Article

Psychosocial Factors Associated with Burnout and Self-Perceived Health in Spanish Occupational Therapists

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Abstract: 1) Background: There are few studies of burnout syndrome (BS) in occupational therapists (OTs), and protective factors of BS has received little attention in the scientific literature. This research aimed to estimate the prevalence of BS, characterize the associated psychosocial factors, and analyze their relationship with health in a sample of Spanish OTs. (2) Methods A total of 127 therapists completed the Maslach Burnout Inventory (MBI) and other standardized questionnaires measuring: personality traits (reduced five-factor personality inventory, NEO-FFI), coping styles (Coping Strategies Questionnaire, CAE), work-family conflict (Survey Work-Home Interaction Nijmegen, SWING), professional factors (role ambiguity/clarity and modified role conflict questionnaires), and the perception of health (Goldberg's General Health Questionnaire). Several correlational and multiple regression analyses were performed to study the psychosocial predictors of burnout and its relationship with health perception. (3) Results showed that 15.8% of the professionals presented BS, with emotional exhaustion (EE; 38.7%) being the most compromised dimension. Neuroticism, role conflict, negative work-family interaction, and open emotional expression (OE) significantly predicted a higher EE. The main predictors of cynicism (CY) were being male, role conflict, and OE. Finally, role conflict and role ambiguity and social support-seeking were significant predictors of reduced professional efficiency (PE). (4) Conclusion: A high percentage of OTs with BS advocates becoming aware of the importance of this syndrome in the health community, it would be critical to consider the protective factors (i.e., emotional management, social support) that help promote OTs' well-being and health.

Keywords: burnout, occupational therapist, emotional exhaustion, health, stress, coping, personality.

1. Introduction

Occupational therapists (OTs) are healthcare workers who promote engagement in meaningful activities as a means of enhancing users' well-being and health [1]. Health professions, oriented to the care of people's health and well-being, are associated with high rates of burnout [2–4], an organism's response to sustained work stress [5]. Various theoretical models [6–8] consider burnout syndrome (BS) as the result of a problematic or

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imbalance relationship between a person's resources and the work situation. Essentially, BS is characterized by the combination of three types of manifestations or dimensions: emotional exhaustion (EE; i.e., wear and tear, emotional and physical exhaustion, loss of energy, weakening and fatigue), cynicism (CY; i.e., negative or inappropriate attitudes, irritability and detached concern toward people and different work aspects), and inefficacy or reduced professional efficiency (RPE; i.e., negative self-evaluation of competence, achievements, and productivity at work) [9]. BS negatively affects the health (physical and psychological) and the quality of care that health professionals provide [3,4].

In particular, various studies report high percentages of burnout in the group of OTs, although the prevalence rates vary considerably. In Canada, about one-third of OTs have burnout symptoms, specifically 34.8%, 43.5%, and 27.5% show EE, CY, and RPE, respectively [10]. In some countries similar to our environment, 44.7% of Portuguese OTs have job burnout, as measured by the cut-off point (≥50) of the Copenhagen Burnout Inventory [11]. In Greece, Katsiana et al. [12] observed that 54% of OTs have moderately high or high scores in all three dimensions of the Maslach Burnout Inventory (MBI) (51% EE, 65% CY, and 48% RPE). In Spain, Escudero-Escudero et al. [13], using different criteria from those of the normative study of the MBI (39), found that 69.4% present at least some manifestation of burnout: EE (63.5%), CY (33.9%), and RPE (2.1%). Only 1.8% of the OTs had all three dimensions compromised. In this context, the measuring instruments, the statistical methods applied, the sociocultural context, and the quality of the studies (i.e., sample size) may explain the heterogeneity of the figures [9,14].

