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Burnout Among Filipino Occupational Therapists: A Mixed Methods Analysis


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Burnout Among Filipino Occupational Therapists: A Mixed Methods Analysis

Abstract

Background: There is a shortage of practicing occupational therapists in the Philippines, with approximately one Filipino occupational therapist per 30,000 stakeholders. One of the possible consequences is the experience of burnout among therapists.

Method: A two-phase mixed methods study using a sequential explanatory approach was used. The first phase involved the administration of the Maslach Burnout Inventory – Human Services Survey (MBI-HSS) with a survey questionnaire that supplied demographic and work-related factors through an online platform. The results were analyzed using frequency distribution and measures of central tendency. Relationships were analyzed using Spearman’s Rho and Cramer’s V. The second phase involved a focus group discussion and a series of in-depth interviews. Directed content analysis was conducted to form themes from the results.

Results: A response rate of 24.7% was achieved. The results indicated that several conditions influenced burnout for Filipino occupational therapists. These included an age range of 24 to 29 years of age, being unmarried, working during the early years of practice, and working longer hours.

Conclusion: The Filipino occupational therapists in this study experienced being drained from different sources of pressure, including their own and society’s expectations. This appeared to lead to at least some level of burnout and a decrease in creativity in practice.

Comments

The author reports no conflicts of interest to disclose.

Keywords

burnout, career satisfaction, human service, occupational therapy

Cover Page Footnote

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A shortage of practicing occupational therapists in the Philippines looms (Jaymalin, 2013). This is despite a heightened demand for occupational therapy services in the country due to a rising number of children with disabilities and an aging Filipino population (Ericta, 2013). According to the Philippine Academy of Occupational Therapists, Inc., there should be at least 5,000 additional practicing occupational therapists by the year 2025 to meet the Filipino people's needs. This would support a ratio of one occupational therapist for every 20,000 Filipinos. This may still not be an adequate proportion, but it is the most realistic and sensible number for a significant improvement in Philippine health care (Grecia, 2015).

Another trend is intensifying this need for additional occupational therapists in the Philippines. Studies have found that burnout is associated with an intention to leave the profession that eventually leads to action and causes a decrease in practicing health care professionals (Dyrbye et al., 2017). This might also be one cause of the occupational therapist drought in the Philippine context. There are only six institutions of higher education in the Philippines recognized by the World Federation of Occupational Therapy, and they produce approximately 200 occupational therapy graduates each year (Jaymalin, 2013). Thus, caring for the well-being of occupational therapists is of primary importance for hiring and retaining a sufficient numbers of therapists in practice and maintaining quality of service (Plessis, Visagie, & Mji, 2014).

The experience of burnout among health care professionals, occupational therapists included, can result in feelings of disillusionment and physical stress-related illnesses. Burnout may also result in reduced productivity, as absenteeism, health care costs, and intention to leave the profession increase. This all results in lower-quality care (Deklava, Circenis, & Millere, 2014; Dyrbye et al., 2017; Felton, 1998). Thus, burnout is a clinical complex that affects not only the individual but also society, especially clients (Felton, 1998; Kamal et al., 2016; Scanlan & Still, 2013).

Despite occupational therapy's popularity as a profession, in-depth analyses of burnout among occupational therapists are limited. Therefore, our study had three aims: (a) to determine the average level of burnout experienced by a group of Filipino occupational therapists, (b) to determine the relationship of demographic and work-related factors to burnout, and (c) to describe the actual experiences of Filipino occupational therapists who have experienced burnout and identify how those factors affect the level of burnout.

