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Faculty of nursing

Master of community mental health Nursing

Burnout among Mental Health Workers in Gaza Strip

{Analytical study}

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بسم الله الرحمن الرحيم

قَالَ رَبِّ ٱشۡرَحۡ لِي صَدۡرِي ﴿٢٥﴾ وَيَسِّرۡ لِيٓ أَمۡرِي ﴿٢٦﴾ وَٱحۡلُلۡ عُقۡدَةٗ مِّن

لِّسَانِي ﴿٢٧﴾ يَفۡقَهُواْ قَوۡلِي ﴿٢٨﴾ طه (25- 28)

صدق الله العظيم

Dedication

I dedicate this humble work to my husband, who did not spare the days , and who supported me throughout the preparation of this research, and he exert his effort with me every time...

To Basil heart and the apple of the eyes of my children, God keeps them…..

To my brothers and sisters

To my colleagues and friends and in particular the Psychological Clinic Rafah Team…

Finally

To all who taught me any characters to illuminate the road in front of me.

Acknowledgements

In the name of Allah, the Beneficent, and the Merciful:

{And (remember) when your Lord proclaimed: if you are grateful, I will surely increase you (in favor)} Surah Ibrahim, verse (7).

My thanks and gratitude to my husband and my brothers for all the support and guidance they gave me on the road to complete this research and I ask Allah Almighty that He may repay them the best reward.

It's my duty to give gratitude and sincere thanks to my Professor, Sanaa Abou-Dagga, and Dr. Abdul Aziz Thabet who supervised this research, and offered their time, effort and encouragement. May Allah bless their sincere efforts in the service of science and Islam.

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I cannot fail at this point to record a word of thanks and gratitude to the Islamic University and its great scientists, professors, its president and Dean of the Faculty of Education and faculty members for their help to complete this research.

In conclusion, I thank everyone who helped and contributed to the completion of this research, and I hope that this research contributes in the path of science. May Allah reward everyone the best of rewards.

STUDY
ABSTRACTS

- ***ENGLISH ABSTRACT.***
- ***ARABIC ABSTRACT.***

Abstract

Objectives: The study aims to investigate the prevalence of job burnout among mental health workers in Mental Health Centers in Gaza strip.

Methods:

The sample consist of (118) workers distributed in (7) Mental Health Centers. The selected workers were classified under the various types of work fields as following: mental health doctors, nurses, Psychologists, and Social workers.

The tools used in the study are: 1) Burnout inventory checklist, 2) Personal data sheet (gender, age, years of experience, place of work…etc.).

Descriptive and inferential statistics were used.

Results:

The results of the study showed that the total score of burnout percentage is 54.9%. The total score of burnout percentage did not show significant results due to the following variables: gender, age, address, marital status, number of children, income, experience, specialization at the level (a = 0.05), whereas the total score of burnout percentage show significant results due to level of education (Qualification) variable.

Conclusion

The recommendations of the study are as follows: Improve the management to reduce burnout among those who work in mental health centers. Also consider improving the status of the holders of postgraduate certificate studies, redesign jobs and reorganize work system according to job description, and activate psychological counseling.

ملخص الدراسة

الأهداف: هدفت الدراسة إلى بحث مدى انتشار الاحتراق الوظيفي بين العاملين في مراكز الصحة النفسية في قطاع غزة.

المنهجية:

تكونت عينة الدراسة من (118) عامل موزعين على (7) مراكز، بما يتضمن ذلك من تخصصات مختلفة مثل: الأطباء، والممرضين، والأخصائيين النفسيين، والأخصائيين الاجتماعيين. تمّ استخدام لقياس الفرضيات مقياس ماشلاج الاحتراق الوظيفي للتمريض، مقياس لقياس العمر والجنس والمستوى التعليمي وسنوات الخبرة.. الخ. تمّ استخدام الاختبارات الاحصائية.

النتائج:

بينت نتائج الدراسة أن مستوى الاحتراق الوظيفي لدى العاملين في مراكز الصحة النفسية كان بنسبة 54.9%، وأن مستوى الاحتراق الوظيفي لم يكن ذا دلالة احصائية عند المستوى (0.05) بالمقارنة مع المتغيرات: (الجنس، العمر، العنوان، الحالة الاجتماعية، عدد الأطفال، الدخل، الخبرة، التخصص)، بينما كان هناك فروق تعزي الي عامل مستوى التعليم (الشهادة العلمية).