Understanding the factors responsible for burnout is crucial for promoting health and well-being. The models differ in the weight given to the components (individual vs. situational) when explaining these factors, but agree that burnout is a dynamic and transactional process [15]. Thus, some studies show that burnout is significantly associated with sociodemographic variables: age [11,13,16], gender [16], or civil status [17]. However, others emphasize the role of situational and psychological factors [18]. Thus, different investigations highlight the role of the work environment in the development of burnout [13,19–21]: high workload [22], type of shift [13], the presence of role conflicts or role ambiguity [23,24][25]. In fact, some researchers [8,26] report six areas of work that may cause burnout: job workload (excessive tasks/work hours), control (role conflict or ambiguity), reward (monetary and intrinsic rewards), community (social interaction, support), fairness (job turnover), and values (moral disagreements, value incongruity). Finally, the work-family interaction is also a central factor in the development of burnout. For example, the negative balance between work and family is associated with lower psychological and physical well-being [27,28], and higher levels of burnout in several public collectives [28–31].

Unlike situational factors, psychological factors have awakened less empirical interest [13,18,32]. Thus, certain personality traits are associated with burnout level [33–35], and neuroticism is one of the best predictors of BS [34,36]. Moreover, the positive effects of specific psychological resources (e.g., resilience, grounded optimism, etc.) to overcome stress and build positive states has been tested in different populations [37,38], but investigations related to personal resources (e.g., stress coping, social support) that could buffer stress and its consequences in OTs are very scarce. Coping strategies comprise continuous efforts (emotional, cognitive, and behavioral) to cope with the environment's demands [15]. In different health professions, it has been observed that problem-focused coping correlates negatively with the three burnout dimensions, whereas emotion-focused coping correlates positively [34,39,40]. Gupta et al. [10] found that OTs with high EE used coping strategies less frequently than the rest of the OTs. In contrast, OTs with high professional efficiency tended to use strategies based on social support (e.g., "keeping in touch with referral networks").

The objective of this study was to estimate the prevalence of burnout in a sample of Spanish OTs and analyze the factors (sociodemographic, psychological, social, and work-related) associated with its manifestations (EE, CY, and RPE). The relationship between

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the dimensions of burnout and the perception of health was also analyzed, controlling for the effect of several covariates in the model.

2. Materials and Methods

2.1. Participants

A sample of 127 OTs working in different geographical areas of Spain (Aragón, Cataluña, and Castilla y León) was analyzed. After contacting various professional territorial associations to disseminate the study, all the volunteer participants who signed a written informed consent became part of it. The representatives of the participating professional associations approved the study, which meets the requirements of the Declaration of Helsinki for research with humans.

2.2. Instruments

Participants completed a questionnaire that collected sociodemographic data (age, sex, civil status), aspects related to professional context (i.e., work environment, work sector), and several standardized questionnaires evaluating psychological, family, professional, and health factors.

Maslach Burnout Inventory (MBI) [41]. The MBI includes 22 items that evaluate feelings and attitudes toward work according to the three subscales/dimensions of the questionnaire. Each item is scored on a seven-point Likert-type scale, ranging from 0 (*never*) to 6 (*every day*). High scores in EE and CY dimensions and low scores in professional efficiency (PE) correspond to BS (38). This questionnaire was validated in the Spanish population by Gil-Monte and Pereiró [42]. The subscales' reliability (Cronbach's alpha [α]) ranged from .72 to .87.

Five-factor Reduced Personality Inventory (NEO-FFI) [43]. This instrument contains 60 items distributed in 5 personality factors: Neuroticism (N), Extraversion (E), Openness to Experience (O), Agreeableness (A), and Conscientiousness or Responsibility (C). Items are rated on a five-point Likert-type scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). The dimensions have a maximum score of 60, with higher scores indicating greater factor intensity. The Spanish version was validated by Manga et al. [44] and showed good reliability, with alpha values ranging between .71 and .82.

*Work-Home Interaction- Nijmegen Questionnaire (*SWING) [45]. The Spanish version of the SWING was validated by Moreno-Jiménez et al. [46]. This instrument evaluates the reconciliation of home-work life with 22 items scored on a Likert format from 0 (*never*) to 3 (*always*). The SWING presents 4 subscales evaluating positive and negative work-home relationships. The total score of the subscales ranges from 0 to 24, with higher scores indicating a greater intensity (positive or negative) of the interactions. The Spanish version's reliability (α) ranged from .77 to .89.

