

Burnout in physiotherapists: Use of clinical supervision and desire for emotional closeness or distance to clients

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Aims: This study aimed to investigate burnout among physiotherapists in hospitals within four health districts in South Tyrol (the German and Italian speaking area of Italy).

Method: Data were collected anonymously by envelope. The German version of the Maslach Burnout Inventory (MBI-D) (Büssing and Ferrar, 1992; Büssing and Glaser, 1998), socio-demographic, occupational data, the use of clinical supervision or support and the desire for emotional distance and closeness to clients were recorded. Questionnaires were sent to 191 physiotherapists in South Tyrol; and 132 participated in the study (return rate 69.63%).

Results: In the MBI-D, which contains three scales: 'emotional exhaustion', 'depersonalisation' and 'personal accomplishment'; the risk of burnout is reflected in high values in the emotional exhaustion and the depersonalisation scales and low values in personal accomplishment. The present study found that about 35% of the physiotherapists who responded to the questionnaire showed burnout risk in emotional exhaustion, 18% in depersonalisation and 14% in personal accomplishment. This is in agreement with many other studies conducted among health professionals. Gender differences were observed only on the depersonalisation scale, with men scoring higher than women. No differences were found regarding length of stay in the profession. Only one third of physiotherapists are offered clinical supervision or support by their employer but about 50% of physiotherapists sought psychological support. The use of supervision or support was 2.72 times more likely when available at work than not. Contrary to expectations, the impact of supervision or support did not reach significance in the burnout scales. The desire for more closeness is predicted by gender (male), higher emotional exhaustion and depersonalisation, and the desire for more distance is predicted by higher emotional exhaustion.

Conclusions: More attention to mental hygiene and support in the workplace and during training would help to prevent burnout among physiotherapists, and benefit the profession, patients and organisations.

Key words: ■ Burnout ■ Clinical supervision or support ■ Emotional closeness ■ Emotional distance ■ Physiotherapy ■ South Tyrol

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Maslach et al (2001) defined burnout as:

'...A prolonged response to chronic and interpersonal stressors on the job and is defined by the three dimensions of exhaustion, cynicism and inefficacy' (Maslach et al, 2001: 397).

Burnout research has its roots in care-giving and service occupations, where the relationship between the provider and recipient is at the core of the profession. Originating as it does from interpersonal contexts, burnout research has focused on individuals' relational transactions

and the associated emotions, and on the motives and values underlying their work.

The concept of burnout evolved from observations and interviews in the 1970s by Freudemberger (1975) and Maslach (1976). Several themes emerged from these early interviews. It was clear that the provision of care services can be very demanding and that emotional exhaustion is not an uncommon response to job overload. A second theme was 'depersonalisation' or 'cynicism', which may be a way of coping by creating emotional distance ('detached concerns': Marcum, 2008: 2), enabling care givers to protect themselves from intense emotional arousal. However, it was found this can lead to care givers responding to

clients in negative ways extending to cynicism and depersonalisation (Halpern 2003; Larson and Yao 2005; Marcum 2008). Freudenberger (1975) and Maslach's (1976) observations gave us first-hand insights into some of the themes their interviews identified: a large caseload, a high prevalence of negative client feedback, and scarcity of resources.

While different measures of burnout were developed in the 1980s, the Maslach Burnout Inventory (MBI) (Maslach and Jackson, 1981) is still the most widely used by researchers and best reflects psychometric properties. The MBI-D contains three scales: 'emotional exhaustion'; 'depersonalisation'; and 'personal accomplishment'. The MBI (Maslach and Jackson, 1981; Maslach et al, 1996) is currently the most frequently-used questionnaire for measuring burnout, making it possible to compare the results of different regional and international studies. Three versions are available, including one for people working in human services and healthcare (Maslach et al, 2001).

Burnout in the MBI is seen as a form of job stress with links to job satisfaction. The key symptoms of burnout syndrome, according to the MBI, are an increasing feeling of emotional exhaustion; depersonalisation that is reflected in cynical attitudes and feelings towards clients; and a sense of not being able to deal properly with tasks in association with a negative self-evaluation of performance (Maslach, 1976; Freudenberger and Richelson, 1980; Maslach and Leiter, 1997; Maslach et al, 2001). The most recent edition of the MBI is Maslach et al (1996).