التوصيات:

خرجت الدراسة بعدة توصيات منها: تحسين النظام الإداري للتخفيف من الاحتراق الوظيفى للعاملين فى مراكز الصحية النفسية وكذلك بالاهتمام بحاملي الشهادات العليا وتحسين وضعهم في العمل، إعادة تصميم نظام العمل وفق منظومة التوصيف الوظيفي، وتفعيل نظام الإرشاد النفسي للموظفين.

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Abbreviations

Shortcut	Meaning
CT/CAT Scan	Computed Tomography/ Computer Axial Tomography scan
GCMHP	Gaza community mental health program
HSJSQ	Human Service Job Satisfaction Questionnaire
MSF	Medicine Sans Frontiers
MBI	Maslach Burnout Inventory
MOH	Ministry Of Health
MHC	Mental Health Center
MRI	Magnetic Resonance Imaging
PHIC	Palestinian Health Information Center
PET	Positron Emission Tomography
U.S.	United States
UNRWA	United Nations Relief and Works Agency
UN	United Nation
WHO	World Health Organization

Chapter one

Background

1. Introduction

Work is the foundation of life in which we live today, where it is considered the main source of livelihood and sustenance required by every human being on earth, and man who does not work is an individual who is ineffective and unproductive. Work determines the level of human living and cultural, and social.

Mental health nowadays is being largely overlooked as part of strengthening primary care services. This is despite the fact the mental illnesses are found in all countries, in women and men, at all stages of life, among the rich, poor, rural, and urban settings (WONCA ,2008). Mental health illnesses are common, affecting more than 25% of all people at some time during their lives. The point prevalence of mental illness in the adult population at any given time is about 10% similarly; around 20% of all patients seen by primary health care providers have one or more mental health illnesses (Kabir & et. al, 2004).

According to the World Health Organization, the term health refers not just to the absence of disease, but to a "state of complete physical, mental and social well-being." Mental health is defined as "state of well-being in which the individual realizes his or her abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (WHO, 2008). The term mental health promotion includes strategies and interventions that enable positive emotional adjustment and adaptive behavior. Thus, it is somewhat different from mental illness prevention in that the former focuses on health, whereas the latter aims to avert onset of illness. Mental health promotion is a subset of health promotion more generally.

Different groups of professionals work in mental health care settings. They include: psychiatrists, psychologists, social workers, counselors, psychiatric nurses, Their jobs mainly focus on helping people to promote optimal mental health and reduce personal stress responses by dealing constructively with their psychological, emotional, and social problems, both individually and in groups .

Mental health professionals face additional strain by the very nature of mental health work and therefore may be more at risk than their colleagues in other areas of health care (Maeran R. & Martino G., 1996). This additional strain had been labeled by researchers as burnout. Maslach & colleagues in (Lippert L. ,2000) have described burnout as a point at which important, meaningful, and challenging work becomes unpleasant, unfulfilling, and meaningless.

Burnout in human service occupations is of interest to researchers and practitioners in the mental health field (Bhui K. and et. al, 2006). It is important for at least for four main reasons. First, burnout affects the staff member's morale and psychological well-being. Second, burnout seems to affect the quality of care and treatment provided to clients. Third, burnout may have a strong influence on administrative functioning. Finally, burnout is important in community settings because it helps community caregivers prevent job stress and thus promotes community mental health (Cherniss C., 1980).

Burning-out process is consistent with some control, cognitive, and behavioral models of reactive depression (Pyszcynsky & Greenberg, 1987). As in these models, the occurrence of burning out is presumed to be highly dependent on a predisposing factor of vulnerability. This vulnerability may be displayed in the investment of self-worth into a single role, and it is the threat to or the loss of this role that is assumed to start the burning-out as well as the depressive process. In contrast to these two models of depression, this framework of burning out emphasizes the achievement motives rather than the facilitative motives involved.

