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Occupational Therapy Job Satisfaction in the Geriatric Setting

Dawn Doctor
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OCCUPATIONAL THERAPY JOB SATISFACTION IN THE GERIATRIC SETTING

By
Dawn Doctor, M.S., OTR

A Thesis
Submitted to the
Faculty of The Graduate College
In partial fulfillment of the
requirements for the
Degree of Master of Science
Department of Occupational Therapy

Western Michigan University
Kalamazoo, Michigan
December 2003
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Lastly, I would like to thank my parents and Kevin Newell for having the patience to come second in my life to my laptop, books, and papers for the past few months.

Dawn Doctor
This study examined the level of job satisfaction among occupational therapists working in the geriatric setting in the state of Michigan. The purpose of this study was to determine if burnout exists among occupational therapists working in a geriatric setting. Questionnaires from 29 therapists who work in a geriatric setting were analyzed. The majority of the respondents revealed they are not burned out, but do report at least one sign of stress within their job. The most common forms of stress were treating difficult diagnoses, excessive paperwork, excessive caseload, increased productivity expectations, the lack of respect for occupational therapy, and the lack of understanding of occupational therapy. These findings suggest that therapists are feeling stressed out at work, even though many of the causes of stress can be fixed by educating others about occupational therapy and restructuring the rehabilitation department.
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CHAPTER I

INTRODUCTION

Definition of Burnout

"The concept of burnout emerged in the early 1970's through the ideas and efforts of Herbert Freudenberger in New York and Christina Maslach and Ayala Pines in California" (Gold 2001). It has been defined as a depletion of inner resources in the form of exhaustion or strain, wearing out or failing (Freudenberger, 1974); a syndrome consisting of emotional exhaustion, depersonalization and reduced personal accomplishment (Maslach & Jackson, 1986); and a sickness of achievers who are committed, but realistically unable to reach their ideals (Pihulyk, 2001). Burnout can be characterized by feelings of fatigue, frustration, irritability, and anger and begins with pessimistic thoughts, leading to apathy, lethargy, exhaustion, and depression. Ultimately, burnout can lead to physical ailments, decreased productivity, and decreased job satisfaction.

Rationale for Study

Studies citing the effects of burnout and job satisfaction are rarely found in the occupational therapy literature. Those studies that have been done cannot be generalized due to the rapidly changing economic, social, and political changes happening in America
today and the rapidly changing health care system. The health care system is no longer in the hands of the therapists, patients, or doctors as the corporate model of health care has prevailed at the expense of a patient care focused health care system. This results in an increasingly stressful environment for the person who must reconcile his or her generic reason for becoming a health care provider-to help people-with the harsh economic realities of the business of health care-a factor that leads to professional burnout.

America is now coming to the age where older adults, age 60 and up, are requiring more health care due to the majority having at least one major illness and advances in medicine and disease control allowing people to live longer and increasing the life expectancy (Bailey, 1990). Statistics have revealed that the elderly is the fastest growing population in the United States because of the baby-boomers (Bailey, 1990). The U.S. Census Bureau (2000) predicts that, by the year 2050, the number of elderly people on the United States will double to approximately 80 million. That is 1 in 5 Americans. Approximately 2% of those ages 65-74 are in nursing homes and 25% of those over the age of 85 are residents of nursing homes (U.S. Census Bureau, 2000).

In the past few years, there has been a shortage of rehabilitation professionals in long-term care settings. These vacancies and large turnover rates can result in burnout of the existing staff. Most of the staff members who left their last position, causing these turnover rates, left due to burnout. “Several studies have linked burnout to employee turnover and/or intentions to quit a job” (Garland, 2002, p. 116).

According to Pihulyk (2001), there has also been a lack of concern for quality of product and of people. There seems to be more work to be done in less time with a shift from person care to productivity and profit. Therapists have undue pressure to
“produce”, leaving them feeling withdrawn from their patients and feeling like they are no longer in a helping profession. These societal pressures can also lead to stress, burnout, and job dissatisfaction.

There have been very few studies on job satisfaction of occupational therapists in long-term care including the reasons therapist’s leave their jobs (Bailey, 1990 and Freda, 1992). The study presented in this paper assesses the level of job satisfaction among occupational therapists working with the geriatric population in long-term care settings in the state of Michigan. Factors related to job satisfaction/dissatisfaction will also be discussed. This study also discusses a few intervention possibilities and identifies a need for stress management in the work place.

Literature Review of Stress and Burnout

As stated above, there have been very few research studies completed on occupational therapists job satisfaction. However, the literature is replete with studies of job satisfaction in teaching and other health care professions. It is necessary to begin talking about these professions and the research to fully understand the lack of recent research completed on job satisfaction vs. burnout in the occupational therapy profession.

There have been numerous studies regarding burnout among teachers. A review of the literature by Gold (2001) found that causes of burnout included harassment by co-workers or supervisors, paperwork pressure, assaults by students, and loss of caring and commitment. She also noted that the high achiever and the perfectionist personalities tend to be more prone to stress. Gold also provided suggestions for prevention, including
increased sensitivity by administration, stress reduction programs, and programs that will help assist teachers in expanding their interests outside of school functions (2001). Gold concluded that current studies are based mostly on untested assumptions and that further research needs to be completed on the objective side of teacher burnout and how to prevent it (2001).

Another study completed on the burnout of teachers was published in 2002 by Benham Tye and O'Brien. The authors compiled results from 114 surveys completed by teachers who completed teaching credentials at Chapman University in California. They found that teachers were "questioning their desire to continue working as classroom teachers, that they [were] feeling alienated, and that they tend[ed] to turn their criticism upon themselves rather than upon the system in which they [felt] trapped" (p. 25). The authors also found that accountability and increased paperwork were also top reasons for leaving the profession. Many teachers responded that the work environment was the number one reason for leaving the profession, mostly because there were so many pressures related to standardized testing. School systems focused on tests much more than teaching ability and teachers felt they were not allowed to be creative in their classroom structure or lesson plans anymore (Benham Tye & O'Brien, 2002). The teachers were expected to focus on more new material in less time. This caused a decrease in teacher morale, causing burnout, which leads to a decrease in student learning which in turn leads to more burnout from teachers. The authors make a good point when they state that it would be less expensive to the school district to improve the working conditions than it would be to replace unhappy teachers. The suggestions made in this article include upgrading school buildings, reducing class size, increasing teacher
responsibility in educational decisions, increasing parental support, and increasing relationships between teachers and administrators. These suggestions seemed to be a common theme throughout most articles written on ways to decrease teacher burnout.