Over the past years, burnout research has extended into models with differing approaches. Maslach's concept has more recently expanded in the direction of job engagement, where the focus is also on positive aspects of occupational behaviour (Linley and Joseph, 2007; Maslach and Leiter, 2008; Schaufeli et al, 2009). Contrary to those who suffer from burnout, engaged employees have a sense of energetic and effective connection with their work activities and see themselves as able to deal well with the demands of their job.

'Compassion fatigue' is another related concept dealing with the costs of caring (Figley, 1995; 2002a; 2002b; Linley and Joseph, 2007). Figley (1995) described compassion fatigue as an occupational hazard specific to severely emotionally-distressing clinical work. Compassion fatigue and burnout differ in some key aspects. Burnout is not directly related to the exposure to traumatic material, and the onset is gradual and cumulative, while compassion fatigue has a faster onset of symptoms (Figley, 2002a; Rossi et al, 2012; Linley and Joseph, 2007). Conversely, compassion satisfaction refers to the satisfaction derived from

being able to help other people (Stamm, 2002).

The International Classification of Diseases (ICD-10) (WHO, 2007) lists burnout as a state of vital exhaustion (diagnosis code Z73.0), resulting from life management difficulties or as job-related neurasthenia (Burn-out-Syndrome Z76.8) (Schaufeli et al, 2001). However, the ICD-10 does not explicitly include compassion fatigue.

A professional's emotional strategy and interpersonal skills in dealing with the demands of physiotherapy are seen as determinant of customer service quality (Lapointe et al, 2012) and may also relate to burnout. While the term 'emotional labour' (Hochschild, 1983) first described how airline cabin crew must suppress their emotional reactions to project a professional manner at work, Hingst (2006), Davies (2009) and Chou et al (2012) applied the term to individuals investing their emotions in their work.

Emotional labour strategies can take various forms. Surface acting involves simulating emotions that are not truly felt, while deep acting involves the real internal modification of negative emotions. Both strategies are considered compensatory in contrast with more sincere, naturally-felt emotions, which may not always fit the organisation's emotional display rules (Gray, 2009a; 2009b; Lapointe et al, 2012). Surface acting is strongly related to emotional exhaustion, while deep acting and natural acting are not related to burnout (Chou et al, 2012; Weng, 2011; Lapointe et al, 2012).

The literature around burnout in physiotherapists has identified: workload; time pressure; and role conflict as important sources of burnout. Role stress may come in two forms: role conflict and role ambiguity. Role conflict may arise in response to incompatible organisational demands while role ambiguity may arise in response to unclear expectations or uncertainty around authority and responsibilities (Donohoe et al, 1993; Li Calzi et al, 2006; Crawford et al, 2010; Chou et al 2012).

Junior physiotherapists (qualified less than 2-4 years) and long-serving physiotherapists seem to experience particularly high rates of burnout (Mandy and Rouse, 1997). The same holds for intern or resident physicians (Thomas, 2004) and student nurses (Smith and Gray, 2001).

Burnout has been investigated in various medical professions. In the context of physical rehabilitation, Li Calzi et al (2006) compared burnout among physiotherapists, nurses, physicians and technicians and reported that physiotherapists scored the highest in emotional exhaustion and physicians scored the lowest.

Maslach et al (1996) provide normative values (means of the scales) for 11076 individuals who they tested using the MBI. Each health-care profes-

Table 1. Sample description

| Gender | n (%) |
|--|--------------------------|
| Women | 104 (78.79) |
| Men | 28 (21.21) |
| Married or cohabiting | n (%) |
| Women | 44 (41.90) |
| Men | 10 (35.71) |
| Age | Mean (SD) |
| Women | 36.55 (8.68) |
| Men | 37.30 (7.61) |
| Health districts | n (%) [women:men] |
| Bozen (BO) | 48 (36.09) [41:7] |
| Merano (MS) | 35 (26.32) [27:8] |
| Brixen (BS) | 18 (13.53) [13:5] |
| Bruneck (BI) | 32 (24.06) [24:8] |
| Employer offers clinical supervision or support | n (%) |
| Women | 33 (33.67) |
| Men | 10 (35.71) |
| Clinical supervision or support was/is used | n (%) |
| Women | 49 (47.62) |
| Men | 15 (53.57) |
| Working with children | n (%) |
| Women | 5 (3.08) |
| Men | 0 (0) |
| Not specified | 7 (5.3) |
| Duration of professional activity (years) | Mean (SD) |
| Women | 12.57 (8.26) |
| Men | 12.48 (7.28) |
| Workload last week (hours) | Mean (SD) |
| Women | 30.87 (9.80) |
| Men | 39.59 (1.23) |

sion can be compared to this normative value or the categories that indicate high, medium or low burnout (Mandy and Rouse, 1997; Daugherty, 2002), see *Table 2*.