Research shows that personal and organizational factors have been associated with stress and burnout for those involved working with people (Cinzia B., 2009), whereas job satisfaction was found to have a protective effect against them (Moore KA., 1996).

The Palestinian people have suffered a lot since 1948 because of the Israeli occupation and the restricted closure and siege in specific. Besides, the last two wars on Gaza (2008/2009) (2012), where many people have been killed or injured or ended as

handicapped, exposed Palestinian residents to psychological problems including trauma, which caused emotional and behavioral disorders.

In Gaza Strip, the Department of Mental Health that follows Ministry of Health (MOH), is one of the main units that is responsible for prevention, care, and rehabilitation in connection with mental illness in the adult population. The department provides for emergency treatment at home or at hospitals; it provides acute admissions wards and hospital first-aid (emergency) units. In order to carry out their mental health programs, the Department of Mental Health draws on the services of outpatient centers or health clinics that provide treatment in a hospital setting or in residential or semi residential communities.

3. Study Justification

Mental health workers in Gaza Strip work together as mental health team; their work focuses on dealing with clients and their families by affording treatment and supporting them in hospitals, out- patient clinics and homes. (Vanheule ST. & et. al, 2003) stated that many factors influence the performance of mental health workers such as: the shortage of mental health workers in relation to the huge number of cases, the absence of transportation vehicles for community home visit to handicapped patients with mental health illness, the lack of facilities as buildings, psychological tests, and absence protective measures from addicted clients and aggressive clients impact the services offered to clients.

Mental health workers in Palestine work in unusual conditions under the continuous Israeli aggression. They face additional constraints while performing their job such as, non-availability of medication most of the time in the clinics which are free, lack of public awareness towards mental illnesses and dealing with it. Moreover, patients do not visit psychiatric doctors at an early stage of sickness. It took them a period of time, after the patients become chronically sick and severely deteriorated, to do that.

The exploratory cross-sectional here aimed primarily to investigate the prevalence of burnout among those who work in (MOH) mental health centers in Gaza Strip.

4. Problem Statement

The problem of the study is stated in the following major question:

What is the prevalence of burnout among mental health workers in mental health centers in Gaza Strip?

Specific questions

The following questions emanate from the above major one:

1. What is the prevalence of burnout among mental health workers in mental health centers in Gaza Strip?
2. Are there statistically significant differences in burnout scores due to gender (M\F)?
3. Are there statistically significant differences in burnout scores due age?
4. Are there statistically significant differences in burnout scores due place of residance?
5. Are there statistically significant differences in burnout scores due to marital status?
6. Are there statistically significant differences in burnout scores due to number of children?
7. Are there statistically significant differences in burnout scores due to level of education?
8. Are there statistically significant differences in burnout scores due to income?
9. Are there statistically significant differences in burnout scores due to working hours?
10. Are there statistically significant differences in burnout scores due to experience?
11. Are there statistically significant differences in burnout scores due to Specialization?

5. The significance of the problem

The importance of this research stems out from:

1. This research gains its importance from the subject matter itself, because it opens the scope for the officials to conduct burnout as a very important issue among mental health workers in mental health centers in Gaza Strip.
2. This research is considered important as it will use analytical approach to investigate the prevalence of burnout among mental health workers in mental health centers in Gaza strip. This will lead to highlight several practical suggestions to that may be adopted by policy makers to improve practice.
3. In Palestine - especially in Gaza Strip -, no study has been conducted on the association of burnout of those who work in mental health care settings.

6. Objectives of the study

A) Main objective

This study investigated the prevalence of job burnout among mental health workers in mental health centers in Gaza strip.

B) Specific objectives

- Identify the extent of the burnout suffering of Gaza mental health workers.
- Investigate the contributions of personal factors to burnout (sex, age, address, marital status, Number of children, the level of education, Monthly Income, Working hours, Experience, Specialization.

7. Operational Definitions:

Burnout:

It is a state of psycho-disturbance which mental health workers experience as a result of work pressures, and extra burdens that usually include the feeling of affectionate stress, apathy, and feeling short of achievement. It produces three important outcomes:

(1) Emotional exhaustion - a lack of emotional energy to use and invest in others;

(2) Depersonalization - a tendency to respond to others in callous, detached, emotionally hardened, uncaring, and dehumanizing ways;

(3) a reduced sense of personal accomplishment and a sense of inadequacy in relating to clients.

