The Interrelationships of Coping Styles and Professional Burnout Among Physiotherapists

A Cross-Sectional Study

Katarzyna Nowakowska-Domagala, PhD, Karolina Jablkowska-Go´recka, PhD, Lilianna Kostrzanowska-Jarmakowska, Marta Morton, and Patryk Stecz, PhD

Abstract: Burnout is a pathological syndrome in which emotional exhaustion (EE), depersonalization (DEP), and a reduced sense of personal accomplishment (PA) develop in response to prolonged occupational stress. Those working in the psychotherapy profession appear to be at risk for professional burnout brought on by the specific character of the medical professions, involving continuous contact with patients and associated stress, as well as poor working conditions. However, literature concerning the scale of professional burnout and its psychosocial correlates remain scarce.

The aim of the present study was to assess the scale of professional burnout among physiotherapists and to determine the interrelationships between coping styles and burnout symptoms.

The sample consisted of 117 professionally active physiotherapists (90 women and 27 men) aged 21 to 55 years (mean [M] 31.88, standard deviation [SD] = 9.14, responsiveness rate of 80.6%) from randomly selected medical institutions of the Lodz Region. The study was conducted using the Maslach Burnout Inventory (MBI) and Coping Inventory for Stressful Situations (CISS) by Endler and Parker. Demographic and job-related data on the respondents were also collected.

Task-oriented coping correlated negatively with DEP, EE, and low PA, in contrast to emotion-oriented coping. No correlation was found between avoidance-oriented coping and burnout symptoms. Similarly, no interactive correlations between coping styles and particular burnout symptoms were confirmed.

Coping styles correlate independently with professional burnout, without any mutual correlations. Physiotherapists employing a wider spectrum of task-oriented strategies are slightly more satisfied with their job. The incidence of burnout syndrome in the analyzed group is similar to that observed in other medical professions and requires the adoption of preventive measures.

(Antonino Bianco. Received: February 16, 2015; revised: April 16, 2015; accepted: April 26, 2015. From the Department of Psychosocial Rehabilitation, Military Medical Faculty, Medical University of Lodz, Lodz (KN-D, MM, PS); Public Health Division, Faculty of Health Sciences, Medical University of Warsaw, Warsaw (KJ-G); Department of Mathematical Analysis and Control Theory, Faculty of Mathematics and Computer Science, University of Lodz, Lodz (LK-J) Poland. Correspondence: Katarzyna Nowakowska-Domagala, PhD, Department of Psychosocial Rehabilitation, Medical University of Lodz, Pl. Hallera 1, b.7, p. 108, 90-647 Lodz, Poland (e-mail: katarzyna.nowakowska@umed.lodz.pl). Data sharing: Extra data are available by email: katarzyna.nowakowska@umed.lodz.pl. The authors have no conflicts of interest to disclose. This publication was funded by the Medical University of Lodz and Medical University of Warsaw. Copyright © 2015 Wolters Kluwer Health, Inc. All rights reserved. This is an open access article distributed under the Creative Commons Attribution-NonCommercial License, where it is permissible to download, share and reproduce the work in any medium, provided it is properly cited. The work cannot be used commercially. ISSN: 0025-7974 DOI: 10.1097/MD.0000000000000906)
who choose it to try to avoid confrontation, engaging in alternative activities, which can be favorable in uncontrollable situations.6–8

The coping style is an important factor influencing the secondary appraisal of the stress situation, the psychological costs associated with overcoming the problems, as well as the short- and long-term consequences of stress. The different coping styles have now been recognized as functioning on a complementary and non-exclusive basis, and even contributing to the achievement of similar goals. Therefore, there is a need for their mutual influence to be determined in the context of burnout symptoms. However, few studies of the global importance of coping styles have been conducted in healthy and patient populations, and no conclusive results have been obtained.9–10