Background of Stress and Burnout in Health Care

There also seems to be a common burnout theme that has emerged in studies of health care workers and job satisfaction. This theme is captured in the following quote: "Those who are more likely to become emotionally involved in their work are more likely to burn out than those who have a more detached work style" (Freudenberger, 1975). Those people working in the health care system, along with teachers, are most likely to become emotionally involved in their work due to the closeness of working with their patients. The next few articles discuss this in great detail.

Lloyd, King, & Lesley (2002) reviewed the literature related to stress and burnout of social workers. They found that the literature seemed to have a common theme - "social workers may experience higher levels of stress and resulting burnout than comparable occupational groups" (p. 55). Social work is typically a profession of high stress. The constant pressure to help many individuals within a limited time and meet the demands of increasing paperwork, as well as having necessary opportunities to interact with co-workers, is a significant challenge. Contributing factors of burnout in social workers include role ambiguity, role conflict, job autonomy, and job challenges. There are only two inherent sources of burnout – the tension between philosophy and work
demands and the organization of the work environment. The rest of the causes of stress and burnout are related to role deployment issues (Loyd, King & Chenwoeth, 2002).

Gomez and Michaelis (1995) assessed burnout in human service providers. They recruited a total of 47 participants from the State Department of Social Services, JOBS Program, the State Division of Vocational Rehabilitation, Unit Office and Goodwill Industries of Northwest North Carolina. The Maslach Burnout Inventory was used to assess the level of burnout of the participants (Maslach & Jackson, 1981). The study found that those participants who spent more time with consumers and less time filling out paperwork felt a higher level of personal accomplishment. The size of caseload did not seem to have an effect on burnout. Other than these two findings, no other significant findings in relation to burnout and job satisfaction were reported. This study also did not describe any intervention strategies related to the decrease feeling of accomplishment related to the increase load of paperwork (Gomez & Michaelis, 1995).

The literature also describes work-related stress among psychotherapists. A study completed by Plutchik & Conte (1994) detailed a list of critical incidents that create difficulties for therapists. A group of clinicians met over the course of four months to describe critical incidents that happened in their practice. They developed a list of 52 critical incidents which were then presented to 21 psychiatrists in the form of a survey. They were asked to rate the critical incidents on a scale from 0-3, 0 being “not important” and 3 being “very important.” The returned surveys concluded that the three most important critical incidents were “patient threatens therapist physically”, “patient threatens suicide”, and patient has seen a second therapist and reveals it” (p. 77). The authors then put the 52 critical incidents into five categories: threat of harm, criticism of
the therapist or of therapy, occurrence of a major life event, an attempt by the patient to seek friendship or achieve seduction, and miscellaneous.

A follow-up to this study was conducted by giving the list of critical incidents to third-year psychiatric residents (Plutchik & Conte, 1994). The residents seemed to find almost all of the incidents less important and more frequent then the professionals did. This shows a significant difference between experienced and inexperienced therapists. More research needs to be completed to find out why this discrepancy is.

While there are fewer studies on stress, burnout, and job satisfaction in the fields of social work, psychotherapy, and human service employees, there is an extensive amount of research relating to physicians and hospital employees. A few of the studies will be mentioned here.

“Employee satisfaction may be important both because of its possible relationship to turnover and absence rates and because of its potential impact upon employee productivity” (Bechtold, Szilagyi, and Sims, 1980, p. 77). This is what Bechtold, Szilagyi, & Sims explored in their research. The study included questionnaires collected from 1161 employees from a large Midwestern university medical center. These employees included administrative, professional, technical, clerical, and service employees. The study measured job characteristics and work satisfaction by using the Job Characteristic Inventory (Sims, H.P. Jr., Szilagyi, A.D., & Keller, R.T., 1976) and the Job Description Inventory (Smith, P.C., Kendall, L.M., & Hulin, C.L., 1969). This study found that the higher the job characteristics and work satisfaction were, the higher the occupational level. The study also indicated that the major source of satisfaction for the professional group (including therapists) was the work itself.
Grunfeld, Whelan, Zitzelsberger, Willan, Montesanto, and Evans (2000) completed a study on the job satisfaction of cancer care workers in Ontario. A questionnaire was mailed to all 1016 personnel (medical oncologists, clinical associate physicians, allied health professionals, and support staff—staff does not include therapists) of the major providers of medical oncology services in Ontario. Of the returned questionnaires, 681 were used for the study. The questionnaire was comprised of 5 different questionnaires combined. The authors found that more than one-third of the overall sample “had high levels of emotional exhaustion and low levels of personal accomplishment” (p.167). The respondents also demonstrated a high level of overall stress. This could be because of the increased depression, illness, and even mortality of the patients at the Cancer Centre. The researchers even found a relation between burnout and the intention to leave the job.

McManus, Winder, and Gordon (2002) recently performed a three year study of UK doctors and the links between stress and burnout. The study was completed on a total of 800 doctors from the UK using the Maslach burnout inventory. The authors found three significant relationships between stress and burnout. They found that “emotional exhaustion makes doctors more stressed and stress makes doctors more emotionally exhausted.” The study also found that depersonalization reduces stress. Lastly, the authors found that personal accomplishment increases stress by increasing emotional exhaustion.

A study completed by Aiken (2001) found that hospital nurses are frustrated to the point of burnout. The study was done at the University Of Pennsylvania School Of Nursing’s Centre for Health Outcomes and Policy Research. 13,471 RNs were studied
and it was found that 43% of those studied scored high on a burnout inventory. They had reached the level of burnout due to inadequate numbers, rising patient loads, declining quality of patient care, and increased verbal abuse directed at them. A third of those under the age of 30 stated that they planned to leave their jobs within the next year.