In this study burnout is measured and evaluated through the total score on Maslach's inventory for burnout.

Palestinian Ministry of Health (MOH):

Comprehensive and integrated health system that contributes to improving and strengthening the sustainable development of health, including the main determinants of health in Palestine.

Department of Mental Health:

The Department of Mental Health (DMH) provides emergency care and comprehensive mental health services and supports District residents in need of the public mental health system. It also evaluates and treats individuals referred through the criminal justice system.

Mental health workers:

They are four categories:

- **Mental health doctor:**

  He/she is a physician who specializes in psychiatry. They authorized to prescribe medicine, conduct physical examinations, order and interpret laboratory tests, and may order brain imaging studies such as Computed Tomography (CT/CAT Scan), Magnetic Resonance Imaging (MRI), and Positron Emission Tomography (PET) scanning.

- **Mental health nurse:**

  Mental health nurse are those who work with people suffering from various mental health conditions and their family and careers to offer help and support in dealing with the condition. The work involves helping the patient to recover from their illness or to come to term with it in order to lead a positive life. The nurses may specialize in working with children or older people, or in a specific area such as eating disorders. Mental health nurses often work in multidisciplinary teams, liaising with psychiatrists, psychologists, occupational therapists, social workers and other health professionals.

- **Psychologist:**

  Psychologists aim to reduce the distress and improve the psychological well-being of clients. They use psychological methods and research to make positive changes to their clients' lives and offer various forms of treatment.

- **Social worker:**

A social worker works with people who have been socially excluded or who are experiencing crisis. Their role is to provide support to enable service users to help themselves. They maintain professional relationships with service users, acting as guides, advocates or critical friends. Social workers work in a variety of settings within a framework of relevant legislation and procedures, supporting individuals, families and

groups within the community. Settings may include the service user's home or schools, hospitals or the premises of other public sector and voluntary organizations. Qualified social work professionals are often supported by social work assistants. They also work closely with other health and social care staff.

Context of the study

Mental health in Gaza Strip

Mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community. In this positive sense, mental health is the foundation for individual well-being and the effective functioning of a community (WHO, 2010).

Related studies by the mental health of Palestinian society in Gaza Strip show the difficulties faced by the sector working in the field, especially with regard to easily provide information and statistics on the level of psychological morbidity in Palestine. This may be due to the recent research in the field of mental health in Palestine, the scarcity of data on the level of proliferation linked to social difficulties faced by the sector and related social stigma. (Ministry of Health, PHIC, Health Status in Palestine, 2011: 25).

In a review of the literature relating to versions of the World Health Organization, shows limited and poor statistics on mental disorders. According to the (WHO) reports, the ideological situation of mental health in Palestine is not available. It is difficult to get rates and accurate figures reflect the situation ideological mental health in Gaza Strip. Also it is founded that there is an urgent need to work with patients with chronic diseases (such as schizophrenia and severe depression, bipolar disorder, and disorders psychotic) to the possibility of interference with them and reduce the possibility (burden of disease) (http://www.who.int).

Early intervention reduces non-productive, which is associated with these diseases, as research has shown the World Health Organization and the international Labor Organization that depression and chronic mental illnesses are five out of ten diseases lead to disability and lack of productivity. For other category of people with mental illnesses account for up 10-20% go to primary health clinics have physical complaints of a psychosocial origin. The other class of disorders is reactive symptoms, especially children, adolescents, and handicapped where the mechanisms are working with them most often in the form of a first and a preventive (Sourani G., 2011: 7).

Mental health care is provided by the government, and non-government sector. Gaza mental health hospital was established in 1979 and was rebuilding in 1994. It has 40 beds. Gaza community mental health program (GCMHP) offers services that support mental health diseases. It has centers in every governate in Gaza.

