team building and strategies to facilitate improved team work**

Team members can support each other: "*…As a team we can support each other much more. So I feel we should make time for it. And for the team members to talk to each other and to say listen here, what is difficult for you at the moment? Which patient affects you?*" (p. 26, age unknown, female) To develop this level of support within the team, team building is necessary: *"It will assist especially when the stress is high between colleagues and in the team and it will have a positive effect on team."* (p. 18, age 33, female) and *"It is important to facilitate team work all the time. If a team falls apart, the individuals suffer."* (p. 28, age 43, female) It was suggested

that team building takes place at least once a month and it could be to go for a quick breakfast or even if it is an afternoon (four hours), when you get away from work and you do something different. It was also suggested that management contribute financially towards it.

A suggestion was made that an effort should be made to understand team dynamics and the different personalities within the teams and thus to increase team cohesion when the team goes through difficult stages, especially when new team members come on board: *"…look at dynamics within the team and the influence of change because when things are at a status quo and everything is functioning well and you bring in new elements like new people…people have to change and adapt and sometimes there is more friction and more different personalities and sometimes these personalities in the workplace contribute towards burnout. You will generally find that in a team there is a peacemaker and that person is more prone to burnout because they are constantly trying to fix things. This will also help staff to understand themselves and each other better."* (p. 52, age unknown, female) The managers also felt that it will assist the manager in approach and management of each individual.

A suggestion was made by a therapist to introduce regular inter-sport days between Life Health Care hospitals. Additionally teleconferences can be used to create a support system among the different units and provide an opportunity to vent frustrations in a positive way: "*We should continue with the teleconferences which we started last year…it is good to hear that other units battle with the same problems…and not only that, but that we could actually meet each other."* (p. 35, age 34, female)

It was suggested that the company should be more selective in hiring staff and that they should only employ people with good coping mechanisms and skills: "W*e're all adults and I think we just have to learn our own coping mechanisms and strategies and the company has to look for people who are 'copers' in general…They shouldn't hire people who are going to fall apart and moan and complain as soon as things get stressful. 'Can you work in a stressful environment and how do you handle stress?'*

Because this is a stressful and sometimes you'll see you have a team member in your therapy team who is not a 'coper' and then you have to pick up the pieces and take the extra load. It is not my responsibility to sit and help cover for people who are in stress − who can't cope with their stress loads, which has happened definitely before here and I don't like it…That puts more strain on the whole thing." (p. 38, age 29, female)

- **Workload**

The therapy staff felt very strongly that there should either be an increase in staff or a decrease in the workload, especially due to the high administrative load:

> *"If the workload could decrease, to enable you to see your quota of patients…or…they will have to increase the staff."* (p. 17, age 25, female)
>
> *"…if at all possible more staff so that you can spend the … quality and the time that's needed on each client, that you could actually spend that time and really focus your attention on that person at the time and not be trying to do three things at the same time".* (p. 70, age 25, female)
>
> *"The therapist:patient ratio formula which they use…is not effective, when you have full bed occupancy. The formula does not cater for 100% staff 100% occupancy, but for 75% staff for 100% occupancy. It means you are understaffed when the unit is full. Then there is (sic) still administrative duties and development. This formula needs to be reviewed and still be managed in such a way that the company makes a profit."* (p. 65, age 29, female)

Another suggestion was to address the administrative load: *"To find a way to streamline paperwork, so that we are not so stressed with it and can focus on patients."* (p. 58, age 37, female) Moreover, the JPM system adds additional stress. Therapists understand that it is about development of the employee and the company, but they do not have time for it and ask that the company reconsider it.

In addition therapists felt that Saturday day work is not very therapeutic and not having to do it will provide them an opportunity to rest and rejuvenate: *"It might help if therapists do not have to work over weekends…You do a neuro or/and a spinal group, so at the end of the day let's say, two, maximum three groups on a Saturday …it feels to me that it is not effective therapy and you are actually only keeping the patients busy."* (p. 65, age 29, female)

If weekend duty cannot be stopped altogether the following suggestions to manage it were made: "*…Maybe they can make use of locum therapists over weekends."* (p. 65, age 29, female)

"Maybe overtime payment (double time) because we battle to take the time off." (p. 23, age unknown, female)

- **Salaries, reward and recognition**

Suggestions were made for proper reward and recognition programmes and to pay staff market-related/better salaries: *"For salaries to be of such a nature that you can pay your stuff at the end of the month and that it is not necessary to work additional hours and weekends."* (p. 65, age 29, female)

The therapists felt that acknowledgement for the staff members would go a long way: *"If there is trouble, the trouble is being dealt with immediately, but when it comes to recognition, then it feels to me that they are bit slower and a bit more withholding…"* (p. 18, age 33, female) *"I think it would be nice to have a little bit of recognition for the good things that you do. Or just, for your therapy manager to say: 'Oh, I know you've been going through a lot, a rough – a rough patch, you've had like twelve patients and you're a five-eighths and you've been doing a great job.' That will be <u>really</u> nice, just to say or someone to say 'oh, you're doing well with this patient'."* (p. 38, age 29, female)

And they also felt that: *"… it's not all about money – but a feeling, a sense of being valuable, appreciated, you are also part of us, and you are special…"* (p. 31, age unknown, female) Some suggestions were that it could be financial, vouchers, movie tickets, a lunch or a gift voucher to spend a day at a spa.

- **Leave and sabbaticals**

Some of the therapy staff made the suggestion that to combat burnout the number of paid leave days per year should be increased: *"In this environment 20 days annual leave is not enough and it should be increased to 25 days."* (p. 49, age unknown, female)

Suggestions were also made that staff must be forced to take leave:

> *"… maybe if they can increase the leave days (you know) and then maybe somehow make a policy, whereby they say to a person, you're supposed to take leave or rest (you know) maybe for four times in a year or three times in a year…"* (p. 78, age 38, male)

> *"Staff must maybe be forced to take a certain amount of leave every month. I know especially in the overseas psychiatric units they do it a lot, you are forced to take two or three days leave every month preferably at the same time."* (p. 65, 29 years, female)

Another suggestion was to introduce sabbaticals:

> *"I do think for people that are working for long in this kind of environment almost need to have a sort of sabbatical, like two, three months off, once every few, not every few years, I mean like every four to five years, have a prolonged break where you completely get away. If you want to take long leave, and the longest leave you take is four weeks, because they do not want you to accumulate more, they want you to take that, so if you do accumulate four weeks' leave, it means that you haven't had leave for a whole year, so a whole year you have gone without leave, which is not good. Now you got four weeks, it takes you two weeks to unwind, to settle down, you enjoy the third week and the fourth week you are really psyching yourself up to go back. So, you do not really have a chance to completely unwind and just completely switch off from work and these sick people. Look, they do it at varsities and stuff like that, they do it with teachers. Teachers have extended leave every so many cycles…That is the only*

> *thing I think, is the company, that they can offer you, I mean, it is a case of well, yes, you have been working for a solid four to five years, now, the company has to say do we still want to keep these staff members, because the only way you then get a break or a change of scenery, is to leave the company. Sometimes a change of scenery is what you need, but it doesn't mean you want to leave permanently…You get to the stage where you can't cope with this anymore, and the only way to change it is to move to another job."* (p. 53, age 37, female)

> *"I know that in overseas rehabilitation systems or a lot of them, particularly like Switzerland and Italy, the staff works for a period of 24 months. They then have (let's call it) a sabbatical of three months or six months where they are paid, they go off and they do something else for a while and then they're refreshed and they come back.*" (p. 73, age 51, female)

Participants felt that implementation of above strategies will be more feasible if a locum network from which locums can be drawn is created.

- **Orientation/ support program for new staff**

"I did not receive enough support when I started, in terms of which forms to use, where the equipment is – there should be orientation for staff with regard to the unit and to Life, for example all information in a little booklet will be very helpful." (p. 77, age 26, female)

- **Opportunities to take time out**

Participants suggested the implementation of set hours for lunch time which people must take and not to use it to do work-related activities for example, administration, meetings or educational activities:

> *"Lunch time is for me an important thing. I cannot work from eight o'clock until four o' clock non-stop and you quickly eat your sandwich but you don't sit still for longer than ten minutes…we do get a half-hour according to our*

> *contracts …but here it never gets considered. Each therapist is entitled to a half hour and for that half hour you are not allowed to have patients and you should also not be bothered during this time. So you can say between 12h30 and 13h00 no therapist will be available because they are on lunch."* (p. 25, age 32, female)

> *"…we have no lunch time and it just feels for me, if you just have that little bit of time to slow down, you will feel less burnt-out, because no person can work eight hours without a break. A person just can't, and it is really that when you go and sit down, just to find yourself, you are being looked at funny, because you have got to work. So I really think it is something that the company must look at – it is in our contracts, but it is not happening because the pressure is too much. Your health is affected by it..."* (p. 25, age 32, female)

The staff felt that weekly relaxation sessions at work should be introduced. This could possibly be incorporated in the suggested lunch hour: *"I mean a lunch time session to do relaxation or something like that might also be a nice idea, just to have that break in the day from all the stress that's happening in the day."* (p. 80, age 28, female) and *"something like being given an extra hour off or having someone come in and give you a half-an-hour massage".* (p. 66, age 36, female)

They also mentioned that they have no place to go and sit if they need a bit of time out to disappear to relax for a few minutes, to have a cup of coffee or lunch, away from the workstation and patients. They suggested a little lounge with comfortable chairs and a table. *"If we could have something like a "time-out" room, where you work, because in our set-up there is no place where you can go and sit and be by yourself, not at all…in the gym, they don't have an office, it is just the table. We have a bit of space at the back, but there you are never alone, and I am someone who just needs to go and sit and be by myself for a little while and just to be still and get my bearings together."* (p. 26, age unknown, female)

- **Development and training**

The company must ensure that staff gets regular training/skills development, because it creates self-confidence and confidence in treating patients. It was also suggested that for major congresses or other workshops which extend over two to three days a bigger budget should be considered. *"There is presently only a very limited amount of people who benefit from this (this does not include Life CPD's events which are free of charge)."* (p. 35, age 34, female)

A need for personal development was also identified and suggested topics for courses included: coping skills, time management, stress management and conflict management. One of the therapists supported this idea by saying: *"I think it is important that one creates opportunities for the team for personal development, in other words you must grow as a person as well, irrespective of your profession, you know – it is actually an awareness. Now that I am getting older, I look back at the younger therapists and I am thinking, these people are working so hard and with so much dedication, they just carry on, they are almost like robots, which just carry on, and that makes me wonder how much (sic) opportunities do they get to stand back and reflect about where they are at…To reflect and maybe to look at how to increase their coping strategies…"* (p. 28, age 43, female)

There was also a suggestion that staff gets supervision similar to what psychologists get. Groups that need special attention with regards to development are assistants and staff who have been working in the same capacity for a long time and who will benefit from a new challenge.

- **The role of managers**

It was felt that you can't build a strong team with an inexperienced manager, who is not properly trained, orientated or qualified to deal with sensitive matters, for example:. "*Conflict management, for example, cannot be done on an ad hoc basis because it results in long-term wounds in people."* (p. 45, age 30, female)

The staff also recommended that the manager should be from a therapeutic profession and not be a nurse.