In 1994, Carr and Kazanowski studied factors that affect the job satisfaction of 347 nurses who work in a long-term care setting. Subjects were obtained from a mailing list of registered nurses living in central and northern New England. These subjects were sent a questionnaire to assess satisfaction, reasons for dissatisfaction, work setting, and socio-demographic data. This study reported that nurses working in long-term care were significantly more dissatisfied than nurses working outside long-term care (P=0.086). The main reasons identified for job dissatisfaction include tremendous workload, poor staff cohesiveness, poor staffing, and poor working relations with administrators. The factors related to increase in job satisfaction included equitable salary and benefits, staff development programs, flexible hours, and more direct patient care (Table 1, p. 880).

There was also an open-ended question placed at the end of the questionnaire that elicited information about job satisfaction and other gerontology nursing issues. Two-hundred and ten nurses responded to this question. Forty-four percent of nurses working in long-term care reported that poor image and stigma of long-term care nursing needed to be improved. Twenty-eight percent reported that the image of the elderly needed to be improved. Twenty-two percent reported that greater autonomy, increased patient care and contact, and less paperwork needed to be achieved to increase job satisfaction. Other hurdles mentioned were the need for more educational opportunities, working conditions, and staffing. Long-term care nurses reported a greater preference to working with the
elderly, therefore leading Carr and Kazanowski (1994) to conclude that the dissatisfaction has more to do with environmental and management issues than the patients themselves.

Occupational Therapists and Job Satisfaction

Few studies have been published on occupational therapists and job satisfaction. This population needs to be studied due to the increased work load, decreased feeling of accomplishment, the increase in paperwork, and the ever changing health care system. Therapists are expected to see a large number of patients, and complete extensive paperwork, solve all the therapy related problems that come up with all of the patients in the facility (whether on caseload or not), and report progress to a number of other people (family members, physicians, nurses, and authority figures), while still remaining highly productive. Those few studies looking at occupational therapists and job satisfaction, job stress, and burnout are presented here.

Painter, Akroyd, Elliot, & Adams (in press) recently completed a study on burnout in occupational therapists. Using a survey containing the Maslach’s Burnout Inventory (MBI) (Maslach & Jackson, 1986), the authors compiled information from 521 occupational therapists that belong to the American Occupational Therapy Association. One thousand, one hundred and eighteen surveys were returned, but only 521 could be used after excluding part-timers. The majority of respondents were women who had less than ten years of experience. The respondents were divided into three categories according to place of employment: community (schools, outpatient clinics, and home health), hospitals, and chronic (long term care, rehabilitation, and psychiatric facilities).
The study found that occupational therapists have a significantly higher incident of emotional exhaustion compared to the MBI norms. It was also determined that occupational therapists experienced low levels of depersonalization and lack of personal accomplishment. For example... The study also compared OT norms to the norms of nurses, radiographers, and radiation therapists found in previously conducted studies. It was found that occupational therapists have a higher level of emotional exhaustion than the nurses and radiographers, but lower levels than the radiation therapists. This may be due to radiation therapists mostly working with terminal patients and nurses & radiographers not being as closely related to their patients as therapists are. The authors also found that occupational therapists working in chronic settings (including long term care) had significantly higher levels of emotional exhaustion and depersonalization than those therapists working in hospitals or community settings. They point out that this may be true because therapists in chronic settings have high stress, larger caseloads, limited resources, and are physically demanding.

Barnes (1998) studied the job satisfaction of physical therapists, occupational therapists, and speech-language pathologists. He sent a total of 1500 surveys with sections including level of career satisfaction, availability and importance of intrinsic and extrinsic factors, and open-ended questions on career satisfaction. Demographic information was also included. Six hundred and twenty returned surveys were used for this study. One-third of those returned were OT and 13 % were from long-term care settings. Unrealistic workload, noncompetitive pay, inadequate staffing, and inflexible scheduling were mentioned as reasons for these therapists to leave their jobs. Reasons mentioned for job satisfaction included seeing patients progress, positive relationships
with coworkers, autonomy on the job, and a pleasant working environment. The results showed that intrinsic factors are more important than extrinsic factors regarding career satisfaction. It is important for management to recognize these factors and improve the work environment, which in turn may improve the intrinsic factors of the rehabilitation professionals. However, it is also important for the rehabilitation professional to take responsibility to ensure his/her own job satisfaction.

There is a large amount of research that has been completed regarding job satisfaction. However, there are very few studies completed on therapists and even less on occupational therapists in long-term care facilities. Maslach stated that working with people who have chronic or terminal conditions, such as in long term care, is emotionally demanding (Maslach, 1978). Clearly, occupational therapists are at equal risk of professional burnout. The purpose of this study is to determine if there is a high incidence of professional burnout of occupational therapist’s working in long term care and to discover factors that contribute to professional burnout.
CHAPTER II

METHOD

Sample

The sample consists of 68 registered occupational therapists from the state of Michigan whom are subscribers to the gerontology special interest section through the American Occupational Therapy Association (AOTA). Permission was obtained from AOTA to purchase their mailing list for this study. A total of 31 surveys out of the 68 were returned (45.6% return rate). Data were successfully collected from 29 of those 31 therapists. 2 therapists sent the surveys back stating why they could not participate (one does not work directly with clients and the other now works with children).

Subject Characteristics

Of the 29 respondents, 25 (86%) are female and 4 (14%) are male. Twenty one (72%) report having a bachelor’s degree and 8 (28%) hold a masters degree. Those who work in a skilled nursing facility or care center make up 22 (76%) of the respondents. The rest are as follows: 4 work in a hospital, 3 in outpatient and 5 in “other” geriatric settings. Five (17%) of the respondents work in more than one setting. Of the respondents, 18 (62%) work full time and 11 (38%) work less than full time. Twenty-four (83%) have caseloads with 20 or less patients. There was an equal number of
responses to “number of years in practice in this setting total” and “number of years working for current employer.” This may mean that many of the therapists have been so happy with their jobs that they have not had a reason to change employers.