This study aims to investigate whether physiotherapists in South Tyrol experience a similar frequency of burnout as physiotherapists and other health professionals in other European countries and the US. Mandy et al (1997) suggested there might be a U-shaped relation between job experience and burnout, with professionals experiencing more burnout experience after a very short (≤ 4 years) or a very long (≥ 15 years) time in the occupation and less in between. Therefore, this study also aims to elucidate the relationship between the length of job experience and burnout.

Since one of the coping strategies for emotional exhaustion and depersonalisation is seeking

distance from clients, we expected high burnout scores to be associated with a wish for greater distance from clients (Halpern, 2003; Larson and Yao, 2005; Marcum, 2008). The authors also expected that attendance of clinical supervision or support in any form would be associated with less burnout. The term clinical supervision or support is used in this paper for any kind of psychological support, e.g. via individual clinical supervision, psychotherapy, Balint group supervision, or other group supervision (Roberts, 1997; Johnson and Milberg, 2004; Awa et al, 2010; Jelinek et al, 2010; Putnik et al, 2011).

METHOD

This study used a questionnaire-based survey. The authors gained informed, written consent from all physiotherapy employees at the public health authority in South Tyrol (the bilingual German- and Italian-speaking region of northern Italy) and the autonomous province of Bozen's (Autonome Provinz Bozen) public health authority. The Interuniversity College for Health and Development Ethics Committee in Graz approved this study on 5 January 2008.

This study collected data using the German version of the MBI for health professionals (MBI-D by Büssing and Perrar, 1992; Büssing and Glaser, 1998). Questionnaire responders rated each item in the MBI-D's three scales: 'emotional exhaustion'; 'depersonalisation'; and 'personal accomplishment' on a six-point scale according to the frequency of the experience (ranging from never=1, to very often=6).

This study also collected socio-demographic and job-related data on. The questionnaire asked responders about their current and previous use of clinical supervision or support and its availability at their institution. The questionnaire followed recommendations for single-item assessment (Alexandrov, 2010) and used two single-item measures relating to the responders' desire for more distance or closeness to clients (scores ranging from never=1, to very often=6).

The authors distributed a total of 191 envelopes containing questionnaires, cover letters and return envelopes to all physiotherapists in the participating hospitals. Study participants were given 12 days to fill in the questionnaires, and their responses were collected over the course of approximately 1 month. From the four health districts of the South Tyrol public health authority, 132 physiotherapists returned completed questionnaires—a return rate of 69.63%.

Multivariate variance analyses were used to elucidate differences in the data with gender

and length of stay in the profession (≤ 4 years, 5–14 years, ≥ 15 years). Age did not correlate with the burnout variables so was not included as a covariate. Using multiple regression analyses, the socio-demographic (gender, age, marital status), career-specific (length of time in the profession, weekly working hours, availability and use of clinical supervision respectively) and burnout variables (MBI scales) were used to predict physiotherapists' desire for more closeness or distance to clients. In a logistic regression analysis, the authors investigated the relationship of the surveyed variables with the use of supervision/clinical support of any kind (yes/no).

The authors used the international approach of aggregating scores and categorising the sum to categorise participants as having a low, moderate or high risk for burnout (Mandy and Rouse, 1997; Daugherty, 2002) (see *Table 2*). This method maintained a comparability with international results. In the German version (Büssing et al, 1992; Büssing and Glaser, 1998) it is suggested to calculate the mean item score and set the cutting score to ≥ 4 for emotional exhaustion and depersonalisation and ≤ 3 for personal accomplishment. This scoring version is used by very few other authors but enables each MBI scale to be directly compared with the other two despite the different number of items in each (Lederer et al, 2006; Pienaar et al, 2008; Weng et al, 2011; Chou et al, 2012).