Managers should acknowledge burnout, be more aware of the therapists' needs and create an environment that is conducive to better working conditions. They should also provide structured ongoing support and guidance:

> *"Maybe just if they acknowledged it more and talked about it a little bit more. Maybe a little more supervision, from like the therapy manager, to just have like a set time…once every, once a month or something.. Just to discuss your frustrations and.. I know the door is always open to go and discuss it but sometimes you get caught up and you don't know how to say it and…It must be a set thing you put in your diary and it comes up and you have to do it, like an hour once a month, or whatever."* (p. 43, age 30, female)

> *"Monthly supervision sessions with the therapy manager, a bit of a bitching session, gripes you have, to have that outlet and someone pointing out something practical that you could do. For example, you deal with a lot of people who die and when you put your heart and soul (into your job) you wonder what else you could do for them not to die."* (p. 52, age unknown, female)

The therapy staff also expects commitment from the managers: *"I think we need to know that management are listening…So I think if staff could actually see that things are changing and things are being put into place and ideas are being listened to, that would make a very big difference."* (p. 66, age 36, female)

They felt that the managers could eliminate a lot stress by being proactive, ensuring that the unit runs smoothly and addressing practical problems: *"When you're dealing in any hospital environment I mean it is stressful because it's not just the patients – it's the families and everything else and I think that if you ensure that everything else goes smoothly, like your pay comes on time; that you've got teaspoons to stir your coffee with – if those things work and the work itself is not I don't think the most stressful thing…. The environment in which you work, if you've got the equipment to*

do it and you don't have to hassle and fight on that, if those things work, then the actual work because that's what you're trained to do, is the easy bit. It's all the other stuff that makes life difficult and I think perhaps that's something that management have to realise, is that their job is to make sure everything is there for the people who are doing the work, to do the work properly…" (p. 72, age 50, female)

It was suggested that staff be included in the decision-making process: *"Management makes decisions, and we are sometimes only informed of it on short notice and then we just suddenly have to adjust, and we were not part of the decision-making process. Management is also part of the team and we should not been seen as subordinates. This has a negative influence on the team and the functioning of the team."* (p18, 33 years, female)

One of the therapists suggested that the company introduces a suggestion box where the staff can anonymously put in suggestions about problems and these issues could be addressed monthly. In this manner one can also pick up a trend − if there are some problems which come to the foreground more frequently it might be an indication that they are not addressed efficiently.

In addition Head Office should be more approachable and visible on the ground. Participants suggested regular meetings to discuss and address therapists' problems and needs, as well as to create an opportunity for therapists to gain insight into the business aspects of the company. Planning sessions during which staff could be a part of the decision-making process regarding company vision and goals will make staff feel more empowered and be beneficial to the company.

- **The role of the case manager**

Case managers should not promise the patient and families unrealistic services which cannot be met by the therapists. For example, that a patient will be seen by each therapist for an hour each day, which is impossible due to staff shortage and high caseloads.

Care must be taken to ensure that patients who are admitted can indeed benefit from therapy. There is no justification to admit patients with poor prognoses; there is no

justification why they are admitted: *"Patients are admitted who are not suitable candidates for rehabilitation…and this creates a lot of stress, because this person must now be seen for an hour, or half an hour at a time, and you can't achieve anything with the patient. You have to give feedback every week, you must write notes and deal with the family and it is not really a patient who will benefit from rehabilitation. Or it is a patient on a very high level and you only deal with the finer stuff and you feel that this patient can be discharged within a week, but then it sometimes feels that the company expects that if the medical aid authorised three weeks that the patient must be kept for longer…"* (p. 23, age unknown, female)

- **A person or system to monitor the well-being of staff**

Better communication and a more constant assessing of the well-being of staff: *"…the work circumstances are not going to change. The patients are traumatised, and they are going through the rehabilitation process…but I think there should be a system in place to keep an eye on the staff, because you don't always realise it, or you realise it, but you don't want to acknowledge it, that you are at that point of burnout, that someone will be able to pick it up and discuss it with you. It is difficult to say who that person must be; it is going to depend on the background and personality of the person. It must be someone who has the background and who is relatively in touch with everybody. It will not help to take the nursing manager, who does not know what is happening on this side. The therapy co-ordinator I think will be the ideal person, because she is involved with everybody, but then she must have the suitable personality and the knowledge."* (p. 34, age 38, female) Other suggestions were to identify burnout by doing a questionnaire (a quick checklist) with staff or one-to-one interviews at least once a month to identify burnout or risk factors for burnout. Another suggestion was to complete the MBI with therapists at six monthly intervals, possibly during the JPM's.

- **Treatment space and equipment**

The therapists felt that more and improved equipment will assist them to a large extent:

> *"I would like more and better equipment, because patients come to rehabilitation with an expectation ….they come here and say: what about this and that (they do research on the internet)… A lot of the stuff is not suitable, but a lot is, and then we have to explain in the family meetings to the family why we don't have this equipment. And sometimes we attend courses and you see that certain equipment will be very useful in the unit and then there is no money to buy it … And families say: but you asked us x-amount of money per day, how is it possible that you don't have the equipment? Then I rather take my family member to a government hospital that is better equipped. It is really embarrassing for me when patients say: Oe, I saw this at Pretoria Academic."* (p. 35, age 34, female)

> *"…the fact that the computers are so incredibly slow and that instead of five minutes to write a referral, it takes half-an-hour or 45 minutes, that's frustrating and it makes it worse because you know that you're missing out on patient time*." (p. 74, age 27, female)

One of the therapists mentioned that access to the internet will assist staff to keep updated, for example to have access to the latest journals.

Therapists felt that more space to treat patients and for equipment should be allocated in some of the units. They find it very frustrating to plan activities and then the space is occupied.

- **Positive feedback from discharged patients**

It was suggested that positive feedback from discharged patients should be provided to therapists as it provides *"a renewed sense of purpose when you see they're doing well, are back at home and in their communities and being productive".* (p. 52, age unknown, female)

- **Burnout policy and management**

The company should develop a policy on burnout. Workshops for staff on burnout were suggested by both managers and therapy staff to provide support, knowledge,

tools and skills. Topics could include: practical advice to prevent burnout, identification and recognition of burnout, intervention and implementation of strategies, guidelines to deal with stress, self-administered burnout measurement scales, education about coping strategies and relaxation. Follow-ups after the workshops should be introduced. The staff should also be empowered to disclose signs and symptoms of burnout to the therapy manager should they experience these.

5.7 Summary

Both the managers and the therapy staff showed good understanding of burnout. All the managers and most of the therapy staff interviewed were of the opinion that therapy staff employed by Life Rehabilitation is at risk for burnout. They were of the opinion that individual, patient/work, management, administrative and private factors contribute to burnout in Life Rehabilitation, and that it is a combination and not a single factor which causes burnout. The managers were able to identify some of the signs and symptoms that would make them aware that a staff member might possibly be suffering from burnout. The participants had varied opinions about the company's attitude towards burnout and they concluded that there was no official burnout policy. It was further established that ICAS is not the ultimate solution for burnout. Many constructive strategies were identified to prevent and manage burnout in future in Life Rehabilitation.

CHAPTER 6

DISCUSSION OF RESULTS

6.1 Introduction

In Chapter Six the pertinent findings of the study will be discussed in an integrated fashion. A response rate of 70% and above is regarded as an excellent response to a study (Ogiwara & Hayashi, 2002). This study had a response rate of 90.32% and can therefore be regarded as suitably representative of the study population at Life Rehabilitation Units. It contributes to knowledge about burnout in the disability rehabilitation field and is to the researcher's knowledge the first study in South Africa which focused on therapists and their assistants employed in physical rehabilitation units. The study results could therefore not be compared with other similar studies in South Africa. Other South African burnout studies in the health industry involved military nurses, doctors and hospice workers (Schweitzer, 1994; Van Wijk, 1997; Spies, 2004). Results will be compared to results of those studies where applicable, as well as to results of related studies from around the world.

6.2 The prevalence of burnout among therapy staff at Life Rehabilitation Units

The prevalence of burnout amongst therapy staff employed by Life Rehabilitation units was high with figures of 57.14% (EE), 20.40% (DP) and 38.77% (PA) respectively in the three burnout dimensions. Levels of emotional exhaustion are high. However, the lower levels of depersonalisation lead one to believe that less than a quarter of the therapy staff allowed their exhaustion to interfere with the way they treat their patients (for example being indifferent and insensitive). However, burnout is regarded as a developing phenomenon; (Bernier, 1998; Innstrand et al, 2002) are of the opinion that DP is the final phase to develop. If that is indeed the case the therapists (if they remain in this environment) might progress towards depersonalisation. It is not possible to comment on whether prevalence of burnout impacted on the quality of patient treatment as measuring quality of treatment was not part of the study, but a 20% prevalence of DP might indicate reason for concern in this regard. The positive correlation between postponed patient contact and DP also raises concerns about the quality of treatment even though it involved only a small percentage (20.40%) of participants.

Table 6.1 compares findings of the current study with other national and international burnout studies which made use of the MBI as measuring instrument. The findings on the prevalence of burnout are pointed out, as well as the variables which impacted significantly on EE, DP and PA.

Table 6.1 shows that the prevalence of burnout was much higher for the current study population than in a population of South African trauma nurses (Spies, 2004). This might be attributable to the difference in professions, as well as to the difference in the type of work. Trauma nursing involves short, intensive periods of mainly physical contact with patients while rehabilitation involves longer periods of emotionally demanding contact. The outcomes of treatment might also be different with the patients in the acute settings having a better recovery prognosis than patients with health conditions such as stroke and traumatic brain injury. Accordingly the nature of rehabilitation work and impairments being treated were identified as contributing factors to burnout by the therapists. In addition Spies (2004) used a sample of volunteers and had a low response rate (51.1%) which causes uncertainty about the representativeness of the results (Spies, 2004).

Sardiwalle et al (2007) did not give specific scores, but indicated that they found a high degree of burnout in a population of hospice workers. Contact with hospice patients is also emotionally demanding. However, that environment does not bring the added pressure of trying to achieve improvement against time deadlines.