Chapter Two

Theoretical Framework

Introduction:

Burnout first emerged as a social problem, not as a scholarly construct. Thus, the initial conception of burnout was shaped by pragmatic rather than academic concerns. In this pioneering phase of conceptual development, the focus was on clinical descriptions of burnout. Later on, there was a second, empirical phase, in which the emphasis shifted to systematic research on burnout and in particular to the assessment of this phenomenon. Throughout these two phases there has been increasing theoretical development in which the concern has been to integrate the evolving notion of burnout with other conceptual frameworks. (Vimantaite R. & et. al, 2006).

2.1 Burnout as concept:

Burnout has been defined in a variety of ways. Freudenberger (1990) was the first to coin the term and by burnout, he means a state of physical and emotional depletion which results from the conditions of work. Freudenberger conceptualizes burnout as due to individual psychological/ personal characteristics: the dedicated worker who takes on too much work with an excess of intensity, the overcommitted worker whose outside life is unsatisfactory, and the authoritarian worker who needs extensive control in his or her job. There is no interaction between the worker and his environment.

Pines and Maslach (1978) propose a broader social/ psychological view of burnout that examines the relationship between workers and their work environments (Maslach, 1987: Pines & Kafry, 1981, Pines & Maslach,1978). For Maslach (1982), burnout is a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that occurs among individuals who do “people work” of some kind. It is a response to chronic emotional strain of dealing extensively with other human beings, particularly when they are troubled or having problems. In other words, the burnout professional loses all concern, all emotional feelings for the persons he works with and

comes to treat them in detached or even dehumanized ways. Cherniss (1980) say the same: the committed professional becomes disengage from his or her work.

In another study: Pines and Aronson (1989) note that burnout is characterized by physical depletion, by feelings of helplessness and hopelessness, by emotional drain, and by the development of negative self-concept and negative attitudes towards work, life, and other people. Similarly, Farber (1983) identify burnout as a negative adaptation to stress which includes a pervasive mood of alienation, with features of depression and a loss of idealistic spirit.

Therefore, a general consensus states that the symptoms of burnout include attitudinal, emotional and physical components. Burnout is a process and it is not identical for each person. Cherniss (1990) define burnout as a transactional process which comprises of three stages. In the first stage, there is an imbalance between resources and demand (stress). In the second stage there exists an immediate, short-term emotional response to this imbalance, and there are feelings of anxiety, tension, fatigue and exhaustion. The third stage consists of changes in attitude and behavior, such as a tendency to treat clients in a detached and mechanical fashion.

Burnout has also been described as a syndrome which occurs in the care provider as a response to chronic emotional stress which arises from the social interaction between a care provider and the recipient of care (Courage &Williams, 1987).

2.2 Burn out and related variables and processes:

There are many contributing factors to burnout. According to Farber (1983) burnout is a function of the stresses engendered by the individual, work related and societal factors. Cherniss (1990) categorizes the sources of burnout at the individual, organizational and societal levels. Courage and William (1987) put forth a multidimensional model to explain the relationships between burnout and the variables which are associated with the care providers, the organization and the recipients of care (clients).

In another study Pines and Kafry (1981) state that burnout can lead to a cluster of symptoms termed as "tedium' which is a general experience of physical, emotional and attitudinal exhaustion. Tedium occurs in the social service profession and it is due to the internal and external characteristics of work conditions. Internal characteristics include pressures imposed on the cognitive capacity and decision-making mechanism of workers (variety and autonomy) as well as those imposed on the worker's sense of meaningfulness and achievement (significance, success and feedback). The external characteristics refer generally to the work environment and they include such variables as work relations, work sharing, support from co-workers, the availability of sanctioned time-out periods, and feedback from supervisors and colleagues.

In brief, when discussing the concept of burnout, variables that need to be considered are: (1) the personal characteristics of the provider (worker); (2) the job setting, in terms of supervisory and peer support as well as agency rules and policies; (3) the actual work with individual clients.

Burning-out process is consistent with some control, cognitive, and behavioral models of reactive depression (Pyszcynsky & Greenberg, 1987). As in these models, the occurrence of burning out is presumed to be highly dependent on a predisposing factor of vulnerability. This vulnerability may be displayed in the investment of self-worth into a single role, and it is the threat to or the loss of this role that is assumed to start the burning-out as well as the depressive process. In contrast to these two models of depression, this framework of burning out emphasizes the achievement motives rather than the facilitative motives involved.