RESULTS

The sample consisted of 132 physiotherapists (104 women and 28 men) aged 23–58 years (mean age: 36.70 years; women: 36.55 years, men 37.30 years). Of the women, 41.9% lived in partnerships and 35.7% of men did so. The mean duration of professional activity was 12.55 years and was about the same for both genders (see *Table 1*).

The survey participants came from the four health districts of the South Tyrol public health authority with approximately the same gender ratio in each of the four districts. Only women (3.08%) dealt with children in their work. Weekly working hours amounted to 30.87 hours for the women and 39.59 hours for the men. The men all appeared to be employed full time, whereas many of the women worked half days (see *Table 1*).

The MBI recorded high scores for emotional exhaustion (MBI-D1) at 34.6% ($n=46$), and for depersonalisation (MBI-D2) at 18.0% ($n=24$). In the personal accomplishment (MBI-D3) category 14.3% ($n=19$) (Mandy and Rouse 1997, Daugherty 2002), which indicates burnout (see *Table 2*).

This study found no differences between the participants' MBI scale scores and the normative

Table 2. Percentage and number of respondents in the burnout categories of the Maslach Burnout Inventory (MBI) in South Tyrol

| MBI subscales | Low | Moderate | High |
|-------------------------|--------------|--------------|--------------|
| Emotional exhaustion | 20.3% $n=27$ | 45.1% $n=60$ | 34.6% $n=46$ |
| Depersonalisation | 26.3% $n=35$ | 55.6% $n=74$ | 18.0% $n=24$ |
| Personal accomplishment | 12.0% $n=16$ | 73.7% $n=98$ | 14.3% $n=19$ |

Table 3. Means and SD for subscale scores of physiotherapists in South Tyrol

| MBI subscales | Male ($n=28$) | Female ($n=28$) | Total ($n=28$) |
|-------------------------|-----------------|-------------------|------------------|
| | Mean (SD) | Mean (SD) | Mean (SD) |
| Emotional exhaustion | 24.71 (7.97) | 23.35 (7.86) | 23.64 (7.88) |
| Depersonalisation | 10.82 (3.89) | 8.75 (3.39) | 9.19 (3.59) |
| Personal accomplishment | 33.89 (3.38) | 34.80 (3.37) | 34.61 (3.38) |

MBI values for health professionals (see *Table 4*) (Maslach et al, 1996; Mandy and Rouse, 1997; Akroyd et al, 2002; Daugherty, 2002). This indicates a similar average burnout burden among South Tyrolean physiotherapists compared with averages in other countries.

A MANOVA test revealed significant gender differences on MBI scales among this study's responders (Pillai Spur: $F_{3,129}=2,796$, $P=0.043$). In the univariate analysis the difference was only significant for MBI-D2 (depersonalisation), with men showing higher scores in depersonalisation than women (see *Table 4*). Burnout experience vs. length of time spent in the profession (≤ 4 years, 5–14 years, ≥ 15 years) showed neither the expected U-shape nor an increase in the burnout dimensions; the differences were not significant in the MANOVA test.

This study found gender differences around the desire for more emotional closeness and more distance (Pillai Spur: $F_{2,130}=8.927$, $P=<0.001$). Male responders reported wishing to have more emotional closeness to their clients than the females (males: $M=2.07$, $SD=.858$; females: $M=1.50$, $SD=0.622$). The desire for more emotional distance was equally pronounced in male and female physiotherapists (men: $M=2.29$, $SD=.937$; women: $M=2.39$, $SD=.915$). Taking the time spent in the profession into consideration (Pillai Spur: $F_{4,254}=2,375$, $P=0.53$), the gender difference in the desire for more emotional closeness remained stable over all three employment phases ($F_{2,127}=0.586$, $P=0.59$), whereas the desire for more distance decreased linearly and to an equal degree in both genders the longer physiotherapists stayed in the profession ($F_{2,127}=4,286$, $P=0.03$) ($M_{\leq 4 \text{ years}}=2.65$, $SD=.935$, $M_{5-14 \text{ years}}=2.43$, $SD=0.931$, $M_{\geq 15 \text{ years}}=2.17$, $SD=0.863$).