Table 6.1 Prevalence of burnout prevalence findings in the current study and national and international studies

Study	Response rate	Percentage of high EE scores	Percentage of high DP scores	Percentage of low PA scores	Variables which impacted significantly on EE	Variables which impacted significantly on DP	Variables which impacted significantly on PA
Current study	90.32%	57.14%	20.4%	38.77%	Absence of children None or poor coping skills Overwhelmingly high workload Too small or overwhelming patient load Work environment	Not working weekends Overwhelmingly high work load Seldom achievable deadlines Postponed contact with patients Work environment	Gender (Male) Absence of children Education (≤ 4yrs) Income (≤ R15000) High administration load Postponed contact with patients
South African studies							
Trauma nurses (Spies, 2004)	51.1%	16.53%	8.87%	33.42%	Nursing experience (burnout appears to be the highest at age 30-39 years and work experience 11-14 years)		
Hospice workers (Sardiwalla et al, 2007)	Unknown	High degree of burnout			Stressors outside the workplace Problem-focused and	Problem-focused and ineffective coping strategies	Problem-focused and ineffective coping strategies

					ineffective coping strategies Physical work conditions Career aspects (job security & long-term career prospects) Younger participants		
International studies							
Pacific Northwest of the USA (Schlenz et al, 1995)	95%	42.5%	10%	5%	Years experience at present job (more experience less exhaustion)		
Massachusetts (Donohoe et al, 1993)	52%	46%	20%	60%	Lack of communication/ connectedness Diminished achievement Time constraints	Lack of communication/ connectedness Diminished achievement	Lack of communication/ connectedness Diminished achievement
Cypriot (Pavlakis et al, 2010)	87%	8%	23%	17.4%	Perception of a stressful job Low salary	Age group Number of years working as a physiotherapist (not a lot of experience)	Low salary Gender (male) Employment sector (private)
German (Kowalsi et al, 2010)	65.8%	Figures not provided			Workload Latitude in decision-making		

					Gender		
Japan (Ogiwara & Hayashi, 2002)	52.2%	Figures not provided			Age Number of years as a physiotherapist Number of years in present employment Time spent on work with clients	Age Number of years as a physiotherapist Number of years in present employment Time spent on work with clients	Time spent on work with clients
South Australia (Scutter & Goold, 1995)	72%	60%	29%	6%	None	None	None
Turkey (Gulalp et al, 2008)	43.3%	53%	39%	46%	Career satisfaction	Career satisfaction	Career satisfaction
Australia (Girgis et al, 2009)	87.51%	32.80% (whose work involved direct patient contact)	9.81% (whose work involved direct patient contact)	14.81% (whose work involved direct patient contact)	Having high levels of patient contact (>31h per week) Dissatisfaction with leave arrangements Reporting a moderate to high need for communication skills training	Dissatisfaction with leave arrangements	Dissatisfaction with leave arrangements

6.2 The prevalence of burnout among therapy staff at Life Rehabilitation Units

Results from the various studies shows a variation in EE prevalence rates from eight percent to 60%. The EE prevalence of 57% in the current study is the second highest. The studies by Schlenz et al (1995) and Donohoe et al (1993) were performed in settings similar to the current one. Although lower than in the current study, both these studies found high EE rates. This might be an indication that the nature of rehabilitation work plays a role in the development of EE as previously discussed when the national studies were compared and as indicated by qualitative findings in the current study. The respondents in the Cypriot study (Pavlakis et al, 2010) had the lowest EE (eight percent). The majority of the Cypriot population is entitled to either free medical care or reduced cost coverage (public sector), the rest of the population purchases health services from the private sector. Large companies and trade unions fund medical care for their employees and members respectively (Pavlakis et al, 2010). By contrast, in South Africa medical insurance is very expensive and it does not provide unlimited medical care. It is therefore possible that the reason for the Cypriot study's low rate of EE is that the therapists are under less pressure to achieve goals in limited time periods.

Scores for DP range between ten percent and 39%. The DP scores were relatively similar with most in the 20s, including that of the current study. None of the variables which impacted significantly on DP in any of the studies mentioned in Table 6.1 were similar, which means no conclusions over specific contributing factors for DP could be drawn.

The PA scores varied between five and 60% and the current study shows the third highest impact on PA. The only variable found to impact significantly on PA in the current study which was also mentioned as a cause of low PA in another study was low salary (Pavlakis et al, 2010). In addition poor coping strategies, lack of communication, diminished achievement, the employment sector, the perception of a stressful job and time spent with patients as found in the qualitative data were also mentioned by various international studies (Table 6.1) as causes of low PA.

6.3 Current understanding, identification and management of burnout

Both the managers and the therapy staff showed a good understanding of burnout when one compares their definitions of burnout, to the definitions of burnout found in the literature (Wandling & Smith, 1997; Maslach & Jackson, 1984; Sonnenschein et al, 2007). Similarly both staff and managers were able to recognise some of the signs and symptoms/risk factors which indicate that someone might be suffering from burnout. There were however no formal identification procedures in place at Life Rehabilitation Units to identify staff members who suffer from burnout on a regular basis. It is not sufficient to have the cognitive knowledge of burnout and not to actively address it, as it has negative consequences for both the staff and the organisation.

The majority of staff felt that the company's attitude towards burnout was poor. This view is supported by the fact that no official policy regarding management of burnout in Life Rehabilitation could be found. The fact that there was no policy in place was probably the reason why both the managers and the therapists were left to their own devices when it came to the management of burnout and that it had been a case of trial and error up till this stage. This trial and error process did not seem very successful and was disorganised since there were no clear guidelines (except to refer to ICAS) to direct staff or managers in terms of individual and/ or group responsibility and there were no set boundaries to work within. The managers did not seem to have the freedom to make decisions (for example to authorise leave) or the confidence to deal with staff suffering from burnout. Without a policy it makes it very difficult to act pro-actively and preventatively.

Sieberhagen, Rothmann & Pienaar (2009) mentioned that employee wellness and health is not clearly addressed by legislation in South Africa and that South African companies lack sufficient policies to deal with these aspects. According to them it is vital for companies to develop health and wellness policies in order to regulate employee health and wellness. They were further of the opinion that South Africa should create a body to deal with policy and operational matters relating to occupational health, wellness and safety issues. Such a body can provide the direction in the overall struggle to decrease the work-related stress in South Africa. In the UK, such a body, the Health and Safety Executive (HSE),

already exits and South Africa can gain knowledge from their established practices (Sieberhagen et al, 2009).

Companies should take responsibility for the wellbeing of their staff, since investing in human resources pays handsomely in the end. The company has a responsibility to provide proper guidelines, procedures and policies regarding the management of burnout. In addition, employees have a degree of responsibility to ensure health and wellness for themselves and their colleagues. They must take sensible precautions to ensure their own health, safety and wellness at the workplace (Sieberhagen et al, 2009)

6.4 Impact of demographic details and personal aspects on burnout

The Cypriot study (Pavlakis et al, 2010) found that age had a significant impact on the development of DP (p=0.002), but it did not specify which age group was associated with high DP scores. The Japanese study (Ogiwara & Hayashi, 2002) found that age had a significant impact on both EE and DP, but again the specific age group was not indicated. Although the participants interviewed in the current study were of the opinion that younger therapy staff are more at risk for burnout, due to reasons like idealism and perceived poorer coping abilities, age had no statistically significant impact on any of the burnout dimensions.

In the current study gender was associated with decreased PA in males. This is in accordance with the German study which found that male professionals working with people with disabilities were over four times more likely to develop EE (Kowalski et al, 2010). It is possible that the decreased PA in this study can be attributed to the traditional role of the male being the breadwinner and the fact that the participants in the study mentioned that their salaries are not market related. The qualitative data also showed that males found the lack of other males to debrief with to be a stressor.

In the current study a higher percentage of therapists without children experienced high levels of EE than therapists with children. Furthermore, the absence of children had a statistically significant impact on reduced PA ($p = 0.03895$). Parenting therefore seems to be a factor shielding therapists against burnout. This is confirmed by Woodside, Miller, Floyd, McGowen & Pfortmiller (2008) and Liakopoulou et al (2008). One can speculate that being a parent can

be seen as a huge personal accomplishment, regardless of what one is experiencing and feel you accomplish at work. The researcher is further of the opinion that having children may change one's priorities and shifts the focus from work to the children's needs and achievements and as a result acts as a de-stressor. One may also develops coping mechanisms and skills when raising children with different personalities and needs.

There is evidence in the literature that level of education might be associated with burnout (Gutiérrez et al, 2004). In this study decreased PA was statistically significantly associated with less than four years of tertiary education. This group were mainly therapy assistants and because of a limited scope of practice and less opportunity to progress professionally they might have been frustrated in their work circumstances. One participant mentioned in an interview that they feel they do the same work as therapists, but get paid less. This is especially true for assistants who have been with the same place of employment for a long time and who have the experience and knowledge but are then surpassed in pay and have to take instructions from junior therapists who might know a lot less than they do in the specific field.

Participants indicated in the qualitative data that racism from patients and families can contribute to the development of burnout. The association between burnout and racism is unknown and research is required to explore this especially since psychological stress reactions to perceived racism includes resentfulness, frustration, paranoia, anxiety, anger and hopelessness (Crocker, 2007). All of these are symptoms that can be associated with burnout as well.

The personality of the healthcare worker can be a contributing cause in burnout (Spinetta JJ, Jankovic M, Ben Arush MW, Eden T, Epelman C, Greenberg ML, Gentils Martins A, Mulhern RK, Oppenheim D & Masera G, 2000). Both the therapy staff and managers were of the opinion that rehabilitation services attract therapists with a so-called Type-A personality and that this type of person is prone to the development of burnout. Wikipedia describes a Type-A personality as: "Type A individuals can be described as impatient, time-conscious, controlling, concerned about their status, highly competitive, ambitious, business-like, aggressive, having difficulty relaxing. They are often high-achieving workaholics who multi-task, drive themselves with deadlines and are unhappy

about delays." However, according to Wikipedia the theory has been criticised for its shortcomings scientifically.

Although certain personalities might be more susceptible to burnout, it is not practical (due to a shortage of therapists and a need for psychometric testing) to appoint therapists with certain personalities and not others. Managers, however, can play a significant role in the prevention of burnout by getting to know their staff and managing the different personalities within the team and not treating everybody the same. For example, if a staff member finds it difficult to relax, it will be useful to make sure that she/he learns relaxation techniques, or that he/she takes regular leave and takes enforced lunch breaks. A person who needs to prove him/herself might require more recognition than for example another. It is necessary for the therapists to get to know, respect and accommodate the different team members with different personalities in order to enhance teamwork.

Gutiérrez, et al (2004) mentioned that research on external personal problems that affect the work environment is presently developing rapidly. There is, however, still limited acknowledgement of this aspect in relation to professional burnout (Gutiérrez, et al, 2004). According to them it is necessary to explore external problems as possible bidirectional variables, because they may be a forerunner of burnout or a consequence of burnout (Gutiérrez, et al, 2004). Participants in the current study were of the opinion that personal problems contribute to burnout, but as mentioned by the authors above they found it difficult to distinguish if personal factors are indeed a cause of burnout or a result of burnout. Another opinion from the literature was that burnout is more likely to develop when an individual lacks a healthy balance between external life and work or when the individual experiences severe problems both at work and in private life at the same time (Spinetta et al, 2000).

However, at its core "burnout represents a problem in the work environment, rather than an internal human problem" (Imai, Nakao, Tsuchiya, Kuroda & Kotoh (2004, p. 764). Thus the rest of the discussion focuses on burnout in the work environment. Since the causes, prevention and management of burnout are complex and interrelated these are discussed together in the following section.

6.5 Causes, prevention and management of burnout

According to the literature there is no single strategy that provides total protection against the harmful effects of the difficulties one is faced with in the workplace. It is therefore advisable that the individual has a selection of methods which can be used as necessary and indicated (Alexander & Klein, 2001).

Empowerment, education and training

According to the participants, education and training on various topics related to burnout, coping strategies, management and leadership, as well as clinical skills will reduce current levels of burnout and decrease future incidence. Training and education will provide knowledge, skills and empowerment which will assist individuals in identifying and managing burnout. Table 6.2 provides a list of possible topics as reflected from the data which can be considered for workshops.

Table 6.2 Topics for burnout education and training

Managers
• Addressing burnout in the workplace • How to provide supportive services to staff • Positive and effective leadership styles • Managing and controlling stress in the workplace
Therapists
• Stress management • Coping strategies and skills • Workload management and prioritising • Time management • Individual wellbeing
Managers and therapy staff
• Burnout sensitisation, prevention, identification and management • Teamwork and team dynamics • Personality types/profiles • Relationship skills (including gender and racism) • Communication skills
Nurses
• Empowerment • Teamwork and team dynamics • Therapeutic nursing
Case Managers
• Criteria for suitable patients

At a professional level opportunities for professional development can be expanded and more opportunities must be provided for staff to attend workshops over and above the professional development workshops which Life Rehabilitation are already presenting and which are free of charge for staff. More CPD

opportunities should be provided for the social workers and the psychologists. It is also important to develop opportunities and new challenges for staff that have been employed by Life Rehabilitation for an extended period, especially for the therapy assistant.