In summary, the typical subject from this sample in Michigan are females with bachelors degrees, working full time in skilled nursing facilities with less than 20 patients on caseload. Most of the respondents also seem to stay in one position for an extended period of time (as noted by the equal number of responses to “number of years in practice in this setting total” and “number of years working for current employer”).

Data Collection/Procedure

The written mailing to the sample of 68 therapists included a two-page cover letter and a three page survey with space for added comments. A self-addressed stamped envelope was also sent with the survey in hopes of a larger return rate. The survey consisted of 29 questions with the first question having multiple parts relating to demographics. The remaining 28 questions were a mix of 17 open-ended questions and 11 multiple choice questions. The questions addressed possible areas of the therapists personal and work lives that would add stress or provide relief to their careers. Frequencies and cross-tabulations were run on the data to compile reasons for burnout and/or job satisfaction for the participating occupational therapists. This survey can be found in appendix A.
CHAPTER III

RESULTS

Of the 69 surveys sent, 31 were returned, resulting in a 45% return rate. Two surveys were rejected as they were not currently involved in the care of older adults.

A total of 83% of the respondents report that they do not feel burnout. However, almost 100% of the respondents reported at least one sign of stress. A positive relationship was found between level of satisfaction and the following: degree earned, number of patients on caseload, and number of years with current employer (See Table 1). Those who were most satisfied with their jobs had obtained a bachelors degree, spent most of their careers with the same employer, and had less than 20 patients on caseload. There was also a link between satisfaction level, desire to stay in the current setting, and level of burnout (the higher the satisfaction, the higher the desire to stay, the less burnout people face). There also seemed to be a connection between length of drive to and from work and the level of burnout (the less the drive, the less the level of burnout).

Table 1
Links to Level of Satisfaction

<table>
<thead>
<tr>
<th>Level of satisfaction</th>
<th>Degree B</th>
<th>Degree M</th>
<th>Yrs w/ current employ.</th>
<th>Pts on caseload</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>&lt;1 1-5 6-10 11+</td>
<td>&lt;10 11-20 21-30 30+</td>
<td></td>
</tr>
<tr>
<td>Very satisfied</td>
<td>5 4</td>
<td>4 3 1 1 1</td>
<td>7 1 1 0</td>
<td></td>
</tr>
<tr>
<td>Satisfied</td>
<td>15 3</td>
<td>4 7 6 2</td>
<td>6 8 2 1</td>
<td></td>
</tr>
<tr>
<td>Unknown</td>
<td>1 0</td>
<td>0 1 0 0 0</td>
<td>1 0 0 0</td>
<td></td>
</tr>
<tr>
<td>Unsatisfied</td>
<td>0 0</td>
<td>0 0 0 0 0</td>
<td>0 0 0 0</td>
<td></td>
</tr>
<tr>
<td>Very unsatisfied</td>
<td>0 1</td>
<td>1 0 0 0 0</td>
<td>0 1 0 0</td>
<td></td>
</tr>
</tbody>
</table>
With respect to the multiple choice questions, the data indicated that 86% felt that professional education commitments (working toward another degree) did not add stress to their day. When answering questions relating to treatment space and equipment, 59% stated that they have adequate treatment space and adequate equipment for treatments. When asked if the commute to and from work added stress, 72% stated no. One person even remarked “it allows me time to prep/de-stress.” When asked how often patients accomplished goals set for them, approximately 90% stated over 50% of the time. A remarkable 100% stated that they get along with their co-workers, while 93% stated that they enjoy the facility they work in. (Note: one person marked both yes and no to both of the above stated questions. They said that it depended on the day and that sometimes there is friction between OT and PT).

On average, the subjects displayed low levels of burnout. However, all of the subjects expressed feeling at least one form of stress that can lead to burnout (taking into consideration the factors of burnout stated in the literature). A total of 65.5% stated that family commitments cause added stress, while the same percentage stated that certain diagnoses added stress. As the respondents reported, most of the difficult cases are those with a neurologic diagnosis (41%) as represented by the following responses to the question: “Do any certain diagnoses you treat add stress to your day? What and why?” Some of the comments were as follows:

“Sometimes you can’t fix it all.”
“Lack of progress.”
Dementia - “Lack of carryover.”
CVA – “Both physically and mentally challenging.”
Multiple Sclerosis – “Due to behavioral issues.”
Spinal cord injuries – “They are so intensive and are usually mixed in with the rest of a full caseload.”
Other difficult diagnoses included hand contractures, depression, deconditioning, unrealistic expectations by the patient or family members, and highly disabled patients whom are still unsafe to return home. The concern with patients returning home while unsafe is that these patients may leave the stove on, trip and fall, forget to eat or take their medications, or cause harm unto themselves or others. The second highest mentioned area of difficulty was terminal and medically complex patients. The respondents felt that there was a lack of progress and too much strict 1:1 treatment. The respondents explained this to mean there seemed to be too much hand-holding with the patients. There was 1:1 sessions because the patient was not progressing and needed that much assistance. Many of the patients were unable to participate in anything other than exercises or sitting on the edge of the bed with maximal assistance.

One of the open-ended questions asked the subject to insert a response to the statement: “I feel _____ when patients accomplish a goal.” A large percentage (73%) stated great/good/satisfied. Surprisingly, only one person (3%) state that they felt excited for the patient. The rest of the answers were very general responses.