It seems that TOC and EOC can support and complement each other in the same stressful situation, with the potential additional role of AOC. For example, a physiotherapist tries to reduce emotional strain by ventilation or self-complacency to be able to prepare for a difficult talk concerning a conflict in the workplace with his supervisor (TOC). Additionally, he or she may refrain from taking any action for a day or two, waiting for developments (AO). The association between burnout syndrome and coping profiles, that is, the interrelationships between coping styles, has not yet been fully investigated.11–13

The development of professional burnout is influenced by numerous intrapersonal and situational factors, such as length of service or satisfaction with health and private life.11,12 The results of some studies suggest that coping style may be another such factor.13 The data concerning the specificity of burnout and coping in physiotherapists are still scarce in the relevant literature, which may indicate their marginalization with respect to other health professionals.14–16

Although burnout syndrome does not constitute a separate nosological entity, it has been included in ICD-10 classification as Z 73.0, and it may be a disorder underlying other disease entities. Its consequences may include deterioration of psychological and physiological functions, disturbances of cognitive functions, somatic and physiological arousal, reduced cellular immunity, lower morale, low productivity, absenteeism, job turnover, alcohol or drug abuse, and other effects.11,12 The ternary model of burnout syndrome developed by Jackson and Maslach16 defines burnout as a syndrome of emotional exhaustion (EE), depersonalization (DEP), and reduced sense of personal accomplishment (PA).16–18

Burnout has been thoroughly investigated in a number of helping professions and social services.19–21 Considering the specific character of medical professions, involving continuous contact with patients and the associated stress, as well as poor working conditions, the physiotherapist appears at risk of professional burnout. Studies of burnout in physiotherapists have also identified time pressure, role conflict, and role ambiguity as significant causes of burnout. Role conflict may develop in response to incompatible organizational demands, whereas role ambiguity may be caused by unclear expectations or uncertainty around authority and responsibilities.13,16–22 As indicated by the literature review concerning burnout among physiotherapists, the scale of this phenomenon may vary between countries, which probably results from differences in the organization of health care systems and working conditions, as well as in the research methodology.1,23–25

The aim of the presented study was to assess the scale of professional burnout among physiotherapists and to make a comprehensive analysis of correlations between coping styles and the degree of DEP, EE, and reduced sense of PA.

It is hypothesized (H1) that TOC correlates positively with the intensity of burnout symptoms, whereas EOC and AOC correlate negatively with the burnout symptoms. In addition, TOC, EOC, and AOC are presumed to have an interactive influence with regard to burnout levels (H2), with lower burnout severity associated with a higher level of all coping styles, and a decreased profile of coping associated with higher burnout severity.

**METHOD**

This investigation employs a cross-section design and quantitative methods with standardized psychometric tools, which are standard in psychological assessment.

**MBI Questionnaire**

The criteria of assessment of the results were based on the Maslach MBI Questionnaire16,26 consisting of 22 test items divided into 3 subscales: EE, DEP, and PA (i.e., Personal Accomplishment – a decreased sense of work-related competence and achievement in professional relationships). The first category (EE) describes the feelings in a general sense, DEP relates to behavior, and PA involves cognitions and feelings affecting self-efficacy. Responses with higher scores for EE and DEP categories correlate with a higher burnout level, whereas a lower score on the PA scale would indicate a reduced sense of PA. Although Pasikowski26 reports that the PA and EE scales have good internal consistency values, the Cronbach alpha for DEP was estimated at 0.59.

**CISS Questionnaire**

The coping styles were assessed using the CISS Questionnaire developed by Endler and Parker and adapted by Strelau et al.9,27 It consists of 48 statements describing the individual’s behavior in a stressful situation. The respondent scores the frequency of a particular behavior on a 5-point scale. This tool makes it possible to calculate the scores in 3 scales: TOC, EOC, and AOC. The minimum score that can be obtained within each scale is 16 and the maximum one 80.27 Estimated alpha Cronbach internal consistency coefficients of 0.84 to 0.91 have been reported by Endler and Parker.9

**Additional Questions**

A questionnaire composed of demographic variables including age, sex, place of residence, marital status, and duration of employment in years was developed for the purpose of the study.