Two multiple regressions analyses were performed with socio-demographic variables to determine which of the surveyed variables con-

Table 4. Previous studies using the Maslach Burnout Inventory (MBI) to study burnout among health and medical professionals

| Burnout scale (norm value) | Physiotherapists USA | | Health provider in rehabilitation Italy | | | | Physiotherapists UK | | Radiographers UK | Sonographers vascular technicians USA | Radiation therapists USA |
|------------------------------|-------------------------|--------------------|---|-----------------------|-------------------|--------------------|-------------------------------|----------------------|----------------------|---------------------------------------|--------------------------|
| | n=129 | High BO | n=57 Physioth | n=23 Nurses | n=24 Physic | n=20 Techn | n=33 | High BO | n= 87 | n=116 | n=503 |
| EE (22.0) | 23.54 | 46% | 22.40 | 15.69 | 15.00 | 20.30 | 22.30 | 29% | 22.9 | 24.3 | 27.9 |
| DP (8.7) | 7.63 | 20% | 4.56 | 3.17 | 6.46 | 3.75 | 9.13 | 23% | 7.1 | 8.1 | 10.5 |
| PA (34.6) | 37.26 | 60% | 36.63 | 38.17 | 38.00 | 34.45 | 37.35 | 16% | 37.0 | 37.9 | 42.1 |
| Maslach et al (1996) | Donohue et al (1993) | | Li Calzi et al (2012) | | | | Mandy and Rouse (1997) | | Probst et al (2011) | Daugherty (2002) | Akroyd et al (2002) |
| Burnout scale (high burnout) | Transplant surgeons USA | Nurses USA | Nurses Taiwan | Nurses Australia | Nurses Austria | Internists Taiwan | General practitioners Austria | Anesthetists Austria | | Tourism management Netherland | |
| | n=209 | n=9425 | n=240 | n=176 | n=110 | n=95 | n=89 | High BO | n=150 | | |
| EE (>27/>4) | 38% | 43.2% | 3.03 | 2.27 | 3.41 | 2.90 | 2.93 | 25.8% | 2.78 | | |
| DP (>12/>4) | 27% | -- | | 1.41 | 2.59 | 2.00 | 2.51 | | 2.56 | | |
| PA (<31/<3) | 16% | -- | | 3.99 | 2.84 | 5.10 | 4.55 | 19.8% | 4.93 | | |
| | Yost et al (2005) | Aiken et al (2002) | Chou et al (2012) | Strasser et al (2010) | Weng et al (2011) | Fuchs et al (2011) | Lederer et al (2006) | | Pienaar et al (2008) | | |

NB: High BO: high burnout category, EE: emotional exhaustion, DP: depersonalization, PA: personal accomplishment. In the above papers there were either MBI means calculated by sum scores or by average item scores (1–6) available or categories indicating high burnout in the respective scale

tributed to predicting the desire for more distance or closeness. The desire for more distance proved predictable ($F_{10,112}=6.50, P<0.0001; R^2=0.367, R^2_{corr}=0.311$), with emotional exhaustion (MBI-D1) emerging as the only significant predictor and correlating positively with the desire for emotional distance (MBI-D1: $\beta=0.500, T=5.268, P<0.0001$). The results found that the desire for greater emotional closeness ($F_{10,112}=4.575, P<0.0001; R^2=0.290, R^2_{corr}=0.227$) was determined by gender (male) ($\beta=0.303, T=3.283, P=0.001$), greater emotional exhaustion (MBI-D1) ($\beta=0.266, T=2.643, P<0.009$) and higher depersonalisation (MBI-D2) ($\beta=0.238, T=2.190, P<0.031$).

Clinical supervision or support of any kind was offered by the employer to only one third of physiotherapists. Despite this low rate of availability, 52.4% of women and 46.43% of men participated in clinical supervision or used other means of psychological support (see Table 1).

A logistic regression results of the attendance of clinical supervision or support (yes/no) showed offers of supervision or support by the employer to be the only significant predictor for attendance (OR 2.715; CI: 1.047-7.040, $P=0.049$). This indicates that the probability of attending clinical supervision or support is 2.715 times higher if supervision or support is available at the physi-

otherapist's own institution. Contrary to our expectations, this study observed no relationship between the frequency/intensity of clinical supervision or support and MBI scores.