Literature Review

Burnout in a variety of service-oriented workers, specifically health care professionals, has been studied extensively over the past decades (Dyrbye et al., 2017; Gupta, Paterson, Lysaght, & von Zweck, 2012). Differences in these studies have suggested that cultural variability has been a crucial factor in the development of burnout (Gupta et al., 2012; Vicente, Oliveira, & Maroco, 2014). Burnout is a clinical complex described as a professional occupational disease that results from the cumulative work-related stress commonly experienced by service-oriented professionals, such as health care professionals (Felton, 1998; Maslach & Leiter, 2016; Vicente et al., 2014; Wressle & Samuelsson, 2014). It includes the presence of distinct dysphoric symptoms that are work-related, with an emphasis on mental and behavioral characteristics. Affected individuals show decreased effectiveness and work performance in comparison to those without any psychopathology (Maslach & Schaufeli, 1993). Moreover, burnout results in physical stress-related illness, such as muscle pain, headache, and insomnia (Felton, 1998). At least one study also suggested that subjective incompetence, fatigue, and increased irritability are key characteristics of burnout (Kakiashvili, Leszek, & Rutkowski, 2013).

In a U.S.-based study of health care workers, Felton (1998) identified that one-third of the surveyed 600 workers thought seriously about quitting work because of stress. One-half of those surveyed reported extreme levels of job stress, and one-third claimed that job stress was their greatest stress in life. The study also identified stress as contributing to the development of poor morale in the workplace, with those health care workers experiencing burnout being less likely to carry over the highest quality of service. Hence, it can be claimed that burnout affects all levels of the health care system, ranging from the service providers to the workplace and, ultimately, to the clients themselves (Dyrbye et al., 2017).

Researchers have consistently found that workload and time pressures are related to burnout. Longer hours of work were associated with higher rates of burnout in a study by Kamal et al. (2016). The findings in Wressle and Samuelsson's (2014) study of 807 Swedish occupational therapists suggested that work-related stress among the occupational therapists existed because of increased workload, a lack of resources, and interruptions of client care due to administrative duties. However, they argued that professional identity and clarity were not a vital source of stress among the occupational therapists studied.

Nearly 3 decades ago, Bailey (1990) cited the negative aspects of occupational therapy that predispose its practitioners to increased vulnerability to burnout as compared to other health care professionals. The causes included a lack of acknowledgement by other professionals, insufficient understanding of occupational therapy by other professionals, excessive paperwork, red tape and bureaucracy, limited development (both professionally and financially), stress, overload, dealing daily with others' trauma and pain, the chronicity of patients' illnesses, the need to continually justify occupational therapy reimbursement, coping with family and job, long hours, and long commutes to work (Bailey, 1990).

Burnout may be caused by the situation and/or work-related or individual factors. It was suggested by Cañadas-De la Fuente et al. (2015) that age, gender, marital status, and type of work show statistically significant differences in levels of burnout. However, there have been differences in reports among locations and settings. In most published works, burnout is described as a three-dimensional construct that includes emotional exhaustion (EE), depersonalization (DP), and reduced personal accomplishment (PA) (Plessis et al., 2014; Vicente et al., 2014).

Emotional exhaustion is described as the state of fatigue caused by too many psychological and emotional demands. It is the most obvious manifestation of burnout and is the most reported and widely analyzed dimension. However, despite being a necessary criterion for burnout, EE is not sufficient to explain the phenomenon entirely. Moreover, EE fails to capture the full impact of burnout on the relationship between people and their jobs.

Depersonalization is the existence of skepticism, which is observed through the creation of distance between the health care professional and his or her clients and a disregard for the client's unique qualities, which leads to impaired relations. Distancing is an initial and instant reaction to exhaustion, which suggests a strong relationship between EE and DP, a connection that most studies about burnout in a broad range of settings have found.

Reduced (PA) is described as the feeling of inadequacy and ineffectiveness. Its relationship with the other dimensions is somewhat complex. A demanding work situation combined with a negative perspective of clients leads to EE and DP, which can affect an individual's sense of accomplishment. However, some researchers have argued that reduced PA occurs simultaneously, rather than

sequentially, in other work contexts (Maslach & Leiter, 2016; Maslach & Schaufeli, 1993; Maslach, Schaufeli, & Leiter, 2001; Plessis et al., 2014; Vicente et al., 2014).