**MATERIAL**

The study was approved by the Medical University of Lodz Bioethics Committee. It was conducted between December 2009 and March 2011 in state health care institutions (both outpatient and inpatient) among professionally active physiotherapists. The inclusion criteria for the institutions were the geographical location (Lodz region, Poland) and that the location provides physical therapy. In total, 30 of 42 randomly selected medical institutions of the Lodz region were interested in participation. Regarding the participants, the inclusion criteria comprised graduating from University with a Bachelors/Masters degree in Physiotherapy and Polish being the mother tongue of the participant. The following exclusion criteria were adopted: leave of absence or being on holiday >14 days, being involved with any other part-time job in social services.
Initially, the full total of available therapists who met the criteria was 145. Formal consent was given by 122 respondents (84.1%) who completed the questionnaires. Five cases with missing data were removed from the analysis, as this accounted for a relatively small proportion of the whole sample. The overall complete response rate was 80.6% (Table 1).

Most of the study participants were within the 20 to 30 years’ age group, whereas subjects over 50 years of age comprised the least numerous group. The group was differentiated with respect to marital status and the places of residence. The majority of the respondents had been working for <5 years. The vast majority of the subjects worked >20 hours a week.

**Statistical Analysis**

Mean values (M), median, and standard deviation (SD) were used to characterize the studied population. Relationships between variables were assessed using Pearson correlation coefficient (r). Compliance with a normal distribution was checked using the Shapiro-Wilk test. To check whether the sex affected results in burnout scales, the Mann–Whitney test was used.

The significance of differences between the means was assessed using 3-way analysis of variance (ANOVA) in the intergroup design. The factors were constructed by dividing the respondents according to the results concerning their coping styles, taking the median as a criterion for division. In this way, 3 factors were obtained, each with 2 levels: decreased score for a particular strategy and increased score for that strategy. Individuals with a result equal to the median were included in the decreased score category.

Three-way ANOVA was performed for different burnout scales: EE, DEP, and PA in Scheme 2 (decreased TOC results, increased TOC results) ×2 (decreased EOC results, increased EOC results) ×2 (decreased AOC results, increased AOC results). To assess the strength of the phenomenon, the effect size, partial eta squared (\(\eta^2_p\)) was used, which gives the percentage of the total variance of the result variable explained by the independent variables.

For all analyses, significance level (\(\alpha = 0.05\)) was adopted as the maximum acceptable probability of type I error. To minimize the risk of measurement error and bias, internationally recognized questionnaires that had been validated in Poland were used, whose psychometric properties are known to be satisfactory. To decrease the sampling bias, participants were recruited from rural, semi-urban, urban, and metropolitan areas.

The analyses and graphical presentation of the results were performed using the following statistical packages: SPSS 21.0 PL for Windows and GNU R 3.1.1 for Windows.

**RESULTS**

The mean results obtained in the burnout scales and coping scales, as well as the coefficients of correlations between the analyzed variables, are presented in Table 2. The results of the Mann–Whitney test failed to confirm any differentiation of the particular burnout scales according to sex. There is no generally accepted cut-off score for MBI among physiotherapists. The cut-off scores were derived for each MBI scale based on one standard deviation above/below the sample mean. To determine a high level of burnout, a score of >22 was identified for high EE, >11 for DEP, and <23 for PA. In total, 17% of the sample reported high EE, 16% reported high DEP compared with 15% reporting decreased PA.

Correlational analysis of duration of work experience and coping styles was performed. The results confirm that no statistically significant relationships exist among these variables, with an exception of small correlation between working experience and AOC (r = -0.22, \(P = 0.017\)). This result was expected since our sample was based mainly on physiotherapists with a relatively short duration of employment: the third quartile of working experience variable is 7 years.