The burning-out process can also be conceived of as an instance of narcissistic activity, as already noted by Fischer (1983). Models of narcissism may offer a basis for understanding burning out, and Cooper (1986) suggested that narcissistically disturbed persons have a tendency to burn out.

This framework for the burning-out process was derived ad hoc and has not been directly tested in any study. It is an attempt to integrate data and models from stress, depression, and burnout research areas as well as from different methodological approaches. Important contributions also stem from empirical data (Hallsten , 1993) and from my informal discussions and observations of staff behavior in human service organizations over many years.

The framework offers a crude structure with the primary purpose of contrasting burning out to related processes. This means that the contrasting processes are treated superficially without sharp distinctions.

Individual change processes are conceptualized here in terms of "phases" (for tack of a better term), although it is well known that phase models may be difficult to validate. There has only been equivocal support for phase transitions as responses to undesirable events (Silver & Wortman, 1980). Consequently, the number of phases here has been reduced to a minimum. The framework has similarities to and has been influenced by other models (Bowlby, 1979; Edelwich & Brodsky, 1980; Klinger, 1977; Viney, 1976; Wortman & Brehm, 1975). However, in contrast to other phase models, no necessary progression from one phase to the other is assumed (Shirom, 1989).

2.3 Model of burnout

When discussing the concept of burnout, research show that there are many variables that need to be considered such as: (1) the personal characteristics of the provider (worker); (2) the job setting, in terms of supervisory and peer support as well as agency rules and policies; (3) the actual work with individual clients. See the following model.

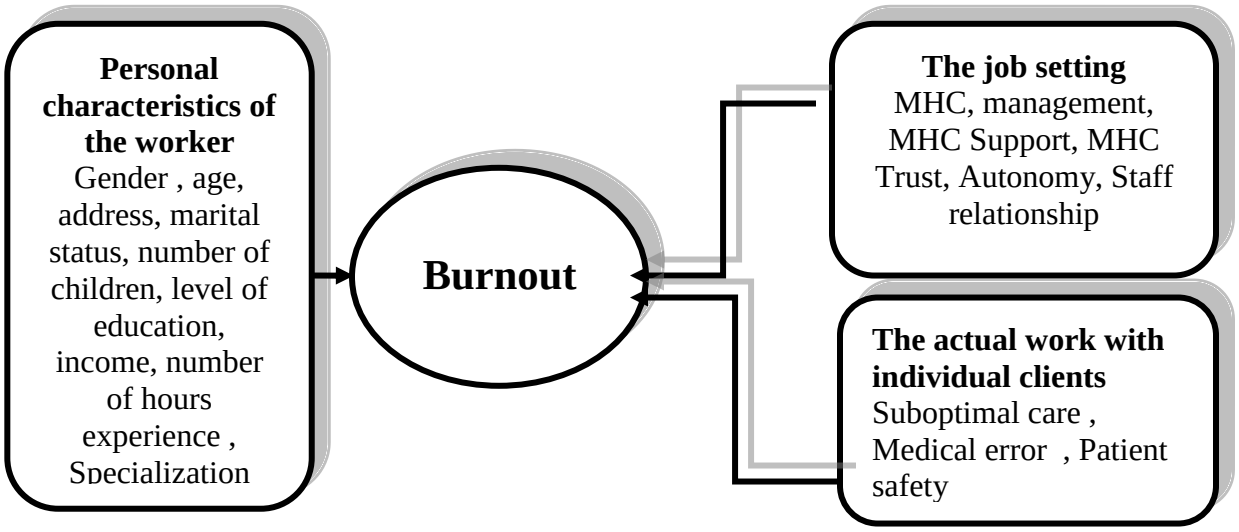

Figure 1: Model of burnout in relation with many factors. (Montgomery, 2011)

In this study, the researcher focuses in measuring the concept of burnout and studies the variables that may influence it. Maslach (1982) indicates that burnout produces three important outcomes: (1) emotional exhaustion - a lack of emotional energy to use and invest in others; (2) depersonalization - a tendency to respond to others in callous, detached, emotionally hardened, uncaring, and dehumanizing ways; and (3) a reduced sense of personal accomplishment and a sense of inadequacy in relating to clients.