Method

Research Design

A mixed methods study design with a sequential explanatory approach was employed to achieve the aims of the study. A quantitative descriptive correlational study (Phase 1) was followed by a qualitative descriptive study (Phase 2). These two phases were distinct but given equal importance (Terrell, 2012). The integration of all data was performed with an emphasis on further exploration of the Phase 1 results. After the analysis of the Phase 1 survey data, questions were formulated that focused on further exploration of those results. Phase 2 was accomplished with a focus group discussion and a series of in-depth interviews. The two methods were used separately. The focus group was held first with the participants identified in Phase 1 to have high levels of burnout. A series of in-depth interviews followed with those identified as having low to moderate levels of burnout.

Ethical Considerations

Ethical approval from the University of Santo Tomas Graduate School Ethics Review Committee (USTGS-ERC) was sought before the study began. In addition, a license through Mind Garden, Inc. to use the Maslach Burnout Inventory – Human Services Survey (MBI-HSS) for Phase 1 was acquired. Likewise, collaboration was obtained from the Philippine Academy of Occupational Therapists, Inc. (PAOT) for the use of its database to disseminate the survey.

Sampling

A convenience sample was used in Phase 1, in which all of the Filipino occupational therapists in the PAOT registry (N = 231) were surveyed. These occupational therapists included those licensed by the Professional Regulatory Board of the Philippines and currently practicing in the Philippines. Phase 2 used purposive sampling from the participants in the online survey, as described above.

Measure

For more than 25 years since the conception of studies in the field of burnout, the standard measuring tool has been the Maslach Burnout Inventory by Christina Maslach and Susan Jackson. There are three varieties of this tool. The Human Services Survey (MBI-HSS) version is more sensitive for professionals like occupational therapists who are involved in human services, and therefore was used in this study (Maslach, Jackson, Leiter, Schaufeli, & Schwab, 2016; Maslach & Leiter, 2016; Plessis et al., 2014; Vicente et al., 2014).

The measure yields separate scores for each construct. Each score can be classified into low, moderate, and high by dividing each possible score into equal thirds. Scores in the upper third correspond to high levels for the construct. High burnout is presumed when at least two constructs are graded as high or, in the case of personal accomplishment, the construct is graded as low.

Data Collection

An email that contained the consent form, an information sheet, and the MBI-HSS was sent to all Filipino occupational therapists in the PAOT registry. A 2-week protocol was proposed and accepted by the USTGS-ERC. During Phase 1 of the study, the participants were contacted 1 week after the initial dissemination via a follow-up email. A reminder email was sent 3 days prior to the end of the survey period.

Phase 2 commenced after a complete analysis of the quantitative data taken from the initial phase. Individuals who met the high burnout threshold on the MBI-HSS were recruited for potential

focus group participation. Text messages were used to contact the participants to accelerate the feedback time. Five occupational therapists who completed the Phase 1 survey agreed to participate in the focus group discussion, which was designed to understand burnout on a deeper level. A welcoming environment was created that allowed the participants to share and further elaborate on their own experiences by hearing others' opinions (Elliott & Associates, 2005). After the focus group, in-depth interviews were conducted with three other participants. Inquiries during Phase 2 included whether they were experiencing burnout, what factors might be affecting their experiences, and how they experienced burnout in actual practice.

Both the focus group and the interviews were conducted face-to-face and took place in a convenient location near the University of Santo Tomas, Manila. The focus group discussion lasted for an hour and a half, while each in-depth interview lasted no more than an hour. The discussion and interviews were recorded and transcribed after each session. Continuous analysis was done during each transcription. When the data were noticed to be repeating and no new concepts were arising, Phase 2 was stopped, as data saturation was reached.

Data Analysis

Descriptive statistics using frequency distribution and measures of central tendency were used with the survey results. Normality testing was conducted first by looking at Q-Q plot. Spearman's Rho and Cramer's V were used to determine relationships between burnout and the ordinal and nominal independent variables, respectively.