### TABLE 1. Sample Characteristics

|                          | Number of Participants | Percentage |
|--------------------------|------------------------|------------|
| Sex                      |                         |            |
| Men                      | 27                     | 22.3%      |
| Women                    | 90                     | 77.7%      |
| Age                      |                         |            |
| Range                    | 21–55                  |            |
| Mean                     | 31.88                  |            |
| Standard deviation       | 9.14                   |            |
| Under 30 years old       | 81                     | 69.2%      |
| 30–50 Years’ old         | 28                     | 23.9%      |
| Above 50 years’ old      | 8                      | 6.9%       |
| Marital status           |                         |            |
| Single                   | 73                     | 62.4%      |
| Married                  | 37                     | 31.6%      |
| Divorced and separated   | 6                      | 5.1%       |
| Widowed                  | 1                      | 0.9%       |
| Place of residence       |                         |            |
| Rural areas              | 15                     | 12.8%      |
| Towns with <50 k population | 29                  | 24.8%      |
| Towns with 50–100 k population | 15               | 12.8%      |
| Towns with 100–500 k Population | 25            | 21.4%      |
| Towns with >500 k population | 33                | 28.2%      |
| Length of employment     |                         |            |
| Less than 5 years        | 77                     | 65.8%      |
| Within 5–20 years        | 23                     | 19.7%      |
| More than 20 years       | 17                     | 14.5%      |
| Number of working hours per week |                  |            |
| More than 20 hours       | 77                     | 87.2%      |
| Exceeded 40 hours        | 35                     | 23.9%      |
TABLE 2. Descriptive Statistics and Results of Correlation Analysis

| Variables | Mean (N = 117) | SD (N = 117) | Median (N = 117) | Shapiro-Wilk Normality Test (N = 117, df = 117) | Pearson Correlation Coefficient \( r \) |
|-----------|----------------|--------------|------------------|---------------------------------------------|-----------------------------------------|
| EE        | 14.15          | 8.72         | 13.00            | 0.97 0.005                                   | EE 0.56 (P < 0.001)                      |
| DEP       | 5.35           | 5.57         | 4.00             | 0.86 0.001                                   | DEP -0.29 -0.46 (P < 0.001)              |
| PA        | 31.88          | 9.18         | 32.00            | 0.98 0.08                                   | PA 0.25 -0.34 0.39 (P < 0.001) (P < 0.001) |
| TOC       | 58.14          | 8.36         | 57.00            | 0.98 0.18                                   | TOC 0.33 0.37 -0.31 -0.08 (P < 0.001) (P < 0.001) (P = 0.38) |
| EOC       | 43.07          | 10.34        | 43.00            | 0.98 0.14                                   | EOC 0.10 0.03 -0.01 0.05 0.12 (P = 0.27) (P = 0.73) (P = 0.95) (P = 0.58) (P = 0.20) |
| AOC       | 48.02          | 8.61         | 48.00            | 0.99 0.85                                   | AOC                           |

AOC = avoidance-oriented coping, DEP = depersonalization, df = degrees of freedom, EE = emotional exhaustion, EOC = emotion-oriented coping, N = number of participants, \( P = \) probability value, PA = personal accomplishment, SD = standard deviation, TOC = task-oriented coping.

analyses controlling the employment duration could be conducted if the proportion of participants with longer working experience, that is, if \( > 10 \) years, had been higher.

The dimensions of burnout demonstrate positive correlations, whereas the coping styles show no significant correlations. Weak negative correlations between TOC and the dimensions of burnout, and similarly weak positive correlations between EOC and burnout dimensions were observed.

Analyses using the Mann–Whitney test failed to identify any sex-related differentiation in the particular burnout scales.

The division of respondents according to the median results obtained for the particular coping styles is illustrated in Figure 1. The presented average results obtained by the subjects in the particular segments, as well as the standard deviations, indicate that reduced or increased TOC and EOC results are combined with a fairly wide distribution of results concerning the burnout dimensions. The associations of burnout and AOC are not presented in Figure 1 due to the lack of correlation between these variables.

More conclusive results concerning the main effect and interaction of the factors (coping styles) with the burnout levels, presented in Table 3, were provided by 3-way analysis of variance.