Several participants were dissatisfied with the limited funding available for continued education opportunities and the lack of time to keep up on professional literature. In the Cypriot study (Table 6.1) 88.2% of participants mentioned a lack of opportunities for professional development as a problem. It does seem from qualitative comments as if therapists in the current study feel that the company is responsible for their professional development. While the company does have a role to play professional development is ultimately the responsibility of the individual. However, time and financial constraints as experienced by the participants in the current study might result in decreased attendance of courses and workshops as most of these are costly and require time off work.

Professional clinical supervision should be implemented as it plays a positive role in the reduction of employee stress and burnout (Edwards, Burnard, Hannigan, Cooper, Adams, Juggessur, Fothergil & Coyle, 2006). Professional supervision is also an essential part of professional development (Boland, Strong & Gibson, 2010). The supervisory relationship should focus on professional competencies which include: assessment, decision-making, treatment planning, implementation and evaluation (Boland et al, 2010).

In addition to training in clinical matters staff must be supported to attend training on emotional matters such as coping strategies and stress management. Poor coping skills and a diminished ability to deal with stress had a significant impact on EE ($p = 0.0318$). Sardiwalla et al (2007), whose study focused on the role of coping strategies and stressors in burnout as experienced by hospice employees, found an association between poor coping strategies and EE, as well as DP. They found that workers who regularly use ineffective or problem-focused coping strategies are more likely to report high levels of EE and DP. They were of the opinion that workers would probably benefit from making use of emotionally focused coping strategies like dealing with traumatic experiences in a religious manner and establishing suitable ways of venting emotions in a caring setting. In the current study active practice of religion did not show a statistically significant

impact on reducing burnout, but participants did acknowledge the value of religion in dealing with work stressors in the qualitative data.

The therapy staff identified a lack of skills under nursing staff as contributing to burnout in them. In the past the guidance for rehabilitation programmes often came from occupational therapists and physiotherapists and nurses were not expected to play more than a supportive role (Hawkey & Williams, 2007). However, in-patient rehabilitation should be a 24-hour process with nurses taking over from therapists while patients are in the wards. The nurse is an essential part of the team. Specialist knowledge and skills are necessary to carry out therapeutic nursing within rehabilitation (Hawkey & Williams, 2007). To apply specialist knowledge and skills the nurse needs to be familiar with the process of assessment, goal setting, therapy roles and contributions, teaching and evaluation (Hawkey & Williams, 2007). They are the most important source of information to the team on progress, complications and difficulties that patients are experiencing (Hawkey & Williams, 2007). If they do not have the necessary skills to provide pain relief, assistance with hygiene and mobility, give pressure area care, ensure adequate nutrition, promote continence and manage in continence, give emotional support and provide opportunities for adequate sleep and rest, then all other activities will be ineffective (Hawkey & Williams, 2007).

Nursing is generally under a lot of strain in South Africa (both publicly and privately) due to problems this profession are experiencing with regard to training challenges, decreasing numbers and the brain drain (Kautzky & Tollman, 2008). It is therefore conceivable that challenges specific to the nursing profession might make it difficult for the nurse to evolve from the traditional role of carer to someone providing all the input mentioned above. Thus it is essential that Life Rehabilitation management provide ample opportunities and support for nurses to be trained in the various aspects that nursing in a rehabilitation unit require of a nurse and to evolve into true members of the rehabilitation team who can take on their role as an integral part of the team.

Finally one needs to look at orientation of new members of staff. Although Life Healthcare offers an orientation/ induction programme it does not seem to address all needs of the therapy staff and should be adjusted and improved. Wanous and Reichers (2000) were of the opinion that these programmes should

not only provide information but assist new employees in establishing relationships and in managing anxiety and stress, which are part and parcel of starting a new job. It is further recommended that an induction/information booklet be created to assist staff in this regard.

Income/Remuneration/Rewards

This study showed a statistically significant relationship between salary and burnout scores. Literature differs on the impact of salary on burnout. The Turkey study (Gulalp et al, 2008) found no relationship, while in the Cypriot study (Pavlakis et al, 2010) 85.5% of participants felt they were underpaid and both EE and PA scores were statistically significantly associated with low salary. It is possible that the respondents in the Turkey study perceived their income as sufficient (the income levels were not elaborated on).

In the current study 71.42% of participants were of the opinion that their salaries were not market-related and 42.85% were doing additional work other than their work at Life Rehabilitation to supplement their income. This additional work showed some impact on EE although it was at 0.0568 only, just not statistically significant. According to qualitative data reduced PA can in part be attributed to feelings of being undervalued by not being rewarded through good remuneration.

Respondents indicated a need for recognition in the form of pay, promotion and perks. Rewards such as time off, a fancy lunch on company expenses and relaxation sessions during lunch are less costly, but also show appreciation and at the same time can act as team building exercise. Personal rewards such as a massage or movie tickets are other options that come to mind.

Research links team building activities to improved job satisfaction and reduced stress and burnout (Canadian Health Services Research Foundation, 2006). Managers can improve interpersonal relationships and communication in order for team members to function as a more cohesive group by the implementation of team building strategies. A lack of communication and connectedness were found to significantly impact on the DP and PA dimensions of burnout in the Massachusetts study (Donohoe et al, 1993). Participants in the current study suggested that team building activities such as inter-hospital sport days would

also promote physical health. Managers can identify resources and assist in organising team building strategies (Amos, Hu & Herrick, 2005).

Type and size of workload

The majority of therapists indicated that they had an above average or overwhelming work load (71.42%) and an above average or overwhelming patient load (66.66%). This was found to have a statistically significant impact on the development of EE, and in the case of work load there was also a significant impact on DP. High workload, patient load and administrative duties are all variables which can cause time constraints. Time constraints were mentioned extensively in the qualitative data as a contributing factor to burnout. The negative impact of high workloads and time constraints on EE is also demonstrated in the literature (Kowalski et al, 2010). A study by Girgis et al (2009) that focused on Australian oncology health professionals found higher EE levels among participants who provide direct patient care. Levels of EE increased with increasing time spent in direct patient care. The authors acknowledged the fact that the emotional part of caring for the dying and ill plays a significant role in the exhaustion element but were of the opinion that burnout may be related to an overload caused by patient load that is high, rather than the patient contact per se. They found that DP was lower in participants who spent more time with patients and it therefore had a positive, instead of a negative effect on DP (Girgis et al, 2009).

The majority of therapists (67.24%) in the current study spend up to 25% of their time on administrative duties per day. An increase in administrative duties was the variable with the strongest negative impact on the PA dimension of burnout. Literature agrees that burnout can be linked to a higher administrative load (Gutiérrez et al, 2004; Lee, Steward & Brown, 2008; Shanafelt, West, Sloan, Novotny, Poland, Menaker, Rummans & Dyrbye, 2009). Shanafelt, et al (2009) studied faculty physicians in the Department of Internal Medicine at an academic centre in the US with regard to burnout. They established which work-related activity was the most meaningful to the participants. Of the 465 respondents 68% reported that patient care was the most significant aspect of their work. Nineteen per cent reported research, nine per cent education and three per cent administration. A decreased risk of burnout was strongly associated with the

amount of time spent working on the most significant activity. Thus, the more time spent on meaningful activities reduced the risk of burnout.

It is possible that participants in the current study also find administration to be a less meaningful activity, especially if one considers that PA is the burnout dimension most negatively affected by the administration load. Another possible explanation for the administration burnout association in this study could be that in this study the participants have to do a lot of administration manually (for example, progress notes, discharge report notes and team meeting feedback) and are not linked to an electronic system which might reduce paperwork and prevent duplication. Report writing and accurate record-keeping are inherent and important functions which are absolutely necessary for good clinical practice. It is however, also important how this is done and how it can be streamlined.

One of the aspects that caused frustration according to qualitative data and time limitations was performance evaluation in the form of JPM projects and specifically the unit development project. According to Gabris & Ihrke (2001) dissatisfaction over a performance-appraisal system may not add significantly to increased burnout, but at some point the dissatisfaction may become so bad that it increases anxiety, which results heightened levels of burnout in employees". Participants from at least one of the units in the study felt that the extra projects therapists are expected to do and subsequently being evaluated on increase stress levels due to time and staff shortages.

DP was associated with not working weekends in this study, a finding which was directly the opposite of what was expected. Working less hours are normally associated with lower burnout levels (Mandy et al, 2004) and this finding is therefore difficult to explain. The researcher could not find studies which focused on the association between weekend work and burnout specifically. Further study is required to explore this association. Be that as it may, working over weekends should be revisited. Originally, weekend duties in medical services focused on emergency or essential treatment. Rehabilitation is not an emergency treatment and can surely be resumed on Monday morning. In fact, it would be much more essential for successful rehabilitation that the person spent increasing time in the home environment and community over weekends in order to identify challenges in these environments which can then be addressed in rehabilitation.

If Life Rehabilitation management wants to seriously address the issue of burnout, the workload of therapists will have to be evaluated and re-aligned to manageable proportions. Workloads and patient loads should be monitored and staff shortages should be addressed. Vacant positions should be filled as a matter of urgency and new positions should be created where necessary. Loads should be monitored to ensure that they are not excessive and employees are not overloaded. A formula to calculate (quantify) workload objectively and weight patient contact time, administration time, research and personal development must be in place to ensure equitable distribution of workload among staff and structure the work day. Unrewarding work and challenging patients should be shared or alternated. Among staff each therapy staff member should have the opportunity to participate regularly in non-patient related tasks. All aspects from the administrative demands, through type of patients admitted to patient-therapist ratio must be taken in consideration. It will be of little value to determine a therapist-patient ratio on eight hours per day if two of those eight hours are spent on the required administrative duties. The efficiency perspective which focuses on inputs versus outputs and only considers the financial balance sheet seems to be in operation currently. However, a decrease in financial gain through either employing more therapists or admitting fewer patients might improve service effectiveness – the ultimate performance measure for human service programmes.

An option that would have even less financial impact is to revisit the administrative burden that the therapists carry. The administrative load should be streamlined, more computerised and software programmes should be developed to assist with Life Rehabilitation's specific needs. At the same time these computers can be used for patient treatment and assist to offset of the problem of inadequate equipment in that area. A decrease in the administrative load or streamlining of administration systems will provide the therapists who are by training and inclination more focused on patient treatment additional time with their patients.

Qualitative data indicated that the problem was exacerbated by difficulties in taking time off or going on leave since therapists needed to find a locum to cover for them and locums were hard to come by. Locums will also be required should

the company consider sabbaticals which are an increasingly popular alternative solution for burnout. To date, studies report that in 2007, 16% of US employers offer unpaid sabbaticals and 4% gave paid sabbaticals. A number of companies offer three-month sabbaticals with no salary but with paid benefits and guaranteed re-entrance if the employee has been employed for at least three years at the company (Goutas, 2008). A locum pool must therefore be built up and it should be made attractive for locums by Life Rehabilitation through competitive salaries and good working circumstances.

The nature of rehabilitation work and the types of impairments treated

The effect of working with individuals with severe disabilities was touched upon under the discussion of prevalence (p.196). The severity of this issue was brought home by the qualitative data where feelings of hopelessness and despair, as well as frustration are clearly visible. According to George and Wolfe (1981), a contributing factor to burnout appears to be an inability of the therapist to achieve success in the treatment of his/her patients. The therapist enters into a relationship with a patient, expecting to improve some problems and most of the patients have similar expectations (George & Wolfe, 1981). When these expectations are not fulfilled, feelings of frustration, failure and a negative self-image may emerge and symptoms of burnout become manifest (George & Wolfe, 1981). This was supported by findings from the Massachusetts study. Regression analysis indicated that patients' lack of achievement was significantly associated with EE (Donohoe et al, 1993).