The Role Ambiguity General Questionnaire [47]. The Spanish version, validated by Peiró et al. [48], presents 30 items measuring role ambiguity/clarity (15 even items) and role conflict (15 odd items). It is rated on a seven-point Likert-type scale ranging from 1 (*strongly disagree*) to 7 (*strongly agree*) [22]. Subscale scores range from 1 to 105, with higher scores indicating greater role clarity and role conflict, respectively.

Coping Strategies Questionnaire (CAE) [49]. The CAE evaluates coping style through 42 items, divided into 7 subscales: Problem-solving focused coping (PS), Negative self-focus (NF), Positive reappraisal (PR), Open emotional expression (OE), Avoidance (A), Social support-seeking (SS) and Religion (RL). Items are scored on a five-point Likert-type scale, ranging from 0 (*never*) to 4 (*almost always*). High scores indicate a higher intensity of the coping style employed. The subscales have acceptable/good reliability, with alpha values ranging from .64 to .92.

Goldberg General Health Questionnaire (GHQ-12), reduced 12-item version [50]. The GHQ-12 is a self-report instrument developed to detect psychological maladjustment and psychiatric disorders in community settings (12). The Spanish version of the GHQ-12 by Rocha and Rodríguez-Sanz [51] consists of 12 items rated on a Likert format (0-3). The total score ranges from 0 to 36, with higher scores indicating poorer health. The questionnaire presents high reliability (internal consistency) in the general population (α = .86).

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2.3 Design and procedure

This is an ex post facto, descriptive-correlational single-group study, developed in a series of phases. First, the study questionnaires were selected and/or adapted, incorporating them into a Google Drive form that participants could complete through a URL. The study was disseminated directly among accessible professionals, and various Occupational Therapists Colleges in Spain were contacted to request their collaboration. After the six months established for the receipt of the responses, the data collection was closed to start with their processing.

2.4 Statistical analysis

First, a descriptive analysis of the sample (means, standard deviations, and percentages) was performed, and subsequently, the prevalence of BS in the sample was estimated. The reference values adopted to establish disturbance were ≥ 25 for EE, ≥ 9 for CY, and ≤ 35 points for RPE [52]. Moreover, the cut-off points of the 66% of the participants above (EE and CY dimensions) and the 33% of the participants below (PE dimension) the distribution were also calculated. Thus, values ≥ 27 and ≥ 9 points in EE and CY, respectively, were considered high, whereas a score of ≤35 in PE was considered low. Next, correlational analyses, with the Pearson (r) or point-biserial (r_{bp}) correlation coefficients, were used to analyze the relationships between burnout dimensions and the sociodemographic, psychological, family, professional, and health variables included in the study. Subsequently, several multiple regression analyses (ENTER method) were performed to predict each dimension of burnout (outcomes). The variables significantly related to each burnout dimension were selected as potential predictors ($r > .20$). Finally, the burnout dimensions predicting health status were selected, controlling for the effect of different covariates related to OTs health ($r > .20$). In all the multiple regression analyses, the Durbin-Watson (D-W) statistic and the variance inflation factor (VIF) were calculated to analyze problems of residual independence and multicollinearity between the variables. Values of DW between 1.5 and 2.5 and of VIF ≤ 5 were established to assume residual independence [53] and the variables' absence of collinearity [54], respectively.

The Statistical Package for Social Sciences (SPSS) version 25.0 (IBM Corp. Released 2013) was used for the statistical analyses. All estimates and inferences from statistical tests were considered significant when the *p*-value was < .05.