EE

A statistically significant difference was obtained for TOC (\( F [1109] = 6.94; P = 0.01; \eta^2_p = 0.06 \)) and EOC (\( F [1109] = 11.00; P = 0.0012; \eta^2_p = 0.09 \)). However, the effects of the interaction between the 3 factors did not reach statistical significance. Among subjects with decreased TOC results (M = 16.36; SD = 9.13), the degree of EE was higher than in those with greater TOC scores (M = 11.91; SD = 7.72). In contrast, subjects with increased EOC results were more exhausted emotionally (M = 16.84; SD = 8.99) than subjects with reduced EOC scores (M = 11.69; SD = 7.74). The differences in the mean levels of EE were found to have relatively low effect sizes.

DEP

Three-way ANOVA revealed a statistically significant difference in the case of TOC (\( F [1109] = 12.55; P < 0.001; \eta^2_p = 0.10 \)) and EOC (\( F [1109] = 12.81; P < 0.001; \eta^2_p = 0.11 \)); however, no significant interaction was found between all 3 styles. Subjects with reduced TOC results demonstrated a higher average level of DEP (M = 7.03; SD = 6.45) than those with higher values (M = 3.64; SD = 3.86). Likewise, people with higher EOC results showed a greater level of DEP (M = 7.25; SD = 6.17) than those with lower results (M = 3.61; SD = 4.31). The effect size on differences in the average levels of DEP was small.

PA

The task-oriented style (\( F [1109] = 8.68; P < .001; \eta^2_p = 0.07 \)) and the emotion-oriented style (\( F [1109] = 6.46; P = .012; \eta^2_p = 0.06 \)) differentiated significantly with regard to the PA results. No statistically significant effects were demonstrated concerning the interactive influence of the 3 factors (TOC, EOC, and AOC).

The mean score of the reduced sense of PA is higher in the study group with decreased TOC results (M = 29.37; SD = 9.16) than those with a higher TOC level (M = 34.43; SD = 8.54). A lower score on the PA scale indicates that the sense of work-related competence is compromised. The respondents with higher EOC results were found to feel less competent and successful (M = 29.46; SD = 6.98) than subjects with reduced results for that style (M = 34.10; SD = 10.38). However, the PA differences revealed between the groups had small effect size.

The performed ANOVA failed to confirm the hypothesis that 2 or 3 of the coping styles interact with each other. This could show the combined effects of coping styles (factors) on EE, DEP, and reduced sense of accomplishment observed within the study group.
DISCUSSION

Other authors have described comparable results regarding the intensity of burnout symptoms among physiotherapists. The average severity of the phenomenon among physiotherapists ranges from 5.98 to 9.19 on the DEP scale, from 20.58 to 23.64 on the EE scale, and between 34.36 and 37.26 on the PA scale.\(^2,20,28,29\) The mean values characterizing the group of physiotherapists obtained by Pavlakis et al were significantly different from other studies, that is, 16.55 for EE, 5.20 for PA, and 39.50 for DEP.\(^25\)

The respondents of this study were characterized by slightly lower PA and EE levels than in other studies, which may be related to the relatively short duration of employment of most subjects. For that reason, many young physiotherapists

![FIGURE 1. Mean values and standard deviations in burnout scales according to the intensity of task- and emotion-oriented styles (decreased, increased).](image)

![TABLE 3. Results of 3-way ANOVA for Burnout Dimensions](image)