The next question was “I feel ____ when a patient does not progress.” Again, 0% answered this question in direct relation to the patient. The answers were much more general, like “disappointed”, “frustrated”, “sad”, discouraged”, “fair”, and “it happens”. About 35% provided responses that indicated a feeling of failure in being effective in their treatment including “Not competent (3); Challenged (4); Didn’t find the right treatment/inappropriate treatment (2); I need to problem solve (1); I have failed (1). These therapists are beginning to internalize their patients’ short-comings, creating significant stress for themselves.
There was also a question related to patient death. When responding to the issue of patient mortality, approximately 20% expressed relief because the patient was really ill or they saw the family suffering. The other 80% tended to internalize the grief just like they would if they lost a family member. When asked to describe ways in which a patient's death affects his/her practice, 24% did not answer. The remaining 22 participants had a wide range of responses. Some of the responses were

"A relief at times if very ill and in pain; sad at times."
"I hate to see people die, but sometimes it's better than seeing them suffer."
"I listen more patiently when patients want to reminisce rather than do what I think is therapeutically appropriate."
"I feel glad that I treated them so well, but shocked that they went through so much and then couldn't live to enjoy it."
"I hope I helped give some additional quality to the patients' life."

Another cause of stress was inadequate treatment space and inadequate equipment. Although the majority of the respondents reported they had adequate treatment space and equipment, 41% stated that the space was not feasible. Many stated that the facility was not designed for rehabilitation, leaving the rehabilitation room too small for all the equipment and therapists. Some stated that there is not enough room for a kitchen for necessary home management training or that increase in staff does not include an increase in space. A total of 75% of those who stated there was not enough space report that inadequate space decreases professionalism and the ability to help the patients the best they could. The same 41% that stated they do not have adequate treatment space, also stated that the have inadequate equipment for treatments mainly due to the lack of space.
Towards the end of the survey, there were five open-ended questions as follows:

- What makes you frustrated with treatment sessions? (Table 2)
- What makes you frustrated with your patients? (Table 3)
- What do you do when you get frustrated or stressed at work? (Table 4)
- What makes you happy with treatment sessions? (Table 5)
- What makes you happy with your patients? (Table 6)

The first four questions were meant to validate the other questions throughout the survey. These questions were meant to corroborate the participants’ previous answers and add some validity and reliability to the questionnaire. The fifth question was formulated to find out how therapists manage stress and if there is a need for stress management within the workplace. The answers to these questions can be found in the corresponding tables.

Table Two describes the reasons most associated with frustration related to treatment sessions. One-third of the respondents reported that a lack of time for treatments and an overabundance of patients was the top source of frustration.

There is also a lack of follow through with staff regarding patients and therapy. Some respondents stated the lack of follow through was getting patients to therapy sessions on time. Other felt it was after therapy was over and the patients were discharged from therapy. The staff were not completing restorative programs and continuing the exercises or feeding programs established by the therapists.

The majority of the respondents (61%) also stated that the most frustrating thing about their patients was the lack of motivation and participation (Table 3). Many therapists reported spend the time planning a treatment session and finding the patient, only to have the patient refuse therapy.
Table 2
What Makes You Frustrated with Treatment Sessions?

<table>
<thead>
<tr>
<th>What Makes You Frustrated</th>
<th>#</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of time/too many patients to treat</td>
<td>15</td>
<td>33</td>
</tr>
<tr>
<td>Lack of follow through with staff</td>
<td>8</td>
<td>18</td>
</tr>
<tr>
<td>Interruptions</td>
<td>5</td>
<td>11</td>
</tr>
<tr>
<td>Too much paperwork/productivity expectations</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td>Refusals/lack of compliance</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td>Client is unhappy</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Lack of quiet environment</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Not enough equipment/space</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Decreased rehab appropriate candidates</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Unrealistic family members</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Minimal progress</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

Note: Many participants gave multiple answers
Note: Percentages are rounded to the nearest whole number

Table 3
What Makes You Frustrated With Your Patients?

<table>
<thead>
<tr>
<th>What Makes You Frustrated</th>
<th>#</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of motivation/participation</td>
<td>22</td>
<td>61</td>
</tr>
<tr>
<td>Lack of progress</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>Medically fragile patients discharged from</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital too soon</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>When they only want PT</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Denial</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Improper pain meds given</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>When staff performs ADLs because it is quicker</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Increased frustration with me</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Patients are verbally/physically abusive</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Interruptions</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Lack of understanding of treatment</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Unrealistic family members</td>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>

Note: Many participants gave multiple answers
Note: Percentages are rounded to the nearest whole number

There was also a question about what the respondents do when they get frustrated or stressed at work (Table 4). A third of the respondents stated that he or she vents, or
talks with fellow co-workers, friends, or a spouse. Fourteen percent responded that they often exercise. Another nine percent stated they complete relaxation techniques and deep breathing.

Table 4
What Do You Do When You Get Frustrated Or Stressed At Work?

<table>
<thead>
<tr>
<th>Activity</th>
<th>#</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vent/talk with fellow co-workers, friends, spouse</td>
<td>13</td>
<td>30</td>
</tr>
<tr>
<td>Exercise</td>
<td>6</td>
<td>14</td>
</tr>
<tr>
<td>Relaxation techniques/deep breathing</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td>Pray</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Go to my office/collect myself</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Take it home/internalize</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Eat/chocolate/drink coffee</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>No answer</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Step away for a little bit/take a break</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Haven't gotten frustrated</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Slow down to avoid looking frantic</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Try to remember why I am working here</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Sleep</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Listen to loud music in the car</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Note: Many participants gave multiple answers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Note: Percentages are rounded to the nearest whole number</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

To get both sides of the spectrum, the respondents were also asked what makes them happy with treatment sessions (Table 5) and what makes them happy with their patients (Table 6). A third of the respondents (39%) reported that progress makes treatment sessions enjoyable. The therapists feel they are doing some good for the patients. They feel that progress today will hopefully lead to progress tomorrow and soon the patient can return to his or her prior level of function. Twenty-two percent stated that this enthusiasm and motivation for therapy was another cause of happy treatment sessions.
Table 5
What Makes You Happy with Treatment Sessions?