3. Results

The sample included 127 OTs (7.1% men and 92.9% women). The women were young (M = 33.66 years, SD = 8.66), mostly single (66.9%), worked in household chores (59.8%), and generally did not support economically dependent people (63.8%). Of the sample of OTs, 86% were dedicated exclusively to their profession; many worked in a single workplace (66.1%), without other OT colleagues (63.8%), and at a single location (79.5%). The private work sector was the most frequent (68.5%), with geriatrics being the most frequent work area (50.4%). Concerning experience, 65% of the OTs had more than 5 years of experience in the profession, mainly with permanent contracts (68.5%) and working days of more than 30 hours (74.8%). However, more than half (55.9%) believed their pay was low or very low.

The professionals obtained the following average scores on the MBI: EE (M = 21.69, SD = 12.37), CY (M = 7.26, SD = 5.32), and PE (M = 37.98, SD 5.51). Table 1 shows that OTs primarily used coping strategies based on adaptive behaviors: SS, PS, and PR. When examining family-work interactions, we observed that the sum of positive home-work interactions (PHWI) obtained the highest score, followed by negative work-home interactions (NWHI). Concerning personality traits, we observed that neuroticism (N) obtained the lowest mean score (M = 34.24, SD = 5.17), unlike conscientiousness (C) (M = 42.43, SD = 3.83), which obtained the highest score.

3.1 Prevalence of Burnout

Of the sample of OTs, 15.7% presented BS according to all three dimensions (high EE, high CY, and RPE), whereas 17.3% presented BS according to two dimensions (EE and CY in 6.5%). Further, 24.4% of the sample presented symptoms in a single dimension

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(38.7%, 35.5%, and 25.8% in EE, CY, and RPE, respectively). Lastly, 42.5% of the OTs manifested no problems in any BS dimension. The prevalence of BS (high EE, high CY, and RPE) was similar (15.2%) when using the cut-off points calculated in the selected sample.15% of the cases presented two affected dimensions, and in 5.5% of these cases, the EE and CY dimensions were implicated.

3.2 Relationship between psychosocial factors and burnout dimensions

When analyzing the relationship between the MBI dimensions, we observed a moderate positive correlation between EE and CY (r = .557, p < .001), whereas PE correlated negatively with EE (r = -.457, p < .001) and CY (r = -.518, p < .001). No significant correlations were obtained between age or number of children and any dimension of the MBI. However, working in the area of geriatrics (r = .203, p < .022) and being male (r = -.201, p = .024) were significantly related to CY. Regarding coping techniques, OE and NF presented moderate and significant correlations with the burnout dimensions, positive with EE and CY, and negative with PE. The SWING questionnaire yielded positive correlations for EE and CY when the home-work interaction was negative and negative correlations with EE when the work-home interaction was positive. In addition, when the home-work interaction was positive, higher PE scores were observed. Concerning role stress, role clarity was positively correlated with PE and negatively with EE, whereas the correlations between role conflict and the three burnout dimensions were positive (stronger for EE and CY). Finally, neuroticism was positively related to higher EE and CY, unlike PE, whose correlation with neuroticism was negative. Table 1 shows the correlations between psychological, family, and professional variables with the burnout dimensions.

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Table 1

Mean, standard deviations, and correlations between psychological, family, and work factors with the dimensions of the Maslach Burnout Inventory (MBI; n=127)

VARIABLES	*M (SD)*	EE	CY	PE
NEO-FFI				
Neuroticism	34.24 (5.17)	.46**	.30**	-.29**
Extraversion	37.52 (2.96)			
Openness	37.44 (4.79)			
Agreeableness	35.31 (4.23)			
Conscientiousness	42.43 (3.83)	.251**	.	
CAE				
PSF	16.80 (3.76)			.20*
NF	8.32 (3.85)	.39**	.33**	-.37***
PR	15.95 (3.35)			
OE	8.35 (3.31)	.33**	.37**	-.24**
SS	15.76 (5.88)			.21*
Religion	1.59 (3.95			
Avoidance	12.26 (4.01)			
SWING	8.65 (5.31)			
NI (Work-Home)	2.04 (1.94)	.60**	.25**	-.24**
NI (Home-Work)	8.39 (3.56)	.19*	.22*	-.20*
PI (Work-Home)	9.97 (3.57)	-.23**		.17*
PI (Home-Work)	8.65 (5.31)	-.23*		.28**
ROLE STRESS				
Role ambiguity/clarity	67.06 (7.65)	-.23*		.46**
Role conflict	(62.18 (10.62)	.41**	.36**	-.25**