However, participants in the United States of America (USA) study experienced the challenging environment of treating clients with head injuries as positive (Schlenz et al, 1995). It was said that it provided more opportunities for professional growth and creativity and some participants claimed that this aspect prevented them from burning out. While data on workload and time pressure were not available from the USA study one can postulate that patient-therapist ratios might have been lower, leaving time for professional growth and creativity. Participants in the current study created the impression that the demand of the work load was so high that little opportunity existed for creativity. In fact, the repetitious nature of the work was mentioned as a contributing factor to burnout. Rehabilitating patients with widely differing impairments from equally differing

environments can only become repetitious if one does not have the time to explore all the various factors impacting on the rehabilitation process.

In addition patients are not followed up at Life Rehabilitation, which means often therapists receive no feedback on how they are coping once discharged. Opportunities to provide feedback should be sourced since it plays an important role in the prevention of burnout (Maslach & Jackson, 1984). In the case of Life Rehabilitation the therapy staff felt that they would like feedback and visits from discharged patients as a source of positive feedback to them. It might be beneficial for therapy staff to be allowed to do home visits and to develop a system whereby discharged patients/ their caregiver provide feedback in the form of a self-evaluation form. Management can not do this since the therapists know what kind of information they require. Another source of feedback mentioned in the literature is co-worker evaluations (Maslach & Jackson, 1984). The advantage is that it is made by a co-worker who is aware of constraints placed on the staff by the organisation and not by clients who may base their evaluations on comparison with an ideal standard (Maslach & Jackson, 1984). The evaluation of co-workers should be based on an understanding of customary professional standards, ethics and practices (Maslach & Jackson, 1984).

Furthermore, the situation is exacerbated through ethical dilemmas such as the admission of patients that therapists felt would not benefit from treatment and admitting more patients than what therapists can effectively treat at any one time. This causes ethical and moral conflict within therapists as they see the admission of these patients as unethical and they feel guilty because they cannot help them. According to Cohen & Erickson (2006) ethical principles and values provide guidelines for *professional* conduct. Employees frequently come across situations that have ethical conflicts and they often have difficulty articulating and recognising them (Cohen & Erickson, 2006). Unresolved conflicts can cause feelings of powerlessness and frustration, which can result in compromises in patient care, job satisfaction, disagreements among those in the healthcare team and burnout (Cohen & Erickson, 2006). According to Haddad (2002) employers are ethically obliged to show respect for their employees by maintaining an environment that promotes staff wellbeing and by not recruiting staff to act unethically (Haddad, 2002).

It is necessary that ethical dilemmas be reduced as far as possible in order to prevent burnout. This can be done, through ensuring that patients who are admitted meet the rehabilitation criteria, not admitting more patients than can be effectively treated by the team, and not making unrealistic promises to families, as well as ensuring that therapists do not have to make illegal copies of test material and that confidential patient notes are treated confidentially at all times.

Profit driven environment

Being a private health care environment the study setting is by nature profit driven. However, it brings a duality of purpose. On the one hand rehabilitation services are offered to clients, but on the other financial statements must show a profit. These two aims are not always compatible since in-patient rehabilitation is an expensive undertaking, and in between stands the person who must deliver the service. Both patient and company expect 100% from the therapists, often with little concern for their wellbeing. According to the McKinsey Quarterly Report (2007) which focused on profit for each employee, companies focus more on their proceeds on invested money than on taking into consideration the contributions made by the employees (Bryan, 2007). One might view issues such as changes in favour of the company in time back policies and therapists who are seen to owe hours to the company after they were sent home since there was not enough work as manifestations of this money above all mentality. “Writing off” these hours would have been a mutually beneficial way of showing appreciation. This would provide one way of rewarding without spending money.

This uneasiness regarding finances was also demonstrated by the fact that most therapists felt their salaries were not market-related and that the company showed no appreciation for what they do in either financial or other rewards.

In this environment medical insurance companies often have the final say about who may or may not be admitted and what the length of the rehabilitation period can be. Length of stay (LOS) for in-patient rehabilitation is getting shorter (Ottenbacher, Smith, Illig, Linn, Ostir & Granger, 2004). Early discharge of patients results in an incomplete rehabilitation programme and sending patients home before goals have been reached. This enforced curtailing of the rehabilitation process might have negative consequences on patient progress and

outcomes, as well as patient performance after discharge with a resultant impact on therapists.

The researcher ascribes many of the ethical issues raised by therapists to this focus on profit. For instance, admitting patients that cannot benefit from the programmes offered might be a mistake in isolated cases, but if it happens often and if the therapists are not consulted as to who should be admitted and who not as qualitative data suggests, one starts to wonder if money does not play a role in these decisions.

However, in spite of these patients' minimal chances of recovery or improvement, admission may be justified in order for the staff to educate the family and caregivers on management of the patient at home. Such stays can be short. "Unsuitable" patients for rehabilitation can pose a problem since those with medical aids have difficulty accessing therapy at state-run facilities e.g. community health centres.

Physical work environment

Sardiwalle et al (2007) found positive correlations between EE and the physical work environment which indicated that employees who are more disgruntled with their work environment experience higher levels of burnout. These findings corroborate the current study's findings of a significant association between a poor work environment and EE. The current study also found a negative association between environment and DP which Sardiwalle et al (2007) did not find. The quantitative findings on work environment in this study are confirmed by the qualitative data of this study.

Private health care in South Africa is hailed as the flagship for health in the country (Harrison, Bhana & Ntuli, 2007). It is also expensive and as the therapists rightly pointed out, families and patients expect the best for the money they pay. Crowded gymnasiums and outdated equipment do not enhance the image of Life Rehabilitation. Improvement in this area will decrease the risk for burnout in therapists while it can be used to advertise and boost the image of the company. It will also assist the therapy staff to provide more effective treatment.

Computers and computer networks should be improved. Internet access will assist therapy staff to keep abreast of the latest developments and research in the rehabilitation arena.

Provision of a "time-out" room/facility in the units with comfortable chairs and tables will encourage staff to take lunch breaks and provide an opportunity for staff to take time out from the work station and patients if required.

Counselling

The ICAS programme that is offered by Life Healthcare is a positive step to assist employees to deal with personal and work-related problems that might affect their work, health and general wellbeing. However, it seems as if the programme was not marketed well, because a lot of staff was not aware of it or did not know what services were offered and how they are rendered.

The study participants differed in their opinions about whether debriefing is helpful or harmful. There were also different opinions on how it should be implemented. This is also the case in the literature. According to Everly and Mitchell (2000) some authors have not only challenged the effectiveness of debriefing, but have raised the spectre that it may cause significant harm. This opinion however, should be further explored and debriefing should be made available to staff who feel that they will benefit from this method to rebalance after a crisis. Options should be explored that are acceptable to everyone. Opportunities for staff to acknowledge the death of patients and to provide an opportunity for grieving should be looked into. Death bereavement opportunities for staff should be available for those who choose to make use of them.

Findings and literature show that making use of counselling intervention could result in a decrease of burnout (Isaksson, Gude, Tyssen & Aasland, 2008). If intervention is easily accessible it can increase motivation to consider it and decrease reluctance to seek assistance (Isaksson et al, 2008). This responsibility should not become the job of team social workers as is currently happening. Some therapists expressed the need for more hands-on counselling at the units. This, however, might have confidentiality and space implications and should be further explored. Counselling should be made available and a counsellor should visit units as the therapy staff is unable to visit counsellors in work time.

Support

The therapists were of the opinion that the managers could play a significant role in the prevention of burnout, a statement with which literature agrees. Managers can either add to or reduce stress levels and burnout by their attitudes, behaviour, decisions and leadership styles (Niehouse, 1984; Bergen & Fisher 2003). It is therefore important that managers explore the different leadership models that can be employed (Niehouse, 1984). Managers must minimise and prevent burnout through their leadership in the following ways: remove job ambiguities, maintain realistic goals, introduce changes gradually, improve stressful working situations whenever possible, be familiar with and monitor for the signs of burnout, initiate and promote a stress management programme where necessary and when realistic (Niehouse, 1984). Managers must also be practical and pro-active and address potential frustrations that can result in stress in the units.

Supervisors and/or colleagues can provide excellent sources of support. Literature proposes that in addressing stressors at the place of work, organisational sources can provide support over and above that which is provided by friends and family outside the place of work. Colleagues and managers are able to provide support such as practical assistance, feedback and information, and/or emotional support applicable to the employment situation. A study by Spooner-Lane and Patton (2005) found that supervisor support assists with coping and lessens the effect of DP and reduced PA.

Telephone conferences between the units must be encouraged to increase support between the units. Support groups in the units should be encouraged to mitigate the effects of stress.

Inclusion and control

Therapy staff should be included in the decision-making process. Increasing employee participation in the decision-making process, increases the degree of control they have, which in turn is an effective way of preventing burnout (Maslach & Jackson, 1984). Regular meetings between management and staff are necessary to discuss needs, issues, common goals and the vision of the company. This will ensure that therapy staff feels less cut off from management and will foster a better understanding of issues like company constraints.

Teamwork

Research has revealed that teamwork can drastically reduce patient morbidity, improve patient satisfaction, increase staff retention and satisfaction, reduce workloads, reduce staff shortages, improve quality of care and patient safety, as well as reduce stress and burnout among health care professionals (Canadian Health Services Research Foundation, 2006). Factors which have an influence on team effectiveness and how to improve teamwork and what organisational factors influence teamwork should be explored and implemented by Life Rehabilitation.

6.6 Summary

The study had a good response rate and was representative of the study population. The prevalence of burnout amongst therapy staff in Life Healthcare was high in all three burnout dimensions. It was also high in comparison with findings from other South African studies and international studies. Both managers and therapy staff showed good understanding of burnout and were able to recognise some of the signs and risk factors regarding burnout, as well as the effects of burnout. There were, however, no formal identification procedures in place to identify staff members who suffer from burnout nor an official company policy to address and manage burnout. The majority of staff felt that the company's attitude towards burnout was poor and that there were no accountability regarding the well-being of staff. Various burnout management strategies and preventative strategies were identified and compared to literature in the discussion.

CHAPTER 7

CONCLUSION AND RECOMMENDATIONS

7.1 Conclusion

The study met the aims and objectives set out in Chapter 1. This study found that the prevalence of burnout is high in Life Rehabilitation units and that it has a negative effect on the overall functioning of therapy staff, service delivery, productivity and staff attitude towards the company. The current existence and future incidence of burnout amongst therapy staff in Life Rehabilitation units can be decreased through pro-active implementation of policy and strategies to prevent and manage burnout. In order to achieve success it is essential that these strategies are incorporated in official company policy and that the implementation of policy is monitored and evaluated continuously. Success will require commitment, time, money, resources and a shared effort on the part of all role players.

However, the ultimate benefits should negate the inputs referred to above as decreased incidence and prevalence of burnout will contribute to a more productive, motivated and healthy workforce. This will in turn benefit the patients and the company in that it will result in less errors, better performance, improved service delivery, less absenteeism and better staff retention.