<table>
<thead>
<tr>
<th></th>
<th>#</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Progress</td>
<td>16</td>
<td>39</td>
</tr>
<tr>
<td>Patients enthusiasm for therapy/motivation</td>
<td>9</td>
<td>22</td>
</tr>
<tr>
<td>Spending time with patients/rapport</td>
<td>5</td>
<td>12</td>
</tr>
<tr>
<td>Getting people to achieve things they didn’t think possible</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>When everything works for all parties</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Effective use of time</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>When I feel treatment was meaningful to the patient</td>
<td>1</td>
<td>2.5</td>
</tr>
<tr>
<td>Co-treat functional activities</td>
<td>1</td>
<td>2.5</td>
</tr>
<tr>
<td>Making it fun/va rity</td>
<td>1</td>
<td>2.5</td>
</tr>
<tr>
<td>Challenging patients and family</td>
<td>1</td>
<td>2.5</td>
</tr>
</tbody>
</table>

Note: Many participants gave multiple answers
Note: Percentages are rounded to the nearest half number

The last open-ended question that was asked of the participants related to the therapists happiness with patients (Table 6). Most of the respondents (35%) felt that a patient’s initiative and motivation made them the happiest. Another 24% felt that a patient progress and return to prior level of function made him or her the happiest.

The last question of the survey was asking the respondents to circle the reasons for burnout and list any that were not already there. Even though only five people expressed burnout, nineteen people answered this question. Those reasons are listed in the last table (Table 7).

Overall, 93% were satisfied/very satisfied with their careers, 72% had a strong to very strong desire to stay in this setting, and 83% felt that they are not burned out.
Table 6
What Makes You Happy With Your Patients?

<table>
<thead>
<tr>
<th></th>
<th>#</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>When they take initiative/try/motivation</td>
<td>13</td>
<td>35</td>
</tr>
<tr>
<td>Progress/return to PLOF</td>
<td>9</td>
<td>24</td>
</tr>
<tr>
<td>Sharing in their daily lives</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>When they thank me for helping them</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>Family support</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Helping them help themselves</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>When they tell others how helpful OT has been</td>
<td></td>
<td></td>
</tr>
<tr>
<td>For them</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Learning from them</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Diversity</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Their happiness</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>No answer</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Note: Many participants gave multiple answers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Note: Percentages are rounded to the nearest whole number</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 7
Reasons for Burnout

<table>
<thead>
<tr>
<th></th>
<th>#</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excessive paperwork</td>
<td>13</td>
<td>68</td>
</tr>
<tr>
<td>Increased productivity expectations</td>
<td>12</td>
<td>63</td>
</tr>
<tr>
<td>Excessive/too low a caseload</td>
<td>10</td>
<td>53</td>
</tr>
<tr>
<td>Others lack of respect for OT</td>
<td>7</td>
<td>37</td>
</tr>
<tr>
<td>Others lack of understanding of OT</td>
<td>7</td>
<td>37</td>
</tr>
<tr>
<td>No recognition for accomplishments</td>
<td>7</td>
<td>37</td>
</tr>
<tr>
<td>Other</td>
<td>7</td>
<td>37</td>
</tr>
<tr>
<td>Poor rapport with co-workers, doctors, nurses, etc</td>
<td>5</td>
<td>26</td>
</tr>
<tr>
<td>Inflexibility of schedule</td>
<td>3</td>
<td>16</td>
</tr>
<tr>
<td>Working environment</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td>Patients lack of progress</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Note: 19 people answered this question, many with multiple answers.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Note: Percentages are rounded to the nearest whole number</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
CHAPTER IV

DISCUSSION

These findings suggest that occupational therapists working in a geriatric setting in the state of Michigan do not express the experience of burnout. However, on average, these therapists are experiencing signs of stressful incidents that can lead to burnout.

One sign of stress reported is over-abundance of difficult diagnoses on a caseload. Therapists reported that they spend an increased amount of time with these patients due to the increased challenge in finding appropriate treatments. There is also more time involved due to the medically complex issues that have to be dealt with during each session. It has been stated throughout the literature that these diagnoses can lead to increased stress due to the increased challenge and sometimes the inability to help these patients.

Of the open-ended questions asked, one related to how the therapist felt when a patient accomplished and goal and another related to how the therapist felt when a patient did not progress. The answers tended to be general (sad, good, great, disappointed) and often related to the therapist. Only one person stated they felt happy for the patient. Does this mean the respondents felt that way about themselves, the treatment, or the patient? These therapists are beginning to internalize their patients' short-comings, creating significant stress for themselves. When a patient does not progress, regardless of whether or not the therapist could have done something different or the patient could have done something different, the therapist reported to feel that disappointment
internally, that they, themselves, have failed. The therapist may then learn from the situation, but a persistent lack of patient progress could lead to stress and eventually burnout.

There was also a question related to patient death. When responding to the issue of patient mortality, approximately 20% expressed relief because the patient was really ill or they saw the family suffering. The other 80% tended to internalize the grief just like they would if they lost a family member. Therapists, just like nurses, work with patients almost every day and tend to form a bond. If a patient dies, therapists tend to grieve as if they were grieving an actual family member. There is relief, yet pain. An internal conflict emerges about whether or not to grieve for a patient. Many or the respondents feel that if they do not grieve, they are seen as inhumane. Others feel that if they do grieve, they are getting too close to their patients. The angst that is created is likely to create occupational stress.

Another reported cause of stress is inadequate treatment space and inadequate equipment. Although the majority of the respondents reported they had adequate treatment space and equipment, 41% stated that the space was not feasible. The respondents reported there is no room for a kitchen, or a bathtub. These functional activities have to be simulated, which does not give accurate results, or time has to be spent transporting the patient to a different area of the building to complete functional tasks. Many stated that the facility was not designed for rehabilitation, leaving the rehabilitation room too small for all the equipment and therapists. The continuous challenge to acquire space or equipment can cause unnecessary stress for those working in long term care as well as impact on proper patient treatment.
One-third of the respondents reported that a lack of time for treatments and an overabundance of patients was the top source of frustration. This goes back to the statement made earlier regarding too much work and too little time. Therapists are feeling like they are in a factory of mass production more than in a helping field. Therapists do not have the time to give each patient the quality therapy session he or she deserves. The medical field has become more of a paper pushing field, as evidenced by the number of respondents stating that there is too much paperwork, than a field that helps, listens to, and appreciates the human race. The feeling of inadequacy, of feeling like you are no longer helping people, leads to stress, burnout, and job dissatisfaction.