Note. EE = Emotional Exhaustion; CY = Cynicism; PE= Professional Efficiency; NEO-FFI= Personality questionnaire; CAE = Stress coping questionnaire; PSF = Problem-solving focused; NF= Negative self-focus; PR= Positive reappraisal; OE= Open emotional expression; SS= Social-seeking support; SWING = Survey Work-Home Interaction-Nijmegen; NI= Negative interactions; PI = Positive interactions.

Significance values *$p < .05$. **$p < .01$.

3.3 *Multiple regression analysis*

Table 2 presents the three multiple regression models to predict burnout dimensions. Working hours, role conflict, negative home-work interaction, neuroticism, and OE-based coping significantly predicted the EE dimension. Similarly, being male, role conflict, and OE were significant predictors of CY. Finally, the presence of role conflict and role ambiguity were negatively related to PE, whereas a SS coping strategy was positively associated with PE. The values of the D-W and VIF statistics indicated the independence of the residuals and the absence of multicollinearity, respectively.

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Table 2

Multiple regression models of burnout dimensions

	B	Error	Beta	*t*	*p*	L Limit	U Limit[c]	VIF
EE								
(Constant)	-19.80	9.25		-2.14	.034	-38.10	-1.49	
Working hours[T]	4.59	1.76	.16	2.61	.010*	1.10	8.08	1.10
Salary	-1.10	1.56	-.04	-.71	.481	-4.18	1.98	1.12
Role ambiguity	-.17	.10	-.10	-1.68	.095	-.38	.03	1.15
Role conflict	.23	.08	.21	3.22	.002*	.10	.40	1.12
NI (Work-Home)	.91	.15	.39	5.92	.001*	.60	1.21	1.23
Neuroticism	.51	.17	.23	3.26	.001*	.21	.87	1.35
OE	.72	.23	.19	3.09	.002*	.26	1.19	1.11
NF	.29	.23	.09	1.30	.196	-.153	.74	1.39
$F_{[8, 118]}$ =19.23. p <.001; R^2 = .585, $R^2_{Adjusted}$ = .557; D-W = 2,25								
CY								
(Constant)	-2.88	4.469		-0.64	.521	-11.73	5.97	
Gender	-4.06	1.54	-.20	-2.63	.010*	-7.12	-1.01	1.02
Work area[#]	.68	.82	.06	0.83	.408	-.94	2.29	1.07
Role conflict	.13	.04	.26	3.34	.001*	.05	.21	1.13
NI (Work-Home)	.06	.08	.06	0.80	.428	-.10	.22	1.16
Neuroticism	.10	.09	.10	1.12	.267	-.08	.27	1.32
OE	.46	.13	.28	3.62	.001*	.21	.70	1.11
NF	0.21	.12	.15	1.74	.084	-.03	.44	1.34
$F_{[6, 120]}$ = 8.93. p <.001; R^2 = .345, $R^2_{Adjusted}$ = .306; D-W = 2,17								
PE								
(Constant)	29.89	4.95		6.04	.001	20.09	39.69	
Role ambiguity	.30	.06	.41	5.34	.001*	.19	.41	1.16
Role conflict	-.11	.04	-.22	-2.80	.006*	-.19	-.03	1.18
NI (Work-Home)	-.00	.08	-.01	-.03	.980	-.16	.16	1.20
Neuroticism	-.10	.09	-.01	-1.20	.235	-.28	.07	1.33
OE	-.25	.13	-.15	-1.92	.057	-.51	.01	1.19
NF	-.20	.12	-.14	-1.67	.092	-.44	.03	1.39
SS	.16	.07	.17	2.23	.028*	.02	.28	1.12
$F_{[7,119]}$ =11.17. p <.001; R^2 = .397, $R^2_{Adjusted}$ = .361; D-W = 1,91								