The concept of burnout by Maslach is used in this research. See the following model:

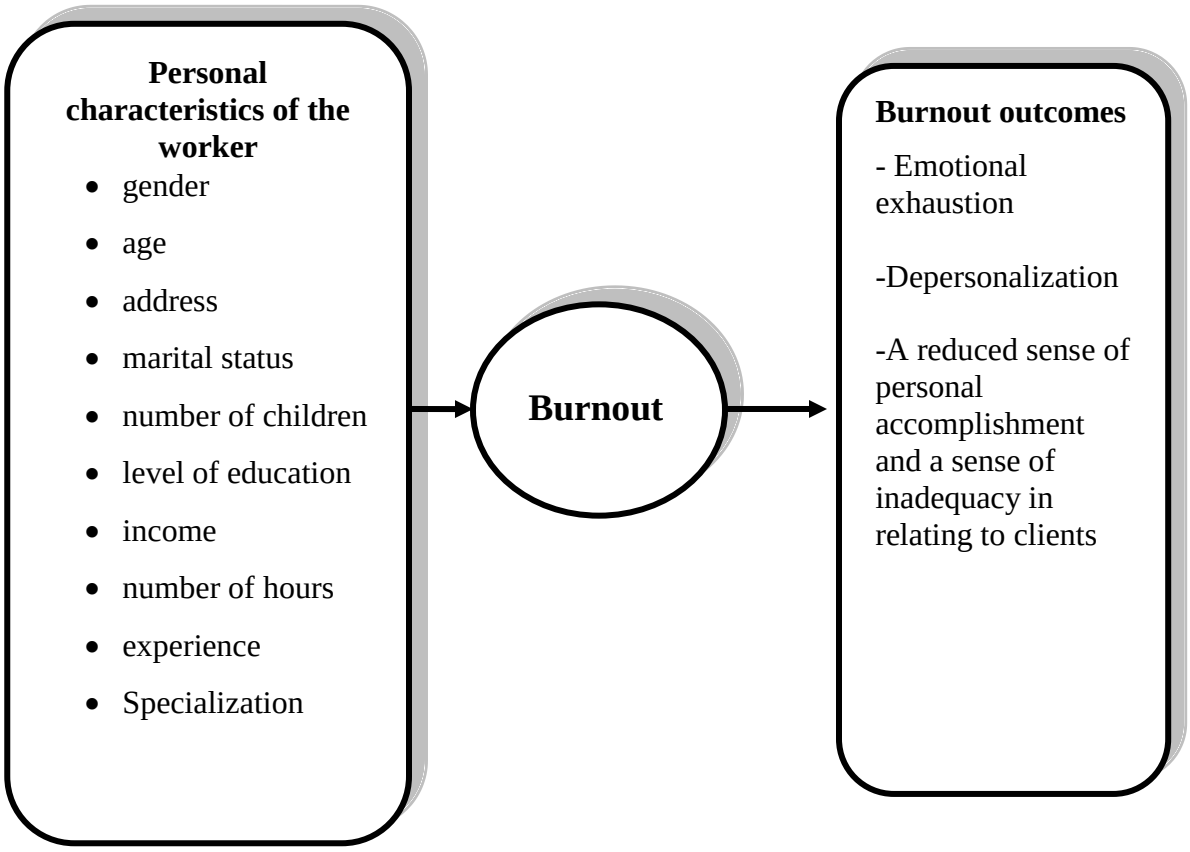

Figure 2: Proposed model of the research on burnout

2.4 Theory of burnout syndrome: A response to occupational stress

2.4.1History and theoretical perspectives

The term burnout was first described in the literature by Freudenberger (1990), who identified a state of fatigue and frustration arising from unrealistic and excessive demands on the personal resources of health and service workers (Maslach, 1982). Freudenberger suggested that a person attempting to achieve unrealistic expectations, whether imposed socially or internally, may become exhausted both physically and mentally (Miller, 1995). At about the same time, Maslach was studying the ways in which people coped with emotional arousal on the job (Maslach & Schaufeli, 1993). Maslach and colleagues originally defined burnout as a syndrome of physical and emotional exhaustion, involving the development of a negative self-concept, negative job attitudes, and loss of concern and positive feeling toward clients (Maslach, 1976; Pines & Maslach, 1978). This definition was late modified to distinguish the three dimensions of the burnout syndrome (Maslach & Jackson, 1981a). A search of the burnout literature suggests that there is no standard definition of burnout, but much of the research focuses on the theoretical perspectives of Maslach and Jackson (1981a) (Collins Long, 2003). Despite the variable definitions of burnout employed in the literature, these definitions all share a common reference to the potential complications of ineffective efforts to cope with overwhelming occupational stress (McDaniel, Farber, & Summerville, 1996).

A number of researchers (e.g., Bennett, Michie, & Kippax, 1991; Visintini &Campanini, 1996; Miller, 1995) have cited various models proposed to describe the syndrome, state, or process of burnout. The most influential was Maslach and Jackson's (1981a) attributional/environmental model of burnout, which focuses on burnout being the result of the relationship between individual and environmental factors. This model and the corresponding measure, Maslach Burnout Inventory (MBI; Maslach & Jackson, 1981b), is the most widely used in burnout research. Maslach and Jackson operationally defined burnout as a debilitating psychological condition that can occur among individuals who

work with other people in some capacity (Maslach, 1982, 1993). It is a response to the chronic emotional strain of dealing extensively with other human beings, particularly when they are troubled or having problems. In this sense, burnout is regarded as an outcome of stressful working conditions (Farber, 1983), or the prolonged process of attempting to cope with occupational demands (Maslach & Jackson, 1981a).