It was reported that there is also a lack of follow through with staff regarding patients and therapy. This refers to the reported increased time getting patients to therapy, having to search for patients when it is time for therapy, and lack of follow through with restorative programs after discharge. This in turn leads to a higher caseload due to those particular patients requiring further therapy because of a decline in function due to poor staff follow through.

The majority of the respondents (61%) also stated that the most frustrating thing about their patients was the lack of motivation and participation. It was stated that it is very difficult to want to help people, and see the potential he or she has to get better, only to be refused due to lack of motivation or willingness. This takes extra time and effort to plan a session and try to motivate a patient. All of which is non-billable, decreases productivity, and causes management to push the therapist even harder.

On top of the lack of motivation from patients, the respondents stated there is also the frustration of seeing lack of progress. It is difficult when a therapist is trying his or
her hardest, sees the patient trying his or her hardest, and still there is no progress. The therapist and patient both want a better life for the patient, but something is blocking progress and neither knows why. At this time therapy is suspended and the patient usually has to deal with living a life that requires assistance from other people. The respondents of this survey stated they tended to feel like it was their fault the patient did not progress, even though many knew they were not the cause.

Many of the respondents have found ways to deal with his or her frustration. Many vent by talking with fellow co-workers, exercise, or practice relaxation techniques. Others tend to internalize, listen to loud music, eat, or take their frustrations out on other people. These are unhealthy ways to cope with frustration or stress. They can lead to problems in personal relationships and physical risk factors.

To get both sides of the spectrum, the respondents were also asked what makes them happy with treatment sessions and what makes them happy with their patients. The respondents feel that progress today will hopefully lead to progress tomorrow and soon the patient can return to his or her prior level of function. This also leads to a higher percentage of satisfaction among patients and the patients tend to look forward to therapy, causing less refusals and work on the therapists part to motivate patients for therapy. When patients are motivated for therapy, they are eager for their sessions and often will seek out their therapists. Sessions tend to move more smoothly and more gets accomplished. The therapist does not have to work as hard to get the patient involved or to find a task the patient enjoys. Often, if a patient is eager for therapy, he or she will offer up tasks that he or she enjoys. This makes for less guesswork, helps build rapport, and tends to make the session more meaningful to the patient.
The respondents reported that a patient’s progress tends to make a therapist feel good about what he or she is doing. The therapists feel they are actually doing their jobs if a patient progresses. This, in turn, gives the therapist the motivation to help the next patient.

Often times therapists can learn a lot from their patients. Patients tend to share their life experiences during sessions. Many of the respondents have stated that they have learned about history, diversity, and family from their patients. It tends to also make a therapist feel good about him or herself when a patient speaks highly of him or her, or if a patient is thankful for the love, support, and help while in therapy.

The last question of the survey was asking the respondents to circle the reasons for burnout and list any that were not already there. Even though only five people expressed burnout, nineteen people answered this question. The most frequently marked answers were excessive caseload, excessive paperwork, and increased productivity expectations. These three statements tend to go hand in hand. Management wants higher numbers, while insurance companies want more documentation, all while the facility is trying to keep beds filled to keep the money coming in. There is more work to be done in less time.
CHAPTER V

CONCLUSION

This study has found that the occupational therapists working in a geriatric setting in the state of Michigan do not report professional burnout. However, many of these therapists have identified risk factors that can lead to burnout, such as lack of respect for their profession, excessive paperwork, excessive caseloads, and increased productivity expectations.

The participants identified use of personal prevention techniques such as “playing”, “slowing down”, “venting”, “relaxation techniques”, and “exercise”. However, there are also ways the employer can decrease employee burnout. Garland (2002) conducted a study to find the consequences, causes, and prevention of burnout in prison treatment staff. He identified ten prevention guidelines for correctional management. They are emphasize rehabilitation within a clear mission statement, clarify roles and responsibilities, empower staff, offer constructive feedback, emphasize strengths along with weaknesses, give frequent feedback on client progress, manage by walking around, provide treatment-based training and information, ensure that adequate office and group space are available, and simplify paperwork.

These ten guidelines can be used in any setting, including the health setting. The most important statement Garland made was that staff burnout is one of the most potent detractors to performance. Some of Garlands findings can be related to occupational therapists and increasing the level of job satisfaction. If there is change at the
administration level to help keep therapists happy, therapists will tend to stay in one job position longer and will demonstrate less risk factors for burnout. This will in turn lead to increased job satisfaction, increased productivity, and increased patient progress.

This study has limitations. It represents only those health care workers in Michigan which could have unique features in terms of those elements that create professional burnout. Those who did not fill out the survey and return it may be too burned out to reply or may not be burned out at all and feel it did not apply to them. Finally, this study focused only on occupational therapists in a geriatric setting. Further research needs to be completed to determine if occupational therapists across all geographic areas and other settings are experiencing burnout or are at risk early in their careers.
APPENDICES
APPENDIX A

Survey: Occupational Therapist Burnout in a Geriatric Setting
Survey Regarding Occupational Therapy Job Satisfaction in the Geriatric Setting

The purpose of this study is to determine the reasons for burnout among occupational therapists in a geriatric setting. My hypothesis is that a high stress environment leads to professional burnout and may be a significant factor impacting on quality of care. Determining the specific factors that create burnout may provide cues on how to prevent this from occurring. You are being asked to participate in the above study for Dawn Doctor’s graduate thesis requirement.

You are being asked to fill out the following survey so that the data may be collected to determine if, indeed, there is burnout among therapists in a geriatric setting. The survey includes multiple choice and short answer questions. It would be beneficial to the research if you answered all of the questions. However, you may refuse to participate or you may refuse to answer any question at any time for whatever reason. The returned surveys will be kept for at least three years and then destroyed.

The survey should take less than a half hour. You may experience some inconvenience due to the length of time the survey will take. You may also experience some discomfort due to disclosing sensitive information by giving examples of causes of job stress/burnout. You will be under no obligation to answer the questions if you feel they are too personal. However, answering each question will greatly benefit the research.