As mentioned, the focus group discussion and in-depth interviews were audio recorded and transcribed. The researcher analyzed the transcripts through directed content analysis, an approach intended to expand the established concept of a phenomenon (Hsieh & Shannon, 2005). It is a more structured analysis where the variables, such as the dimensions of burnout, are the initial coding categories. Data gathered were familiarized through repeated readings initially. Repetition of words or phrases was tallied. Then data were clustered into smaller units and attached to the identified codes, which reflected the constructs of burnout in the study. To enhance the trustworthiness of the qualitative data, an independent allied health analyst with postgraduate training in the topic of burnout completed a review. Member checking with the sample followed the coding and theming process. Further, the developed themes from this study were compared with the three-unit concept of burnout found in Maslach's studies, and this is consistent with the application of constant comparative analysis concepts (Maslach et al., 2016; Maslach & Leiter, 2016; Maslach & Schaufeli, 1993). All of these methods were used to help ensure the rigor of the study (Noble & Smith, 2015).

Results

Two hundred and thirty-one Filipino occupational therapists were initially approached to participate in the Phase 1 survey. In response, 57 (24.7%) occupational therapists completed the necessary forms used for analysis. For Phase 2, five individuals participated in the focus group discussion, and three others agreed to participate in an in-depth interview. The comparatively low response rate might have been caused by the short time period in the protocol for the survey during Phase 1. The Filipino occupational therapists' agreement to participate in the focus group discussion and the in-depth interviews was affected by their time conflicts and business commitments.

Characteristics of the Participants

Sixty-three percent of the 57 participants were Filipino occupational therapists aged 24 to 29 years. Seventy-five percent of the participants were female, and 81% of the participants were

unmarried. The participants' highest educational attainment included a bachelor's degree (74%), currently enrolled in a master's program (16%), a master's degree (9%), and doctorate units (1%).

Most of the Filipino occupational therapists who responded to the survey were working part time (58%); the remaining participants were working full time (42%). Also, 42% of the participants had worked as an occupational therapist for 2 years or less, and 26% had worked for 3 to 5 years. Forty percent of the participants indicated that they worked in the National Capital Region (NCR) only, 32% worked in the provinces, and the remaining 28% worked in both the NCR and the provinces. The 63% of the participants mentioned previously had an average of 4 to 7 client contact hr per day. Thirty-two percent of the remaining participants had between 8 and 11 hr per day, and 5% had between 1 and 3 hr per day. All of the participants were practicing in pediatrics, but some also worked in academe, community settings, adult settings, and similar organizations.

Based on these data, it could be said that a typical Filipino occupational therapist is female, between 24 and 29 years of age, unmarried, holds a bachelor's degree, has worked part time in a NCR-based pediatric setting for 2 years or less, and has an average client contact range of 4 to 7 hr per day. This profile is an extrapolation because there are no current statistics about the characteristics of Filipino occupational therapists.

Results of Phase 1

The participating Filipino occupational therapists in our study appeared to experience moderate levels of EE, DP, and PA, since the mean scores of all constructs closely resembled the median values (see Table 1). Hence, it appears that these Filipino occupational therapists experienced moderate levels of burnout.

Table 1

Burnout Among Filipino Occupational Therapists (N = 57)

Burnout Construct	Mean (SD)	Median
Emotional Exhaustion (EE)	23.56 (10.287)	23.00
Depersonalization (DP)	6.44 (5.23)	5.00
Personal Accomplishment (PA)	38.18 (6.173)	39.00

Moreover, there is an inverse relationship with the ordinal variables (age, educational attainment, years as an occupational therapist, and average contact hours) in terms of EE and DP. However, neither EE nor PA follow this pattern on contact hours, with an exception on the score for educational attainment (see Table 2).

Table 2

Spearman's Rho Correlation (N = 57)

Ordinal Variables	EE	DP	PA
Age	-0.337*	-0.174	0.235
Educational Attainment	-0.121	-0.011	-0.051
Years as an OT	-0.386**	-0.248	0.085
Average Contact Hours	0.197	-0.002	0.157

Note. *Correlation is significant at the 0.05 level (2-tailed). **Correlation is significant at the 0.01 level (2-tailed).