7.2 Extrapolation of results

Although this study focused on therapy staff employed by Life Rehabilitation it might be possible to extrapolate results and recommendations to other categories of health care staff employed by Life Rehabilitation, Life Health care in general, as well as other public and private rehabilitation services and/or health care services, with careful comparison of demographic and employment details.

7.3 Recommendations to Life Rehabilitation

Recommendations to Life Rehabilitation focus on practical strategies which can play a positive role in the detection, prevention and management of burnout in therapists. These strategies are presented in Table 7.1. Some of the

recommendations are already in use at Life Rehabilitation. It is, however, recommended that those aspects be reviewed and/or further developed. It is further recommended that special attention should be given to the monitoring and evaluation of the strategies after implementation as it will not be sustainable or successful without this aspect. The strategies can be broadly divided into policy development, detection, prevention, management and monitoring.

A employee wellness task team/body should be appointed to deal with policy and operational matters relating to burnout. The task team should focus on the prevention of burnout and work-related stress, support, education and sensitisation of staff regarding burnout, as well as the monitoring of the well-being of staff. The task team should involve all role players and could include representatives from Head Office, Human Resources Department, ICAS, therapy, psychologists and/or consultants who specialise in burnout related matters.

During tough economic conditions, a burnout programme might not be a priority in companies. However, an investment in such a programme will save the company money in the long run through improved employee performance, better employee health and retention of skilled and experienced staff. The company and patients will benefit from a better working environment for staff and it will raise the organisational profile in the community. However, if the company does not budget sufficiently for such a programme it will not happen. The budget should be correlated with the number of employees.

Table 7.1 Recommendations to address burnout in Life Rehabilitation

Aims	Objectives	Actions	Responsible body	Time frame
Policy development				
Develop a burnout policy and burnout action plan	• To formulate policy that will minimise the incidence of burnout and provide guidance with regard to management of burnout where it is already present	• Identify a employee wellness task team	Management in consultation with employee representatives	Within three months
		• Develop a burnout policy	Employee wellness task team	Complete within six months from formation of team
		• Drive implementation of burnout policy	Employee wellness task team	Full implementation within one year
		• Allocate resources (staff time and budget)	Management in consultation with task team	Within six months
Detecting burnout				
Detecting burnout	• The early detection of employees suffering from burnout or who are at high risk for the development of burnout	• Regular completion of the MBI	Psychologist/ psychometrist identified by task team	Annually
		• Monitor leave, sick leave patterns and behavioural changes	Therapy manager	Six-monthly
		• Follow up on patient complaints	Therapy manager	Immediately after complaint
		• Implement scientific instruments/questionnaires to measure and monitor employee wellbeing and satisfaction	Employee wellness task team	Annually
Prevention and management of burnout				
Sensitising and empowerment of staff	• Provide education and training on	• Develop/ source and present workshops and training programmes	Employee wellness task team	To develop within one year then

regarding burnout	burnout to all staff			annually workshops and training
Improve managerial related aspects and communication between staff and management	• Provide sound leadership and improve communication between management and staff	• Develop a compulsory orientation management programme where good leadership models are taught and submit new and existing managers to it	Head Office and employee wellness task team	Annually
		• Implement a questionnaire where staff can rate the managerial skills of a manager and provide suggestions for improvement	Employee wellness task team	Annually
		• Meetings between Head Office, management and staff	Managers	Every four months
		• Involve staff in decision- making processes by requesting their input on relevant matters, for example uniforms	HO, Therapy and Unit Managers	As required
Implement formal supervision and improve professional development	• Provide professional growth, developmental and learning opportunities for staff	• Investigate different supervision models and decide on a suitable one	Employee wellness task team and therapy managers	Within six months
		• Identify supervisors and implement supervision	HO and managers	Twice a month (1hr sessions)
		• Extend CPD opportunities so that all professions have equal opportunities to attend (for example, not to mainly focus on physiotherapists and OT's) and provide more opportunities for staff to attend academic gatherings such as congresses	HO and managers	Each staff member to attend at least 10 professional development days per year
		• To explore new challenges for "old" staff, e.g. promotion, other positions	HO and managers	Annually
		• Reorientation of nurses with regards to their role in a rehabilitation unit	Nursing and Therapy Managers	Within six months

Review current orientation/induction programme	• Provide sound preparation of new staff members	• To review and extend the orientation/induction programme and develop induction booklet for new staff members	HO, Human Resources and employee wellness task team	Within eighteen months
Re-evaluate leave, hours and Saturday work	• Decrease exhaustion levels of staff members	• To explore the option of sabbaticals and introduce if feasible	Human Resources and employee wellness task team	Within eighteen months
		• To explore the option of increase of annual leave	Human Resources and employee wellness task team	Within eighteen months
		• To allow flexibility in terms of working hours	Unit managers	Within eighteen months
		• To re-evaluate the necessity of Saturday work	Human Resources and employee wellness task team	Within six months
Create an ethical work environment	• Address ethical dilemmas and conflicts and issues	• To appoint an ethical committee	Head Office and Therapy Managers	Within six months
		• To review current ethical practises	Ethical committee	Within a year
		• To provide education to staff and management regarding ethical principals	Ethical committee	Annually
Reward staff	• Re-evaluate and adjust salaries and to re-evaluate	• Review salaries and to adjust where possible	HO, Therapy Managers, Human Resources and Hospital Managers	Within the next two years

	reward and recognition programme	• Review reward and recognition programme	HO, Therapy Managers, Human Resources and Hospital Managers	Within the next two years
		• To acknowledge the value/contribution of the therapy assistant e.g. financially	HO, Therapy Managers, Human Resources and Hospital Managers	Within the next two/three years
Improve resources and equipment	• Provide suitable and necessary resources and equipment to staff	• Make more space available in units for treatment etc.	Head Office, Therapy and Hospital managers	Within the next two/three years
		• Improve computer networks and introduce more computers	Head Office and Hospital and therapy managers	Within six months
		• Provide internet access to all therapy staff members	Head Office and Hospital and therapy managers	Within eighteen months
		• Provide more and improved equipment	Therapy managers and Hospital managers	Within two years
		• Enrol in professional journals and make it easily available to staff members	Therapy managers and Head Office	Within eighteen months
		• To appoint porters	Therapy managers and Head Office	Within eighteen months
Improve team	• Provide sustainable	• Provide regular team building activities	Therapy managers	Every three months

building and team work	moral building activities	• Organise inter-sport days between LHC hospitals	Therapy managers and staff	Once or twice a year
Develop a burnout sensitive culture	• Develop culture conducive to staff wellbeing	• To provide “time-out” rooms/facilities	Hospital and therapy managers	To complete within a year
		• Implement fixed lunch breaks/forced lunch and tea breaks and to monitor that staff takes it	Therapy managers	Within six months
		• Introduce relaxation activities during lunch times	Therapy managers and staff	Within six to twelve months
Provide a supportive and caring work environment	• Increase support to staff and monitor support perceptions of staff	• Promote ICAS to assist with employee personal problems and to make counselling more readily available to staff	HR and ICAS	Every four months
		• Develop/research and implement a support questionnaire to measure support perceptions of staff	Employee wellness task team	To complete within twelve months, thereafter six-monthly
		• Encourage teleconferences between units	Therapy managers	Every four months
		• Explore debriefing models and to implement if indicated	Employee wellness task team	Within a year
		• Encourage the development of staff support groups	Therapy Managers	Within a year
		• Ensure that units are running smoothly and deal proactively with potential problems	Therapy Managers and hospital managers	Daily
		• Provide suggestion boxes in all the units for therapy staff and to implement feasible suggestions	Therapy managers	As suggestions are received

		• Provide patient death bereavement opportunities for staff	Employee wellness task team	As required
Monitoring and evaluation				
Monitor and evaluate burnout policy and programme	• Evaluate if policy objectives were achieved and to establish how well the policy is performing	• Develop audit or management system by making use of both quantitative and qualitative methods, group discussions, surveys, observations and the data gathered from the questionnaires suggested above	The process should be driven by the employee wellness task team	Annually
		• Implement changes according to the findings	The process should be driven by the employee wellness task team	After the findings have been established

7.4 Recommendations for further studies

- It is recommended that the current study be repeated in other settings and populations.
- It is recommended that the impact and/or effect of the implemented recommendations of the current study be investigated.
- A study of the effectiveness of ICAS in relation to burnout is recommended.
- The relationship between racism and burnout must be further explored.

7.5 Limitations of the study

This study has certain limitations:

- The sample size of the qualitative component of the study was large and ensured a representative distribution of the study population. It however, might have been more significant and time saving to have only focused on interviewing the participants with high and low burnout rates, when considering for example contributing factors and effects, as well as ways of combating burnout.
- The qualitative data was gathered and interpreted by the researcher and is limited by the fact that it was not independently verified and could therefore contain potential sources of bias that should be noted as a limitation.
- The study population was limited to therapists. Nursing staff and their managers, as well as medical doctors, might have been able to provide additional insights.
- The standards used in the inclusion criteria could have been more limited e.g. at least six months employment.

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Appendix 1

Question on	Changes made to version	Reason for change
Marital status	The Researcher changed the word "never married" to "single" and took "separated" out. The Researcher also added the question "if married, for how long".	"Never married" was confusing due to the fact that traditional marriages are not recognised and participants were not sure what to indicate in this regard. The Researcher felt that "separated" could be indicated under "other". The Researcher also felt that it will be important for the research, to know for how long the participants were married.
Children	The Researcher took the word "dependents" out.	"Children/dependents" was confusing to the participants, because dependents do not necessarily means children, for ex. it could be an elderly parent etc. The Researcher's focus however in this particular case is on the number of children.
Education	The Researcher added that the participants must indicate "the highest level of education" and structured the levels a bit clearer; the Researcher also added examples of post graduate degrees.	To prevent confusion.
Working experience	The Researcher added the word "total" to the question related to years of working experience and also added a question with regards to "how long the person have been employed in his/her current position at Life: Rehabilitation."	The participants were confused about if the Researcher meant how long they were employed in total or in particular at Life: Rehabilitation. The Researcher felt that both questions added value to the study.
Working hours	The Researcher changed the number of hours worked from "per day" to "per week".	It made it easier for the participants to indicate an answer because their contracts stipulated hours per week worked and not per day. The participants are also allowed to work flexitime and this created confusion.

Question on	Changes made to version	Reason for change
Income	The Researcher added the words: "gross income per month."	The participants were confused to whether the Researcher wanted the nett or gross income and if the Researcher meant per month or per week.
	The Researcher added the question: "Would you regard your salary as market related?"	The Researcher added this question for the sake of completeness, as income and burnout are closely related, according to the literature.
Weekend duty	The Researcher also deleted the question about "how often do you work during weekends and public holidays."	The question the Researcher deleted was confusing due to the fact that not all the months have public holidays.
Leave	The Researcher added the question about "unpaid leave."	The Researcher felt it will be significant to know if participants take unpaid leave, after their annual leave was exhausted.
Additional work	The Researcher added questions about "additional work."	The Researcher felt that this information is important with regards to burnout.
Sport and leisure activities	The Researcher decided to split the question with regards to "sport" and "leisure" activities and made it 2 (two) separate questions	It was confusing for the participants and they were not sure what to indicate as some was involved with sport and some not. The same applied to leisure activities.
Leisure activities	The Researcher decided to group "recreational/leisure and social" activities together as it focused on one particular aspect and provided examples of this.	The participants were confused between the differences between leisure and recreational activities when it was stated in different questions (it actually has the same meaning).
Answer options	The Researcher changed "not at all" to "none", "a little" to "poor" and "very much" to "excellent".	It is more describing.
Support systems	The Researcher added another question with regards to the support system in order to clarify between support at work and support at home.	The participants were confused to whether the Researcher meant support system at work or at home. Both these aspects are valuable with regards to the study.
Answer options	The Researcher changed the	The participants felt that is an easier

Question on	Changes made to version	Reason for change
	fractions to percentages.	way to indicate their answer.
Work pressure	The Researcher changed the question: "I experience time pressure in my job" to "I have reachable deadlines in my work."	The participants felt that this question was a bit vague.
Patient contact	The Researcher changed the question: "I tend to postpone contact with patients" to "I delay the treatment of my patients."	The participants felt that this question was not clear enough.
Additional questions	The Researcher added these questions.	The Researcher went back to the literature and felt that these questions will add value to the research.