You may benefit from the opportunity to discuss the pros and cons of your job, reflecting on your answers to the questions and possibly using the information to better your own practice or to benefit others in finding job satisfaction by teaching other therapists what you have learned about yourself and your job.

This study may also give the occupational therapy profession a baseline regarding job stress and burnout in the geriatric setting. It may provide information regarding the causes of stress and burnout, therefore leading to possible solutions. This research may help in guiding the OT profession in finding ways to keep therapists in the geriatric setting.

The conditions of participation include the following:
1. You must be a registered occupational therapist in the state of Michigan.
2. You must work in a geriatric setting.
3. You must be a member of AOTA and subscribe to the Geriatric Special Interest Section.

The list of names used for this research came from AOTA. The list came on address labels and those labels were put on the envelopes sent to you. Therefore, your name will
not be kept on file and there is no way to connect you to your answers to the survey. As stated above, the surveys will be kept for at least three years in a locked file cabinet.

You may refuse to participate or refuse to answer any question without prejudice or penalty.

**Filling out the following survey implies consent to participate in this study.**

If you have any questions or comments regarding this study, please call Dawn Doctor at (616) 530-5709 or (419) 306-8595 or call Ben Atchison at 269-387-7270. You may also contact the Chair, Human Subjects Institutional Review Board at (616) 387-8293 or the Vice President for Research at (616) 387-8298 if questions or problems arise during the course of the study.

This survey has been approved for use for one year by the Human Subjects Institutional Review Board (HSIRB) as indicated by the stamped date and signature of the board chair in the upper right corner. Do not participate in this study if the stamped date is older than one year.

*(Comments are welcome. Please place them on the back of the survey. Thank you.)*
1. Background information
   Highest degree earned
   □ Bachelors
   □ Masters
   □ Doctorate
   Gender
   □ Male
   □ Female
   Setting you work in
   □ Skilled nursing facility/care center
   □ Hospital
   □ Outpatient clinic
   □ Mental health
   □ Other geriatric setting
   □ Do not work in geriatrics
   Number of hours per week you work in this setting
   □ Less than 40
   □ Full Time: 40 +
   Approximate number of patients on caseload
   □ -10
   □ 11-20
   □ 21-30
   □ 31+
   Number of years in practice in this setting total
   □ -1
   □ 1-5
   □ 6-10
   □ 11+
   Number of years working for your current employer
   □ -1
   □ 1-5
   □ 6-10
   □ 11+

1. Do family commitments cause added stress to your job?
   □ Yes
   □ No

2. Do school commitments cause added stress to your job?
   □ Yes
   □ No

3. Do any certain diagnoses you treat add stress to your day?
   □ Yes
   □ No
4. What and why? ____________________________

5. In a typical week, how many days do you reflect that “today was a good day at work”
   □ One
   □ Two
   □ Three
   □ Four
   □ Five

6. How often do your patients accomplish the goals you set for them?
   □ 0-25%
   □ 26-50%
   □ 51-75%
   □ 76-100%

7. I feel ____________________________ when patients accomplish a goal.

8. I feel ____________________________ when a patient does not progress.

9. I feel ____________________________ when a patient dies.

10. Describe the way in which a patient’s death affects your practice:

11. Do you have adequate treatment space?
    □ Yes
    □ No  Why? ____________________________

    How does this affect your treatment? ____________________________

12. Do you have adequate equipment for treatments?
    □ Yes
    □ No

13. How far do you drive to work?
    □ 0-10 miles
    □ 10-20 miles
    □ 20-30 miles
    □ more than 30 miles

14. Does this drive add stress to your work day?
    □ Yes
    □ No

15. Do you get along with your co-workers?
    □ Yes
    □ No  Why? ____________________________

16. How does this affect your job?
    □ Makes it very stressful
    □ Makes it stressful
    □ No affect
    □ Makes it pleasant
    □ Makes it very pleasant

17. Do you enjoy the facility you work in?
    □ Yes
    □ No  Why? ____________________________
18. How does this affect your job?
   □ Makes it very stressful
   □ Makes it stressful
   □ No affect
   □ Makes it pleasant
   □ Makes it very pleasant
19. What makes you frustrated with treatment sessions?
20. What makes you happy with treatment sessions?
21. What makes you frustrated with your patients?
22. What makes you happy with your patients?
23. What do you do when you get frustrated or stressed at work?
24. Does your mood affect how you treat a patient? How?
25. Level of career satisfaction
   □ Very satisfied
   □ Satisfied
   □ Unknown
   □ Unsatisfied
   □ Very unsatisfied
26. Desire to stay in this setting
   □ Very strong
   □ Strong
   □ Unknown
   □ Weak
   □ Very weak
27. Burnout consists of emotional exhaustion, depersonalization and reduced personal accomplishment. Are you burned out from your job?
   □ Yes
   □ No
28. Reasons for burnout (circle all that apply)
   □ Others lack of respect for OT
   □ Others lack of understanding of OT
   □ Excessive paperwork
   □ Excessive/too low caseload
   □ Increased productivity expectations
   □ Poor rapport with co-workers, doctors, nurses, etc
   □ Inflexibility of schedule
   □ Patients lack of progress
   □ Working environment
   □ No recognition for accomplishments
   □ Other

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APPENDIX B

Approval Letter from the Human Subjects
Institutional Review Board
Date: May 27, 2003

To: Ben Atchison, Principal Investigator
    Dawn Doctor, Student Investigator for thesis

From: Mary Lagerwey, Chair

Re: HSIRB Project Number 03-05-19

This letter will serve as confirmation that your research project entitled "Occupational Therapy Job Satisfaction in the Geriatric Setting" has been approved under the exempt category of review by the Human Subjects Institutional Review Board. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note that you may only conduct this research exactly in the form it was approved. You must seek specific board approval for any changes in this project. You must also seek reapproval if the project extends beyond the termination date noted below. In addition if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: May 27, 2004
BIBLIOGRAPHY