In terms of the nominal variables (gender, marital status, type of employment, and practice location), there are strong relationships between these factors and EE and PA. But there is only a moderate relationship on DP (see Table 3).

Table 3

Cramer's V Correlation (N = 57)

Nominal Variable	EE	DP	PA
Gender	0.763	0.589	0.669
Marital Status	0.682	0.517	0.526
Type of Employment	0.796	0.570	0.692
Practice Location	0.753	0.534	0.618

Note. Cramer's V varies between 0 and 1. Close to 0 shows little association between variables. Close to 1 indicates a strong association.

Based on Table 4, the most salient factor of burnout is EE. occupational therapists between the ages of 24 and 29 experience burnout more often, as they have the highest scores in EE and DP and the lowest scores in PA. This correlates with the typical description of burnout, which is said to have high EE and DP with low PA. Scores between males and females on all constructs were almost the same, with only a point difference in the constructs. Nonetheless, great differences in the EE scores between the unmarried and married participants were noted. Also, it showed that the participant with the highest scores in EE and DP was the one taking doctorate units. Next were those who had either finished a bachelor's degree or those who were currently taking units for a master's degree. Table 4 also illustrates that those who had worked for 2 years or less experienced the highest scores in EE and DP and the lowest score in PA.

Furthermore, those having an average range of 8 to 11 client contact hr per day experienced the highest scores in EE and PA. This was followed by those who were working 7 hr and less in both constructs. Those who were juggling work between the NCR and provincial workplaces exhibited the highest level of EE, and it is interesting to observe that those who were only working in the provinces responded with the highest level of PA. Lastly, those who were working part time were more likely to experience higher scores in EE and DP compared to those who were working full time (see Table 4).

Table 4

Association of Burnout on Each Variable (N = 57)

Age	EE	DP	PA
18-23	24	6	40
24-29	26	8	37
30-35	21	5	42
36-41	17	4	40
41 and up	10	3	41
Gender			
Female	24	6	38
Male	23	7	39
Marital Status			
Married	16	4	41
Unmarried	25	7	38

Educational Attainment			
Bachelor's degree	24	7	39
Master's units	24	7	37
Master's degree	16	4	37
Doctorate units	36	10	41
Years as an OT			
2 or less	27	8	39
3 to 5	25	7	35
6 to 9	25	6	39
9 to 11	21	5	42
12 to 15	21	7	33
16 to 19	10	1	46
20 and above	5	0	42
Average Client Contact Hours			
1-3 hr per day	20	8	34
4-7 hr per day	23	6	38
8-11 hr per day	26	6	39
Practice Location			
Both	25	6	38
NCR only	24	8	37
Provincial only	22	5	40
Type of Work			
Full time	20	6	38
Part time	26	7	38

Results of Phase 2

There were 18 participants who were said to be experiencing high levels of burnout, and 39 participants were classified under low and moderate levels of burnout. Following the coding process, the following themes emerged.

Filipino occupational therapists tend to be “pagod na.” Participant 1 said, “Ugh, [burnout] is pagod na!” This is the term commonly associated with burnout among Filipino occupational therapists. It is characterized by an imbalance between personal and work life caused by doing more than what one is capable of doing because of the pressures of being a Filipino occupational therapist. The most reported sign of burnout was the experience of being mentally drained, along with physical and emotional manifestations, such as being tired, irritable, and feeling helpless.