Appendix 2

DATA CODING FORM

(Demographic, employment and social information)

Demographic details:

1. Research identity number: ☐☐☐

2. Gender: ☐

1	M	
2	F	

3 Age: ☐☐

4. Marital Status: ☐

1	Never married	
2	Married	
3	Divorced	
4	Widow/er	
5	Separated	
6	Other	

If other, please specify:

_____

_____

5. If married, for who long have you been married? ☐☐

6. Do you have children/ dependents? ☐

1	Yes	
2	No	

7. If you have children/dependants, how many of them are currently living with you?

8. Educational status (highest level): ☐

1	Grade 10 -11	
2	Grade 12	
3	1-3 years tertiary education	
4	> 3 years tertiary education	
5	Post graduate degree	

Employment details:

9. Occupation: ☐

1	Physiotherapist	
2	Physiotherapist Assistant	
3	Occupational Therapist	
4	Occupational Therapist Assistant	
5	Social Worker	
6	Dietician	
7	Speech Therapist	
8	Psychologist	

10. Years working experience: ☐

1	0 – 1 years, 11 months	
2	2– 4 years, 11 months	
3	5 – 6 years, 11 months	
4	7 – 8 years, 11 months	
5	9 – 10 years, 11 months	
6	> 11 years	

11. How long have you been working in your current position? : ☐

1	0 – 1 years, 11 months	
2	2– 4 years, 11 months	
3	5 – 6 years, 11 months	
4	7 – 8 years, 11 months	
5	9 – 10 years, 11 months	
6	> 11 years	

12. Income bracket ☐

1	R 0 – R 5000	
2	R 5001 – R 10 000	
3	R 10 001 – R 15 000	
4	R 15 001 – R 20 000	
5	R 20 001 – R 25 000	
6	> R 25 000	

13. Place of employment; ☐

1	New Kensington Clinic	
2	Eugene Marais Hospital	
3	Little Company of Mary	
4	Riverfield Lodge	
5	Louis Pasteur Hospital	
6	Entabeni Hospital	

14. On average how many hours do you work per week? ☐

1	8 hours	
2	16 hours	
3	24 hours	
4	32 hours	
5	40 hours	
6	> 40 hours	

15. Do you work over weekends & Public Holidays? ☐

1	Yes	
2	No	

16. If yes, approximately how often do you work during Weekends and Public Holidays?

1	Less than once a month	
2	Once a month	
3	Twice a month	
4	Once a week	
5	More than once a week	

17. Do you normally work overtime? ☐

1	Yes	
2	No	

18. If yes, how many hours overtime do you work on average per month? ☐

1	0 – 4 hours	
2	5 - 10 hours	
3	11 - 15 hours	
4	16 - 30 hours	
5	>30 hours	

19. Do you sometimes work less hours than you should? ☐

1	Yes	
2	No	

20. If yes, on average how often? ☐

1	Less than once a month	
2	Once a month	
3	Twice a month	
4	Once a week	
5	More than once a week	
6	Daily	

21. How many days annual leave did you take during the last year?

1	None	
2	1 – 5 days	
3	6 – 10 days	
4	11 – 15 days	
5	16 – 20 days	
6	> 20 days	

22. How many days sick leave did you take during the last year?

1	None	
2	1 – 5 days	
3	6 – 10 days	
4	11 – 15 days	
5	15 – 20 days	
6	> 20 days	

Leisure and other activities:

23. Do you participate in sport and/or leisure activities?

1	Yes	
2	No	

24. On average how many hours do you spend on sport and/or leisure activities per week?

1	1 hour	
2	2 hours	
3	3 hours	
4	4 hours	
5	5 hours	
6	6 hours	
7	7 hours	
8	8 hours	

25. Are you actively involved in your religion?

1	Yes	
2	No	

26. Do you partake in any other social or recreational activities?

1	Yes	
2	No	

27. If yes, please name them and state approximately how many hours per week do you spend on these activities:

_____

_____

_____

_____

_____

_____

Burnout related issues:

In questions 28-43 choose the option that best describes your situation. Please tick one option under each question.

28. I have an adequate social network and support system:

Not at all	A little	Fairly good	Excellent

29. I have well developed strategies to cope with stress:

Not at all	A little	Fairly good	Very much

30. I feel competent in my job:

Not at all	A little	Fairly competent	Very competent

31. I feel confident in my job:

Not at all	A little	Fairly confident	Very confident

32. My work load is:

To small	Just enough	A bit much	Overwhelming

33. My patient load is:

To small	Just enough	A bit much	Overwhelming

34. On average what part of your work day is spent on administrative duties?

None	Up to a ¼	¼ - ½	½ - ¾	> ¾ or more

35. I experience time pressure in my job:

Never	Seldom	Often	Always

36. I am unsure of my role in the team:

Never	Seldom	Often	Always

37. I experience conflict with colleagues:

Never	Seldom	Often	Always

38. I experience conflict with patients:

Never	Seldom	Often	Always

39. I have the authority to make my own decisions regarding my work:

None	A little	A fair amount	Completely

40. My job/profession is seen as prestigious:

Not at all	A bit	Fairly	Completely

41. I experience job satisfaction:

None	A little	A fair amount	Comletely

42. I tend to postpone contact with patients:

Never	Seldom	Often	Always

43. Do you experience any of the following signs and symptoms on a weekly basis? Tick the appropriate ones:

1.	Lingering colds	
2.	Sleeplessness	
3.	Head aches	
4.	Anger	
5.	Resentment	
6.	Decrease sense of humour	
7.	Cynicism	
8.	Impatience	
9.	Increased irritability	
10.	Bitterness	
11.	Sense of failure	
12.	Denial	
13.	Paranoia	
14.	Depression	
15.	Addiction to a substance	
16.	Exhaustion	
17.	Shortness of breath	
18.	Weigh control problems	
19.	High blood pressure	
20.	Impersonality with patients	
21.	Lack of motivation	
22.	Difficulty to concentrate	
23.	Tired all day long	

Appendix 3

CHRISTINA MASLACH • SUSAN E. JACKSON

MBI–Human Services Survey

The purpose of this survey is to discover how various persons in the human services or helping professionals view their jobs and the people with whom they work closely.

Because persons in a wide variety of occupations will answer this survey, it uses the term *recipients* to refer to the people for whom you provide your service, care, treatment, or instruction. When answering this survey please think of these people as recipients of the service you provide, even though you may use another term in your work.

On the following page there are 22 statements of job–related feelings. Please read each statement carefully and decide if you ever feel this way *about your job*. If you have *never* had this feeling, write a "0" (zero) in the space before the statement. If you have had this feeling, indicate *how often* you feel it by writing the number (from 1 to 6) that best describes how frequently you feel that way. An example is shown below.

Example

How often:	0	1	2	3	4	5	6
	Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times times a week	Every day

How Often 0–6	Statements:
1. _____	I feel depressed at work.

If you never feel depressed at work, you would write the number "0" (zero) under then heading "How often." If you rarely feel depressed at work (a few times a year or less), you would write the number "1." If your feelings of depression are fairly frequent (a few times a week, but not daily) you would write a "5."

cpp

1055 Joaquin Road, 2nd Floor, Mountain View, CA 94043
800-624-1765 www.cpp.com

MBI–*Human Services Survey*

How often:	0	1	2	3	4	5	6
	Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times times a week	Every day

How Often 0–6	Statements:
1. _____	I feel emotionally drained from my work.
2. _____	I feel used up at the end of the workday.
3. _____	I feel fatigued when I get up in the morning and have to face another day on the job.
4. _____	I can easily understand how my recipients feel about things.
5. _____	I feel I treat some recipients as if they were impersonal objects.
6. _____	Working with people all day is really a strain for me.
7. _____	I deal very effectively with the problems of my recipients.
8. _____	I feel burned out from my work.
9. _____	I feel I m positively influencing other people s lives through my work.
10. _____	I ve become more callous toward people since I took this job.
11. _____	I worry that this job is hardening me emotionally.
12. _____	I feel very energetic.
13. _____	I feel frustrated by my job.
14. _____	I feel I m working too hard on my job.
15. _____	I don t really care what happens to some recipients.
16. _____	Working with people directly puts too much stress on me.
17. _____	I can easily create a relaxed atmosphere with my recipients.
18. _____	I feel exhilarated after working closely with my recipients.
19. _____	I have accomplished many worthwhile things in this job.
20. _____	I feel like I m at the end of my rope.
21. _____	In my work, I deal with emotional problems very calmly.
22. _____	I feel recipients blame me for some of their problems.

(Administrative use only)

		cat.		cat.		cat.
EE:	_____	_____	DP:	_____	PA:	_____

Appendix 4

INTERVIEW SCHEDULE: MANAGERS

Section A: Personal knowledge, beliefs and practices on burnout

1. What do you understand about the concept of burnout?
2. In your opinion what is the cause/s of burnout?
3. How would you identify a staff member who is suffering from burnout?
4. Do you have any experience in the management of burnout?
5. If yes, how did you address the problem?
6. Do you think the therapy staff employed by Life Health Care: Rehabilitation Units is exposed to/ at risk for burnout?
7. In your opinion what factors might contribute to burnout in therapy staff employed by Life Health Care: Rehabilitation Units?
8. In your opinion what is the effect of burnout on staff?
9. In your opinion what is the effect of burnout on the company?
10. What strategies would you like to implement/ recommend to address this problem in the workplace?

Section B: Company policy and practices on burnout

11. What is the company's attitude towards burnout?
12. Is there an official company policy in place for the management of burnout?
13. If yes, what does this policy entails?
14. Who in the company is ultimately responsible for addressing this problem?

Appendix 5

INTERVIEW SCHEDULE: THERAPY STAFF

Section A: Personal knowledge, beliefs and practices on burnout

1. What do you understand under the concept of burnout?
2. In your opinion what is the cause/s of burnout?
3. Do you think the therapy staff employed by Life Health Care: Rehabilitation is exposed to/ at risk for burnout?
4. In your opinion what factors might *contribute* to burnout in therapists and assistants employed by Life Health Care: Rehabilitation Units?
5. In your opinion what is the effect of burnout on staff?
6. In your opinion what is the effect of burnout on the company?
7. Have you experienced burnout yourself?
8. How do/did you manage the problem?
9. What strategies would you like to see implemented to address this problem in the workplace?

Section B: Company policy and practices on burnout

10. What is the company's attitude towards burnout?
11. Is there an official company policy in place on the management of burnout?
12. If yes, what does this policy entails?
13. Who in the company is ultimately responsible to address this problem?