| Variability source | Sum of SQUARES SS | Df | Mean Square | F     | P     |
|--------------------|-------------------|----|-------------|-------|-------|
| TOC                | 462.92            | 1  | 462.92      | 6.94  | 0.010 |
| EOC                | 733.73            | 1  | 733.73      | 11.00 | 0.0012|
| TOC\(^*\) EOC      | 134.74            | 1  | 134.74      | 2.02  | 0.158 |
| TOC\(^*\) AOC      | 49.01             | 1  | 49.01       | 0.74  | 0.393 |
| EOC\(^*\) AOC      | 0.06              | 1  | 0.06        | .001  | 0.976 |
| TOC EOC\(^*\) AOC  | 69.02             | 1  | 69.02       | 1.04  | 0.311 |
| TOC                | 315.25            | 1  | 315.25      | 12.55 | <0.001|
| EOC                | 321.86            | 1  | 321.86      | 12.81 | <0.001|
| TOC\(^*\) EOC      | 71.76             | 1  | 71.76       | 2.86  | 0.094 |
| TOC\(^*\) AOC      | 62.20             | 1  | 62.20       | 2.48  | 0.118 |
| EOC\(^*\) AOC      | 7.03              | 1  | 7.03        | 0.28  | 0.598 |
| TOC EOC\(^*\) AOC  | 6.38              | 1  | 6.38        | 0.25  | 0.615 |
| TOC                | 663.92            | 1  | 663.92      | 8.68  | 0.004 |
| EOC                | 493.80            | 1  | 493.80      | 6.46  | 0.012 |
| TOC\(^*\) EOC      | 18.39             | 1  | 18.39       | 0.24  | 0.625 |
| TOC\(^*\) AOC      | 43.62             | 1  | 43.62       | 0.57  | 0.452 |
| EOC\(^*\) AOC      | 18.75             | 1  | 18.75       | 0.25  | 0.622 |
| TOC EOC\(^*\) AOC  | 2.46              | 1  | 2.46        | 0.03  | 0.858 |
| TOC EOC\(^*\) AOC  | 27.22             | 1  | 27.22       | 0.36  | 0.552 |

\(AOC\) = avoidance-oriented coping style, \(df\) = degrees of freedom, \(EOC\) = emotion-oriented coping style, \(F\) = ANOVA F test statistic, \(P\) = probability value, \(TOC\) = task-oriented coping style.

\(^*\) Represents the interaction of the variables.
may experience no long-term effects of occupational stress. However, studies show that both physiotherapists with a prac-
ticium shorter than 2 to 4 years and long-serving physiothera-
pists seem to experience particularly high rates of burnout²⁸
equivalent to those of intern or resident physicians³⁰ and student
nurses.³¹

Taking into account the variability of the results and the
confidence intervals presented in other studies, differences in
the absolute values lose their importance.

A literature review concerning burnout severity assess-
ment among physiotherapists indicates that it may vary in
different countries. Research carried out in Spain indicates that
only 4% of physiotherapists in that country demonstrate a high
level of burnout,³² whereas Italian researchers have shown that
physical therapists in their country suffer from burnout more
often than nurses, doctors, and technicians.¹ Austrian research-
ers have shown that 35% of physiotherapists have a high EE,
18% DEP, and 14% a reduced sense of PA.²⁹ This difference
may be associated with the range of methodologies used and
possibly, with the incompletely explained or non-uniform
methods of calculating the raw results used by the individual
authors. In our study, we calculated the prevalence rates based
on one standard deviation above or below the mean, and which
must be interpreted very carefully. We assume that the deter-
mined proportion is only at increased risk of burnout. Further-
more, Cherniss³³ describes burnout as a dynamic and complex
process, which develops gradually. The first symptoms would
include EE before DEP escalates, indicating that the full-
syndrome would be indicated if 3 criteria were met.³²

The severity of burnout in the analyzed group did not differ
significantly from other health professions. Similar mean values
of the syndrome scale measurements were observed in general
practitioners, family doctors, and nurses.³³–³⁵ Although other
Polish studies have shown that physiotherapists manifest
slightly fewer burnout symptoms than other medical pro-
fessions,³⁶ this could be due to the use of a small sample size.
In view of the high job demands, job stressors, and expectations
of the patients and staff, our results seem to be justified.

The correlation analyses confirm the predictions concern-
ing the positive effects of TOC and rather negative effect of
EOC on assessment of the burnout symptoms. However, they
did not confirm the expected positive correlation of AOC with
the severity of burnout.

The literature lacks data concerning the correlations
between coping styles and professional burnout in physiothera-
pists. In a study conducted among nurses, Fearon and Nicol³⁷
found a negative correlation between TOC and the severity of
burnout. Additionally, they found that TOC is preferable under
poor organizational conditions.