Filipino occupational therapists are branded as “caring therapists.” There are many pressures surrounding a Filipino occupational therapist that create both positive and negative effects. In some instances, these pressures motivate therapists to bring about changes and improvements for their clients. However, when these goals and expectations are not met, it causes emotional exhaustion that leads to burnout. Filipinos, in general, are caring due to the country's family-orientated culture. This means that therapists are fully involved with each client and become stressed when things occur beyond their control (especially applicable in relation to the difficulty of conditions in local pediatric occupational therapy practice). Participant 2 said, “Doctors, parents, and others expect a lot, making us expect it also from ourselves.” Furthermore, there are still too few Filipino therapists, which equates to

a higher demand and a greater workload for occupational therapists; most cannot say “no” due to client-centered practices and the culture of trying to care for everyone. Participant 5 said, “It seems like they made you a superhero, right?” There are certain times when occupational therapists cannot give more because they are already unable to recharge or take a break. Participant 1 added, “Sometimes one forgets to eat already. My body shutdowns already when I get home.” These clinical demands are further aggravated by other factors, such as travel, budgeting, and time. These other factors are being combatted while occupational therapists are already being drained from work and vice versa.

Filipino occupational therapists fall into “routine practice.” Participant 2 said, “I think it’s becoming only a routine in general.” Occupational therapists are expected to provide individualized and creative activities to promote participation in occupation. However, due to fatigue caused by a variety of factors in practice, the Filipino occupational therapists in our study indicated that they tended to lose creativity, resulting in routine practice where the meaningfulness and relevance of activities provided to clients might be questionable. Most agreed that sometimes they ended up thinking that they would just do their best next time. One suggested that this “next time” mentality could create a loop that the therapists could not escape. Another example of routine practice was when the therapist did not create a fit environment for a client. Participant 5 claimed that she would not challenge the child anymore to avoid stress. In addition to difficulties in direct client care, administrative duties, such as documentation, peer education, or clinical supervision duties, were often compromised.

Filipino occupational therapists want to “do more with so little time.” Participant 4 said, “I have many things in mind I want to start, but I just cannot start.” Most of these Filipino occupational therapists wanted to be competent in their practice, but struggled because of the pressures they experienced. It was stated more than once that occupational therapists put too many things on their plate or are wearing too many hats at the same time. With the need for competence, the therapists tended to occupy themselves with many endeavors aside from simple, daily client care. This eagerness to do more in the demanding nature of local Filipino occupational therapy practices created a mismatch, resulting in anxieties and worries that eventually led to reduced personal accomplishment. The issue of quality over quantity in both client care and professional growth existed, aggravated by the need for further training and certifications. Also, the participants indicated that a ladder for the profession is missing, leaving most with feelings of defeat as their efforts for self-improvement went unrecognized. The Filipino occupational therapists tended to be very active in pursuing a lot despite the absence of concrete goals and focus. But Participant 2 questioned, “By the end of the day, I want to do a lot for others, but I end up thinking where will I be going? Will I be stuck here [clinic] forever?”

Consolidation of Phases 1 and 2

The two phases of our study complemented each other as the qualitative phase (2) further enriched the data gathered during the quantitative phase (1), backing up the results and explaining possible reasons for such results. It was clear that the Filipino occupational therapists did experience burnout, but at varying levels. There were reports of higher incidences of burnout constructs with certain demographic and work-related factors and themes: being a caring therapist led to a tendency to do routine practice due to exhaustion, which was also affected by the goal of doing a lot of things with little time.

Discussion

Burnout across countries and contexts varies, as noted in studies that have included the association of different factors that influence burnout (Vicente et al., 2014). Hence, in our study in the Philippines, the following outcomes can be compared with other studies.

The findings from our study suggest that Filipino occupational therapists had moderate levels of burnout, as they experienced EE, DP, and decreased PA in the middle of the spectrum. It confirmed that occupational therapists are not among the high-ranking professionals that experience the highest levels of burnout (Wressle & Samuelsson, 2014). In fact, in a study of nurses in Europe, moderate to high levels of burnout were noted compared to other health care professions (Cañadas-De la Fuente et al., 2015). Physiotherapists, a profession close to occupational therapy, have been reported to have no cases of burnout, but in one study they had high average emotional effects that are consistent with reports of high EE among Filipino occupational therapists (Silva & Alchieri, 2014).