DISCUSSION

This study's sample of physiotherapists from South Tyrol showed a risk of burnout (emotional exhaustion, depersonalisation and personal accomplishment) comparable to that of normative values from other health and medical professions (Maslach and Jackson, 1996; Mandy and Rouse, 1997) and from other burnout studies (Akroyd et al, 2002; Daugherty, 2002). Burnout manifested as emotional exhaustion in approximately 35% of this study's responders, as cynicism and depersonalisation in 18% and as a lack of personal accomplishment in 14%. Among junior physiotherapists in the UK, 29% showed high levels of emotional exhaustion, 23% high levels of depersonalisation and 16% low levels of personal accomplishment (Mandy and Rouse, 1997). In an older study by Donohue et al (1993), 46% of physiotherapists from the US scored high on emotional exhaustion, 20% high on depersonalisation and 60% low on personal accomplishment. Li Calzi et al (2006) investigated Italian health professionals in rehabilitation hospi-

tals and found medium-to-high levels of burnout in the emotional exhaustion and depersonalisation scales and low levels for personal accomplishment (see *Table 2*); the same holds for physiotherapists who also reported a high emotional overload in the PSQ (Perceived Stress Questionnaire), see *Table 2*.

One country known for its particularly low rate of burnout among physiotherapists is Norway, with approximately 4% (Mandy et al, 2004). However, Mandy et al (2004) used the Bergen Burnout Inventory, which was validated for a Norwegian population and the levels of burnout may be different from the categories of the MBI. Mandy et al (2004) reported that the low levels of burnout in Norway were explained partially by the high rate of married or cohabiting individuals (80.3%). Peeters et al (2005) emphasised that family and social network are important in combating burnout. Conversely, subjects who are burnt out, exhausted and depersonalised are less likely to make friends and maintain interpersonal relationship (Greenglass et al, 1996; Schaufeli and Enzmann, 1998). Another possible explanation may be the fact that 53% of the sample worked part time (Mandy et al, 2004). The Norwegian physiotherapists also reported high self-efficacy, suggesting that they demonstrated a broad sense of personal competence and felt able to deal effectively with a variety of stressful events (Mandy et al, 2004). Despite not explicitly investigating burnout, Svendsen (2001) reported that job satisfaction among Norwegian physiotherapists is high; however, Svendsen (2001) also reported that 89% of physiotherapists complained about symptoms such as headache, which could indicate stress and burnout (Schaufeli and Enzmann, 1998; Langballe et al, 2009; Khamisa et al, 2013).

Crawford et al (2010) showed a strong relationship between job demands, emotional exhaustion, job resources and job engagement in their job demands-resources model. Santos et al (2010) reported that highly stressful situations in physiotherapy include: lack of professional and social recognition; interpersonal conflicts with seniors; hierarchical seniors' pressure; and interpersonal conflicts with colleagues. Other items frequently identified as stressful were lack of social and emotional support from the institution, the emotional burden of the task, and facing death or permanent incapacity in patients.

The literature on gender differences in burnout has produced inconsistent results regarding the magnitude and direction of differences. A meta-analysis of the relationship between gender and burnout using 409 effect size values from 183 studies revealed that women are slightly more emotionally exhausted than men, while men are somewhat more depersonalised than women (Purvanowa et

al, 2010). This current study's South Tyrol sample also observed small gender differences, the most conspicuous was higher scores in men on the MBI depersonalisation scale. Innstrand et al (2011) investigated gender differences among physiotherapists in the two dimensions of the Oldenburg Burnout Inventory (OLBI), namely exhaustion and disengagement, and found women to report more exhaustion, but not more disengagement, than men. te Brake et al (2003) observed Dutch dentists and reported that males report more depersonalisation in the Dutch MBI than females. They found no gender differences in the other dimensions (i.e. emotional exhaustion and personal accomplishment). They also reported no gender-related differences in the degree of work stress or health-related aspects experienced. It was seen, however, that male dentists put in more working hours and see more patients per week than female dentists. Therefore, the small gender differences and the lack of differences in emotional exhaustion in the South Tyrol sample might be related to differences in workload between male and female physiotherapists, since females work on average about 10 hours per week less than males.