The results of ANOVA failed to confirm the key hypoth-
thesis concerning the interactive effects of coping styles, reveal-
ning only the main effects. In light of this, coping styles were
found to be relatively independent of each other and did not
demonstrate mutual interactions, which allow burnout level to
be predicted. It can be stated that TOC is associated with a better
professional adaptation of the physiotherapist, regardless of the
configuration of the other coping styles: it seems important that
the EOC neither strengthens nor weakens that correlation. We
suspect that this is caused mainly by the lack the representa-
tiveness of the sample and its modest sample size. Our data
consist of subjects who voluntarily participated and were not
randomly selected in a nationwide survey. This should also be
considered as a limitation.

Second, the examined subjects who differed in the profiles
of coping styles (low vs high CISS scores) did not differ
significantly with regard to the mean severity of burnout
symptoms. Hence, employing a wider spectrum of coping styles
did not correlate with better occupational adaptation by the
physiotherapist. However, a limited spectrum of strategies
(poor resourcefulness) was not found to be associated with
more burnout symptoms.

A few characteristics of the sample, such as relatively low
work experience and the higher proportion of females, limit the
possibility to draw clear conclusions. Estimating the coping
burnout interactions among physiatrists would be more accurate
if probability sampling was used, yet the present study reports
merely the preliminary results. Additionally, the low magnitude
of the effect revealed that the influence of the explanatory
variables (coping styles) on the burnout syndrome is limited.
Such results suggest that burnout is a more complex phenom-
emon, dependent also on other factors, and therefore cannot be
simply correlated with the coping styles.

The major limitation typical for cross-sectional design may
be temporal bias. The causal effect of coping style on burnout
cannot be determined if the data are collected at 1 specific point
in time. As coping style is generally a stable, dispositional trait³⁸
and burnout syndrome is a temporal state which may occur in
specific situation, burnout may potentially be influenced by
coping style. Although job exhaustion may affect the coping
strategies, coping style, as one of the prevailing tendencies, is
able to influence the development of certain dysfunctions.³⁸

Response bias may occur on several occasions. In this
study, the researchers aimed to minimize the risk of simulation
and dissimulation. The respondents were anonymously inter-
viewed and their results were collected directly by post. Second,
the measurement tools were chosen carefully in terms of
psychometric properties (reliability and validity). Additionally,
making inference about the general population of physiothera-
pists should be avoided because of the weaknesses of self-report
methods and psychological assessment.

This particular study has not analyzed physical activity as
an individual category, which may be both a means of coping
and protective behavior against burnout among physiothera-
pists. Exercise and sports contribute to achieving work-life
balance, but they also might be a specific coping strategy:
avoidance, emotional, or task-oriented depending on the con-
text. As it is both a mediating factor and diverse coping
behavior, it would be problematic to determine its role in
this study.

Personal resources such as optimism,³⁹ self-esteem,⁴⁰ a
hardy personality,⁴¹,⁴² sense of coherence,⁴³ and self-efficacy⁴⁴
have also been found to be linked to burnout. Alarcon et al⁴⁵
found that employee personality traits were related to EE, DEP,
and PA. Garossa et al⁴⁶ confirmed that the locus of control and
hardy personality particularly predicted the burnout level
among nurses. Social support and active coping were also
relevant predictors of burnout dimensions. Due to the relative
stability of personality traits, each intervention is difficult and
requires long-term impact, for example, by training the subjects
to cope with stressful situations, developing resources and
relaxation training. Such measures, however, may provide
the individual with a buffer against burnout development.

We conclude that providing physical therapists with cop-
ing resources is important in their professional development,
which has been confirmed by other studies⁴⁷ and may support
existing preventive strategies (anti-burnout prophylaxis).
Application of that knowledge, perhaps via counseling or psychological training, may support the prevention of burnout.

CONCLUSIONS

1. TOC, irrespective of the other coping styles employed, is associated with lower burnout indexes in the studied population sample.

2. There is no empirical evidence confirming the interactive association between the coping styles and burnout symptoms in the studied physiotherapists.

3. The scale of burnout in physiotherapists is significant, which confirms the reports published to date, and seems to be similar to the findings obtained for representatives of other medical professions.

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