Among the different age groups in our study, those aged 24 to 29 exhibited the highest scores in EE and DP and the lowest score in PA, thus fitting the definition of burnout in the study. Similar results were found in studies by Plessis et al. (2014) and Kamal et al. (2016), in which young health care professionals experienced higher EE. The participants in Phase 2 of our study claimed that this was aggravated by social expectations and those of social media that expect this age group should have achieved more. Wressle and Samuelsson (2014) claimed that a lack of time was one of the greatest stressors for Swedish occupational therapists, which can be related to the pressure of achieving more. The Filipino occupational therapy narratives suggested that the occupational therapists planned and wished to do a lot professionally, but eventually could not accomplish it due to time constraints; this led to frustration and cynicism, which eventually could lead to a decreased sense of achievement. However, it appears that as they passed that age range of the 20s, PA increased while the inverse relationship for EE and DP remained true. It appears age makes one more stable in practice due to experience and continued exposure, which correlates with years as an occupational therapist.

There was minimal difference between the scores in EE, DP, and PA for males and females, suggesting that they experience the same level of burnout. Males scored one point higher in DP and PA, but scored one point lower in EE. However, it was raised during Phase 2 that females may deal with burnout more emotionally and thus have a score greater than males in EE. Participant 6 said, “[Females] feel things more strongly than males [Females] deal with problems emotionally [rather] than like cognitively.” This higher score relates to the study of Scanlan and Still (2013) in which females scored higher in the exhaustion aspect of the tool they used. The studies of Shanafelt et al. (2015) and Dyrbye, West, Satele, Sloan, and Shanafelt (2011) suggested that female physicians had a 30%-60% higher chance of experiencing burnout than males. Some female participants also put an emphasis on their hormonal cycle, indicating that it heightened their responses to things most of the time. On the other hand, males had higher scores in DP in the present study. This is consistent among most studies of burnout where DP was usually higher in males (Maslach et al., 2001). Male participants claimed that they tended to be more objective. A participant said, “[Male] is concrete, not as emotional.” Hence, the correlation on gender that conveys a strong relationship with EE and PA complements the testimonies of the participants.

In our study, the married participants had remarkably lower scores in EE and DP along with higher PA scores; this conveys a possible protective factor for burnout. In the study by Plessis et al. (2014), those without children had higher scores in EE along with a significant decrease in PA as well.

One participant in our study asserted that being married makes one settle down since everything a married individual does is not solely for his or her own purpose. A great difference in the EE scores between the unmarried and married participants, with nine fewer points in the latter scores, was noted, which is a significant difference to consider. This result was further emphasized during Phase 2 when the participants attested that having a partner, despite not being married, did aid in handling stress. The presence of someone who is romantically linked apparently provides benefits that cannot be satisfied by support of other family members and friends. One participant's response implied that there are supports that cannot be obtained by mere friends. High PA was also associated with a higher sense of fulfillment when meeting the needs of one's family instead of just one's own expectations. These propositions were also noted in the study by Maslach et al. (2001), which indicated that unmarried individuals were more prone to experiencing high levels of burnout.

In relation to educational level attained, it was noted that the one participant finishing the doctorate degree experienced the highest scores in all constructs, which tended to negate the correlation of having an inverse relationship for each construct with level of education. But based on other studies, as noted in the review by Maslach et al. (2001), higher education is related to the experience of higher burnout, possibly due to greater responsibilities and expectations, which means higher stress. On the other hand, the participants who completed a master's degree showed the lowest level of EE and DP. Hence, it was observed that there was a notable decrease in EE and DP with sustained PA for those having attained the master's level. Thus, one can infer that during the study period before attaining the degree, scores in EE and DP tend to be heightened, and follow the premise of an inverse relationship when the degree is obtained. This assumption was substantiated during the discussion when a participant confessed that she was stressed at the time due to her master's program requirements despite her initial intent that pursuing the program would ease EE. According to a study by Plessis et al. (2014), lower education has a significant impact on PA due to limited scope of practice compared to those with higher degrees. Moreover, the pursuit of a higher degree or training should only focus on improving one's capabilities to ensure quality services. When some go for other reasons, perhaps due to the pressures of society, this might make them vulnerable to burnout.