Note. B = nonstandardized coefficient; Beta = Standardized coefficient; L= Lower; U = Upper; t = Student-t; VIF = Variance inflation factor; EE = Emotional Exhaustion; CY = Cynicism; PE= Professional Efficiency; [T] Weekly hours (40 hours vs. less than 40 hours); # = Geriatrics Area vs. other areas; NI = Negative interaction; OE = Open emotional expression; NF= Negative self-focus; SS= Social-seeking support; R^2= proportion of variance explained by predictor variables; $R^2_{Adjusted}$ = adjusted proportion of variance explained by predictor variables; D-W = Durbin-Watson statistic.

Significance values *p < .05. **p <.01.

3.4 Relationship of Burnout and General Health

All the dimensions of burnout significantly correlated with a poorer health status: EE (r = .563, p < .001), CY (r = .283, p < .001), and PE (r = -.296, p < .001). Likewise, the health status of the OTs was related to different psychosocial factors: role ambiguity (r = .278, p < .001), negative home-work interaction (r = .358, p < .001), neuroticism (r = .460, p < .001), FN (r = .398, p < .001), and OE (r = .270, p < .001). The multiple regression indicated that the EE dimension, a negative home-work interaction, and neuroticism contributed

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statistically and significantly to the prediction of health perception when controlling for the effect of sociodemographic factors (age and sex) and the other burnout dimensions (CY and PE). The VIF and D-W values of regression models were satisfactory.

Table 3
Multiple regression for the dependent variable: General Health Questionnaire (GHQ-12)

	B	Error	Beta	*t*	*p*	L Limit	U Limit	VIF
(Constant)	13.40	7.21		1.86	.066	-0.88	27.69	
Age	-0.03	0.05	-.04	-0.67	.504	-0.14	0.07	1.034
Gender	0.12	1.75	.01	0.07	.944	-3.34	3.59	1.08
EE	0.24	0.05	.44	5.12	.001	0.15	0.34	1.83
CY	-0.01	0.11	-.01	-0.11	.912	-0.24	0.21	1.91
PE	0.11	0.11	.09	1.04	.300	-0.10	0.32	1.83
Role ambiguity	-0.13	0.07	-.14	-1.91	.058	-0.26	0.01	1.35
NI (Family-Work)	1.083	0.25	.31	4.43	.001	0.60	1.57	1.19
Neuroticism	0.29	0.10	.22	2.84	.005	0.0	0.49	1.43
NF	0.12	0.14	.07	0.87	.388	-0.15	0.39	1.47
EA	-0.09	0.15	-.04	-0.57	.572	-0.38	0.22	1.34
	$F_{[10,116]} = 18.85$. $p < .001$; $R^2 = .526$, $R^2_{Adjusted} = .485$; D-W = 1.98							

Note. GHQ-12= Goldberg General Health Questionnaire; Beta = Standardized coefficient; t = Student-t; L= Lower; U = Upper; VIF = Variance inflation factor; EE = Emotional Exhaustion; CY = Cynicism; PE = Professional Efficiency; NI = Negative interaction; NF= Negative self-focus; OE = Open emotional expression; R^2= proportion of variance; $R^2_{Adjusted}$ = Proportion of adjusted variance; D-W = Durbin-Watson statistic.

4. Discussion

The present research estimated the prevalence of burnout in a sample of Spanish OTs, as well as the main factors associated with BS. The results indicated that 15.7% of the OTs presented burnout with all three dimensions affected conjointly; 17.3% showed burnout on two scales (6.5% EE and CY, namely, the core of burnout); and 24.4% presented a single affected dimension (38.7%, 35.5%, and 25.8% for EE, CY, and RPE, respectively). Other investigations carried out in Spain with OTs indicate that 1.8% of OTs present burnout, whereas 26.1% present EE and CY (11). The variability in the estimates of burnout prevalence seems to be related to the measurement instruments, the method of estimating burnout, and the sociodemographic aspects of the sample [14]. Escudero-Escudero et al. (11) used a different burnout estimation method, based on a sample of social workers, making comparisons difficult. On the contrary, the present study used the cut-off points established in the normative criteria of the MBI in Spain (38,39).