Appendix 6

National Rehabilitation office
Oxford Manor, 21 Chaplin Road, Illovo, 2196
Private Bag X13, Northlands, 2116, South Africa
Telephone +27 11 219 9620
Facsimile +27 86 686 0441
www.rehab.co.za

17th October 2007

Theresa du Plessis
Social Worker
Life New Kensington Clinic
23 Roberts avenue
Kensington
Johannesburg

Dear Theresa**,**

Re: Approval to proceed with research study:
A descriptive study to determine the prevalence of burnout among therapy staff employed by Life Health Care: Rehabilitation Units

It is with great pleasure that on behalf of Life Healthcare, I hereby grant you permission to proceed with your research study, entitled as above, according to the protocol detailed in your research proposal.

There is no doubt that the study will carry enormous benefit to the company's understanding of the factors leading to burnout in the rehabilitation service delivery environment, and it is well aligned with Life Healthcare's value relating to 'passion for people'.

It is understood that you will keep the company updated with regards the progress of your studies, and create the opportunities to discuss your results at critical points during your data collection.

The company will support the publication of your results in line with our support of the study's active implementation into the business, and would like a copy of your final research report. Please do not hesitate to request resources and support to ensure optimal conditions are created within the company to facilitate the study.

Best of luck with the work ahead!
With best regards,

Kathy Wundram
Acting National Rehabilitation Manager
Tel: **+ 27 11 219 9626**
Fax: **+ 27 86 686 0441**
Mobile: **+ 27 83 968 5644**
Email: **kathy.wundram@lifehealthcare.co.za**

Appendix 7

INFORMATION AND INFORMED CONSENT DOCUMENT FOR MANAGERS

Research Identity number: …….

Title of research project:

The prevalence of burnout amongst therapy staff employed by Life Health Care: Rehabilitation

Declaration by participant:

I, the undersigned **……** (name*)*

ID No: **……**

Of **……..……..** (address)

Hereby confirms that:

a) I was invited to participate in the above-mentioned research project which is being done under the auspices of the Centre for Rehabilitation Studies, Faculty of Health Sciences, Stellenbosch University;
b) The following aspects have been explained to me:

Aim:

The aim of this research project is to determine the prevalence of burnout amongst therapy staff employed by Life Health Care: Rehabilitation as well as factors contributing to burnout in this environment.

Background to the research project:

Burnout is a prolonged response to chronic emotional and interpersonal stressors at the workplace. Health workers and others in the "caring" professions are at increased risk for this stress syndrome because of the intensity of their work and the emotional bonds they form with the people they are helping.

Generally burnout is caused by a person's inability to relieve the physical and mental symptoms associated with unrelenting stress. It can result in poor job performance, absenteeism, impersonality with patients, and lack of motivation. Health problems such as high blood pressure, insomnia, depression or addiction can also occur as a result of burnout.

It appears that burnout is acknowledged as a problem in the healthcare industry but little is done to address this problem.

The researcher hopes to establish positive change regarding the management of burnout and by participating in the research you could be part of the solution.

Procedures:

Should I decide to take part in the study:

1. I will be requested to sign this document stating that I fully understand the nature of the study and that I freely agreed to participate in the study.
2. I will be requested to participate in an interview with the Researcher, where I will be invited to share opinions on the factors that contribute to burnout and possible solutions to the problem. The Researcher will make use of a digital recorder to record the interview. The interview will take approximately 30 minutes.

Access to data:

Only the Researcher will have access to written data as well as digital recorded material. The Researcher will transcribe the recordings herself. Written data as well as recordings will be stored securely at the Researcher's home. On completion of the study, tapes and written data will be destroyed.

Possible benefits:

My participation in the study will assist the Researcher to determine the extent of burnout in my work environment and with the development of strategies to manage burnout.

Risks:

There are no risks associated with participation of the study.

Confidentiality:

Confidentiality will be guaranteed at all times. My identity will not be disclosed to anybody at any time.

Access to findings:

The findings will be made available to interested participants of the study, but no personal information will be disclosed.

Voluntary participation/refusal/discontinuation:

1. I am under no obligation to part take in the study.
2. I volunteer to take part in the study of my own free will and may withdraw my consent at any time during the study.
3. Refusing to part take in the study or withdrawal from the study at a later stage, will in no way affect my employment at Life Health Care: Rehabilitation.

Financial aspects:

I will not receive any remuneration for participating in the study. There will also not be any costs for me to participate in the study.

Ethical considerations/ Rights of the participants:

The study has been approved by the Standards Manager of Life Health Care: Rehabilitation and by the Committee for Human Research and Ethics of Stellenbosch University. The study will be conducted according to the ethical guidelines and principals of the international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and Medical Research Council's Ethical Guidelines for Research.

Reporting of the data:

1. The Researcher will make the general findings available to the Management of Life Health Care: Rehabilitation as well as the Human Resources Manager, but not specific information regarding specific individuals. The identity of individual participants will not be disclosed.

2. The researcher will act on the findings of the research and motivate for action.

3. The findings will be published as a thesis and in relevant scientific journals.

The information above was explained to me by **……**in English. I was given the opportunity to ask questions and all these questions were answered satisfactorily. No pressure was exerted on me to consent to participation and I understand that I may withdraw at any stage.

I hereby consent voluntary to participate in the abovementioned project.

Signed at **……** (place) on **……..** 20 **……..** (date)

_____ _____

Participant **Witness**

Declaration by the Researcher:

I, declare that:

1. I explained the information given in this document to the participant.

2. The participant was encouraged and given ample opportunity to ask questions.

3. This conversation was conducted in English.

Signed at **……** (place) on **……..** 20**……** (date)

Appendix 8

INFORMATION AND INFORMED CONSENT DOCUMENT FOR THERAPY STAFF

Research Identity number: …….

Title of research project:

The prevalence of burnout amongst therapy staff employed by Life Health Care: Rehabilitation

Declaration by participant:

I, the undersigned **……** (name)

ID No: **……**

Of **……..……..** (address)

Hereby confirms that:

a) I was invited to participate in the above-mentioned research project which is being done under the auspices of the Centre for Rehabilitation Studies, Faculty of Health Sciences, Stellenbosch University;
b) The following aspects have been explained to me:

Aim:

The aim of this research project is to determine the prevalence of burnout amongst therapy staff employed by Life Health Care: Rehabilitation as well as factors contributing to burnout in this environment.

Background to the research project:

Burnout is a prolonged response to chronic emotional and interpersonal stressors at the workplace. Health workers and others in the "caring" professions are at increased risk for this stress syndrome because of the intensity of their work and the emotional bonds they form with the people they are helping.

Generally burnout is caused by a person's inability to relieve the physical and mental symptoms associated with unrelenting stress. It can result in poor job performance, absenteeism, impersonality with patients, and lack of motivation. Health problems such as high blood pressure, insomnia, depression or addiction can also occur as a result of burnout.

It appears that burnout is acknowledged as a problem in the healthcare industry but little is done to address this problem.

The researcher hopes to establish positive change regarding the management of burnout and by participating in the research you could be part of the solution.

Procedures:

Should I decide to take part in the study:

1. I will be requested to sign this document stating that I fully understand the nature of the study and that I freely agreed to participate in the study.
2. I will be required to complete a data demographic coding form with questions regarding personal and employment details and issues that are related to burnout.
3. I will be requested to complete the Maslach Burnout Inventory (MBI) questionnaire, which is an instrument used to measure the prevalence of burnout. This instrument will be administered and interpreted by a qualified Psychologist.
4. Finally I will be asked to participate in an interview with the Researcher where I will be invited to share opinions on the factors that contribute to burnout and possible solutions to the problem. The Researcher will make use of a digital recorder to record the interview.
5. The administration of the questionnaires and interview will take approximately 1 hour.
6. Should the MBI indicate that I suffer from/or are close to burnout, the Researcher or the Psychologist (who is assisting with the study) will discuss these findings with me. Advice regarding intervention/treatment options will be provided to me. It will however remain my responsibility to pursue this issue. It will also be my prerogative to disclose this information.

Access to data:

Only the Researcher will have access to written data as well as digital recorded material. The Researcher will transcribe the recordings herself. Written data as well as recordings will be stored securely at the Researcher's home. On completion of the study, tapes and written data will be destroyed.

Possible benefits:

My participation in the study will assist the Researcher to determine the extent of burnout in my work environment and with the development of strategies to manage burnout.

Risks:

There are no risks associated with participation of the study.

Confidentiality:

Confidentiality will be guaranteed at all times. My identity will not be disclosed to anybody at any time.

Access to findings:

The findings will be made available to interested participants of the study, but no personal information will be disclosed.

Voluntary participation/refusal/discontinuation:

1. I am under no obligation to part take in the study.
2. I volunteer to take part in the study of my own free will and may withdraw my consent at any time during the study.
3. Refusing to part take in the study or withdrawal from the study at a later stage, will in no way affect my employment at Life Health Care: Rehabilitation.

Financial aspects:

I will not receive any remuneration for participating in the study. There will also not be any costs for me to participate in the study.

Ethical considerations/ Rights of the participants:

The study has been approved by the Standards Manager of Life Health Care: Rehabilitation and by the Committee for Human Research and Ethics of Stellenbosch University. The study will be conducted according to the ethical guidelines and principals of the international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and Medical Research Council's Ethical Guidelines for Research.

Reporting of the data:

1. The Researcher will make the general findings available to the Management of Life Health Care: Rehabilitation as well as the Human Resources Manager, but not specific information regarding specific individuals. The identity of individual participants will not be disclosed.
2. The researcher will act on the findings of the research and motivate for action.
3. The findings will be published as a thesis and in relevant scientific journals.

The information above was explained to me by **……** in English. I was given the opportunity to ask questions and all these questions were answered satisfactorily. No pressure was exerted on me to consent to participation and I understand that I may withdraw at any stage.

I hereby consent voluntary to participate in the abovementioned project.

Signed at **……** (place) on **……..** 20 **……..** (date)

…… **……**
Participant **Witness**

Declaration by the Researcher:

I, declare that:

1. I explained the information given in this document to the participant.
2. The participant was encouraged and given ample opportunity to ask questions.
3. This conversation was conducted in English.

Signed at **……** (place) on **……..** 20**……** (date)

…… **……**
Researcher **Witness**

Appendix 9

CONFIDENTIALITY STATEMENT BY PSYCHOLOGIST

Declaration by the Psychologist

I, the undersigned CLAUDIA DA ROCHA KUSTNER (name)

ID number: 8205250176085

of LAKEFIELD, BENONI. (address)

Hereby confirm:

1. That I fully understand the nature of the study, which is being done under the auspices of the Centre for Rehabilitation Studies, Faculty of Health Sciences, Stellenbosch University.
2. That I freely agreed to assist in the study.
3. That I am a qualified psychologist and registered with the HPCSA & the Council for Psychologists - (HP Nr: PS 0095834).
4. That I will assist the Researcher with the administering of the Maslach Burnout Inventory (MBI) and the interpretation of the results.
5. That I will treat all information as confidential.
6. That I will not report any of the data to anybody.
7. That I will provide all the completed tests, data and results to the Researcher in order for the Researcher to use it in the study.

Signed at KENSINGTON on 02/04 2008

Psychologist

Witness

Researcher

Witness

Appendix 10

CONFIDENTIALITY STATEMENT BY TRANSCRIBER

Declaration by Transcriber

I, the undersigned SJ duPlessis (name)

ID number: 560509 0031 080

of Plot 1, Swaingpark (address)

Hereby confirm:

1. That I will treat all information as confidential.
2. That I will not report any of the data to anybody.

Signed at Pretoria on 24/6/2008

Transcriber

Witness

Researcher

Witness