During the early years or initial practice as an occupational therapist, it was noted that the EE and DP scores were highest, with the lowest scores in PA. This result may be due to the characteristics of being a novice practitioner, as they are expected to be exploring and adjusting from being a student to being a professional. This was confirmed with the participant discussions in our study. Moreover, therapists who stay in the profession tend to develop more skills and improve personally; thus, a decrease in EE and DP could be expected along with an increase in PA. This was in comparison with the claims that younger employees were at higher risk during the start of their career due to work exposure (Maslach et al., 2001). However, there was a contention that this was also due to the personality of the new generation, which is different and possibly less resilient than the older generations of practitioners. Also, experience hones a therapist, building a routine for problems or instances that occur in practice. Nonetheless, there were some participants in our study who argued that the absence of a ladder for the profession in the local context may pose some vulnerability for burnout. The absence of a ladder was mentioned in the study of Madill, Brintnell, Stewin, Fitzsimmons, and Macnab (1985); it was considered a factor of job dissatisfaction.

The participants with more client contact hours in a day tended to experience higher scores in EE along with higher scores in PA. The participants expressed that an increase in contact hours was

demanding, especially for those in pediatric practice, as they needed more patience. Although this was the case, they also expressed increased PA as they were more satisfied in having used their time for work rather than any other activity that they would categorize as nonproductive compared to client contact hours. However, it was also mentioned that it was not the number of hours one worked that may have affected the feeling of burnout; rather it was the number of clients with which a therapist dealt. In a study of palliative care clinicians in the United States, it was noted that working longer hours was associated with higher levels of burnout (Kamal et al., 2016), upholding the positive relationship of average client contact hours to burnout in our study.

Working in the NCR and in the provinces simultaneously generated the highest EE, but only a point higher than those working in the NCR only. The participants in Phase 2 further justified the results when they said that there was a certain pressure to work better than usual in the NCR since clients were more demanding and skepticism was present. The participants said that working in the provinces gave them confidence and a sense of fulfillment.

Last, there was a great difference between working part time and full time with regard to scores in EE; the latter experienced less EE. Both types of employment demonstrated almost the same scores in DP and PA. In the discussion in Phase 2, it was said that the problems encountered in having part-time work included travel issues. The traffic, the distance, and the demand to adjust at different work places imposed greater stress, hence greater scores in EE.

Based on the results of our study, burnout is experienced by Filipino occupational therapists in a similar way to the results indicated by other studies. Some distinct features, specifically related to the themes that emerged from the discussion, eventually supported the quantitative data gathered in Phase 1. The caring nature of Filipino occupational therapists made them want to become the best occupational therapists they could be. They wanted to provide everything for the betterment of their clients; however, they felt defeated at times because of uncontrollable circumstances that made them fall into routine professional practices.

Limitations

Our study may be limited in generalizability due to the small sample and the comparatively small number of occupational therapists practicing in the Philippines. The data set may not have represented Filipino occupational therapy demographics accordingly. Also, the study used a self-report methodology, so common method bias may be a concern. This bias is the context in which the participant gives a construct's accurate score, but due to common method (e.g., mood, social pressure), gives a different rating (Burton-Jones & Straub, 2004). Further, cultural inputs from the participants might not be generally applicable across the Philippine culture. Thus, further study of Filipino occupational therapists with a focus on culture and burnout, as well as other factors not explored by this study, is warranted.

Conclusion

Filipino occupational therapists experience moderate levels of EE, DP, and reduced PA that are somewhat alarming because burnout can worsen if it is not given proper attention. Factors, such as being between the ages of 24 to 29 and unmarried while being in the initial years of practice with longer working hours, may exacerbate the level of burnout experienced by Filipino occupational therapists. This experience can lead occupational therapists to feel defeated, but EE is likely to be the most salient factor in determining burnout quantitatively.

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