Physiotherapists are often in close physical contact with their clients, depending on their area of activity. One possible indication of burnout is the desire for more distance or closeness. Pines et al (1981) stated that if physical distance is not possible, people distance themselves emotionally as a coping strategy. Fox and Lief (1963) introduced the term 'detached concern' for behaviour where therapists distance themselves in their attitude from clients while remaining objective enough to make reliable medical decisions, maintain their equanimity and preserving sufficient empathy. They assumed it is only possible to help a patient if a certain distance is maintained. Nevertheless, there is a risk that the distance becomes too great and that a decreased participation and dehumanising attitudes characteristic of burnout take hold (Fox and Lief, 1980; Pines et al, 1981; Halpern, 2003; Larson and Yao, 2005; Marcum, 2008; Chou et al, 2012).

The desire for more distance was predicted by higher emotional exhaustion (MBI-D1). The desire for more closeness was stronger in men and in those with higher levels of emotional exhaustion (MBI-D1) and depersonalisation. The desire for more closeness or distance to clients indicates an imbalance between the reality of the treatment situation and the wellbeing of therapists.

There is some face validity that higher emotional exhaustion fosters a desire for more distance. According to Demerouti et al (2001), the development of burnout follows two processes: the first is related to job demands, which lead to frequent overtaxing and consequently to exhaus-

tion; the second is a lack of job resources (e.g. lack of social support), which leads to disengagement from work. Considering the prediction of more closeness in men, one might speculate that men who show more depersonalisation and emotional exhaustion may foster ambivalent feelings. They may feel too detached from their patients and feel the need to be closer. Emotional interaction with patients can add value and meaning to the work and often leads to a sense of accomplishment (Davies, 2009; Weng et al, 2011).

Burnout could also be seen as the result of unrealistic expectations and a loss of meaning, both of which are factors potentially relating to burnout (Freudenberger et al, 1980; Cherniss, 1995; Roberts, 1997). Schaufeli and Enzmann (1998) emphasised that burnout syndrome often remains undetected for a long period of time. Due to unfavourable coping strategies like depersonalisation and cynicism, behaviours leading to burnout often appear to be maintained and reinforce pre-existing maladaptation. Coping resources most commonly used by professionals with lower levels of stress and higher levels of perceived efficacy in stress resolution were social support and active coping strategies, e.g. problem solving, cognitive restructuring and stress monitoring (Santos et al, 2010).

Going forward, burnout needs to be prevented, recognised, and both individual and organisational strategies implemented. Prevention of burnout could be provided on an individual level, an organisational level or on both. Awa et al (2010) reported that 80% of the 25 burnout intervention programs they systematically reviewed reduced burnout. Person-directed interventions (e.g. clinical supervision) reduced burnout in the short term, while a combination of both person- and organisation-directed interventions (e.g. professional skills interventions) had longer-lasting positive effects. Positive effects of interventions diminished over

time but lasted longer with refresher sessions (Rowe, 2000). Problem-focused strategies and emotion-focused strategies such as reflection may protect against burnout (Fearon and Nicol, 2011).

Regular clinical supervision or support can help reduce the risk of burnout by enabling workers to recognise the emotional distancing (e.g. blunted or cynical behaviour), which can make them prone to depersonalisation (Johnson and Milberg, 2004; Awa et al, 2010; Jelinek et al, 2010; Korunka et al, 2010). A correct, subjective assessment of stress through feeling and thinking protects against burnout (Roberts, 1997; Maslach and Leiter, 2008; Korunka et al, 2010; Fuchs et al, 2011; Putnik et al, 2011).

Human service professionals are often dedicated workers who may have an internalised ideal of their professional role that they strive to maintain at their cost. Professionals take a long time to seek psychological help for burnout as it is less accepted than somatic symptoms (Putnik et al, 2011); however, help-seeking may be easier in organisations that do not regard stress as a moral flaw and react pejoratively.

On an individual level, personality traits such as emotional intelligence (EI) (Davies, 2009; Weng, 2011) and coping strategies (Santos et al, 2010) play an important role in dealing with stress. Beyond EI, Wood et al (2011) reported that using personal strengths (Wood et al, 2011) leads to increases in wellbeing.

The focus of occupational studies of the past on employees' weaknesses has begun to change with the appearance of positive psychology (Seligman and Csikszentmihalyi, 2000; Strümpfer, 2005; 2006; Linley and Carter, 2007), and the connected concept of salutogenesis (Antonovsky, 1979; 1987). Antonovsky's salutogenesis concept (1979; 1987) focused on 'what keeps us healthy' and could be introduced to staff rather than simply offering treatment for burnout. Additionally, a sense of coherence may also lead to less negative psychological changes and compassion fatigue (Linley and Joseph, 2007).