Concerning the different psychosocial predictors related to burnout, we found that role conflict, negative work-home interaction, neuroticism, and OE-based coping predicted EE. Consistently, CY was associated with role conflict and OE-based coping, and with being male. Finally, role conflict and role ambiguity were negatively related to RPE, whereas a SS coping strategy was positively associated with PE. Previous works have reported that overwork [22,32], role conflict and role ambiguity [23–25], negative work-

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home interaction [28,31], neuroticism [33–35], and the use of emotion-focused coping strategies [39,40] are associated with the onset of burnout. These same constructs are also relevant in determining burnout in our reseach sample of OTs. Similarly, other studies claim that social support positively affects coping with stress and preventing its negative consequences [55,56]. The only dimension associated with gender was depersonalization or CY, which is consistent with results indicating a higher prevalence of this dimension in men [29,57].

Of all the predictors, role conflict was the only common predictor of all three dimensions, reinforcing its impact on burnout in OTs [23]. On the contrary, role clarity only predicted a better perception of PE, with a less decisive role in burnout, as other studies have indicated (30). Negative work-home interaction also affected EE negatively, as previously demonstrated [29]. Concerning psychological variables, only neuroticism or lack of emotional stability was associated with EE, but not the other personality factors [33]. This study also confirm that emotion-focused strategies are not the best option for coping with stress [39,40], whereas social support contributes to greater professional effectiveness [10].

Finally, the results indicated that EE was the only burnout dimension that predicted the general health of OTs, apart from negative home-work interaction and neuroticism, after considering the sociodemographic variables and the other burnout dimension in the model. Previously, other studies have shown that burnout is associated with workers' poorer physical and mental health [58]. In fact, as we have seen, negative work-home interactions and neuroticism are associated with greater EE, the main dimension related to the general health of the OTs we evaluated. These results are consistent with other studies pointing out that EE is significantly and positively associated with the loss of subjective well-being [59].

This study has a series of limitations that should be commented upon. Firstly, sample size was limited, which makes it difficult to generalize the results to the Spanish population. In addition, the sample was composed mainly of women, while men were underrepresented. We note that women are very numerous in the group of OTs, as indicated by the study with the largest sample of OTs in our country (11). Secondly, the study is based on a self-report methodology, although all the questionnaires used have been validated in Spanish population and have adequate psychometric properties. Finally, the results were obtained with a cross-sectional design and using a limited number of variables because diverse factors are associated with burnout at the psychological, family, and professional levels. Future research should look into other psychosocial predictors of burnout in OTs, introducing protective psychological resources (e.g., optimism, resilience, etc.). We also recommend a prospective methodology, which allows analyzing the natural course or development of burnout. The design and implementation of more OT-specific assessment instruments (i.e., quality of praxis or specific stressor delimitations) is also an aspect to consider in future studies.

5. Conclusions

To conclude, the findings of this study provide new evidence to better understand BS in the group of OTs. Beyond objective stressors, different psychosocial factors have

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significant influence on the development of BS. Organizations and workplaces need to become aware of the impact of the syndrome and its related factors, knowing that BS harms professionals' health, the quality of care provided, and the effectiveness of organizations. The development of intervention actions/programs that help prevent its occurrence is a cornerstone of the care of our health professionals and our own self-care.

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RJ General design of the study, adaptation and preparation of questionnaires, data collection (full resposable) and first draft.

IC. Critical review and statistical methods

BF. Critical review and statistical analysis.

AN. Critical review of the manuscript.

FR. Study design and manuscript review.

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