Burnout is a problem for organisations as well as the individual, as it may reduce job performance (Maslach and Leiter, 1997; Maslach et al, 2001; Halbesleben, 2006). Maslach and Goldberg (1998) and Maslach and Leiter (2008) suggested this could be achieved by creating a better fit between the individual and their job to help them engage more with their work, e.g. work schedule reorganisation, or job re-training (Awa et al, 2010).

Limitations

The primary limitation of this study is its cross-sectional research design, which does not allow causal statements to be made. Another limita-

KEY POINTS

- Of physiotherapists in South Tyrol, 35% showed signs of burnout in emotional exhaustion, 18% in depersonalisation and 14% in personal accomplishment.
- No differences in burnout were found regarding length of stay in the profession.
- Gender differences were only seen in depersonalisation—higher scores in men.
- 50% of physiotherapists sought psychological support but only one third are offered clinical supervision or support by their employer.
- Male physiotherapists reported wishing more emotional closeness to their clients than females. The desire for more emotional distance was equally pronounced in both gender.
- Preventing burnout among physiotherapists would benefit the profession, patients and organisations.

tion is the exclusive use of self-report measures as self-report studies could have validity problems. Self-reporting can be limited as individuals may exaggerate or under-report symptoms to show socially desirable reactions (Paulhus, 1991). However, the anonymous nature of the data may have prevented a pronounced response bias.

Future research

Khamisa et al (2013) conducted a systematic review of burnout in relation to factors such as work-related stress, job satisfaction, burnout and health outcomes among nurses. They stated that very few longitudinal studies are available to date and that the relationship between the factors they explored can be in either direction. Further research exploring mediating or moderating effects of the relationships between these variables over a longer time and with different health-care providers is necessary.

A further recommendation for future research is to investigate both strength and deficiency behaviour and their relationship to work stress, burnout, job engagement and wellbeing. Understanding causality rather than just relationships between factors may provide the basis for tailored interventions, which would benefit health workers, patients and organisations.

CONCLUSION

This study of physiotherapists in South Tyrol found no associations between emotional exhaustion or depersonalisation and increasing time spent in the profession. This suggests that not only newly-qualified physiotherapists but also more experienced medical carers need sensitive clinical supervision and additional training to enable them to better deal with their own psychological reactions to difficulties (Mandy et al, 1997). Physiotherapists need opportunities to verbalise their feelings towards such difficulties in a supportive atmosphere (Cherniss, 1995; Fearon and Nicol, 2011). **UJR**

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COMMENTARY

Research has been conducted into burnout and job satisfaction for health care professionals in many countries. It reveals that work-related stress affects the interpersonal functioning of teams and colleagues with increased conflict, substandard patient care, problems at home, and physical and mental health problems. It may lead to practitioners changing practice specialism or leaving the profession altogether.

Many studies favour the use of Maslach Burnout Inventory-Health Sciences Survey (MBI-HSS) (Maslach and Jackson, 1996) due to its standardisation and vast international data. It is not surprising that the levels of burnout in physiotherapists practicing in South Tyrol do not differ from the norms reported in MBI-HSS. This study attempts to tease out gender differences on the various dimensions of burnout and additional studies are required to further understand

these differences. One of the challenges is that many health professions are female-dominated and, in many studies, there is insufficient participation of male health-care providers to fully tease it out. Nevertheless, the authors are to be commended for their attempt to add to this body of knowledge.

This study in its literature review brings in information from compassion fatigue and Hirschfeld's (1983) notion of emotional labour, which may help further elucidate the burnout dimensions of emotional exhaustion, depersonalisation and cynicism. Perhaps the conflicting desire for emotional closeness and distance, as well as seeking supervision are examples of emotional management attempts by the physiotherapists as they try to mediate their stress, burnout and job performance. This is an interesting area of study and would benefit from further examination. Mixed method or qualitative studies may

help to unpack the themes and deepen our understanding.

The authors have examined prevention strategies and looked at them from the individual (seeking distance or closeness) and organisational level (seeking supervision). The article is thought provoking and will likely encourage introspection within its readership regarding their coping style, the support provided to them by their organization and any next steps that would alleviate burnout symptoms.

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