According to Maslach and Jackson's (1981a) conceptualization, burnout is a multidimensional process with three central constructs: emotional exhaustion, depersonalization, and reduced personal accomplishment. Emotional exhaustion refers to feelings of being emotionally overextended and depleted of one's emotional resources by one's work. Depersonalization refers to a negative, callous, excessively detached or dehumanized response to other people, who are usually the recipients of one's services or care. Reduced personal accomplishment refers to feelings of incompetence, lack of productivity and successful achievement in one's work, and negative self-worth. A high degree of burnout is represented by high emotional exhaustion, high depersonalization, and low personal accomplishment (Maslach, Jackson & Leiter, 1996).

Maslach and Jackson's burnout model depicts distinct predictors of burnout, which include both demands of work and the lack of various resources (Maslach & et. al, 1996). The model asserts that the development of depersonalization is related to the experience of emotional exhaustion (i.e., emotional exhaustion is seen as mediating the environment's relationships with depersonalization); thus, these two aspects of burnout are believed to be correlated (Maslach & et. al, 1996). The third dimension of burnout, reduced personal accomplishment, is believed to be separate and independent of the two other burnout dimensions (Maslach, 1993), and may develop in parallel with emotional exhaustion (Maslach & et. al, 1996). However, burnout remains an unclear concept despite the large body of research (Söderfeldt, Söderfelt & Warg, 1995). While the argument remains unresolved as to whether emotional exhaustion causes depersonalization, which in turn creates diminished personal accomplishment, others have viewed the three dimensions as

interacting dynamically in some way (Collins & Long, 2003).

Although it has some of the same deleterious effects as other stress responses, burnout is unique in that the stress arises from the social interaction between helper and recipient (Maslach, 1982; Buunk & Schaufeli, 1993), or specifically, the continual giving relationship from the helping professional. Close interaction with clients, excessive demands, time pressure, and job-related stress can lead to severe reactions of burnout (Bellani et. al, 1996). Thus, burnout can be considered as the result of chronic occupational stress occurring principally in professional contexts where work demands lead to psychological debilitation and depletion of personal resourcefulness (Pines & Maslach, 1978; Maslach, 1982; Gueritault-Chalvin et al., 2000; Visintini & Campanini, 1996).

Burnout threatens to undermine the efforts toward effective health care, and it has become a problem of increasing public and professional concern (Farber & Heiftz, 1982).

2.4.2 Consequences of burnout

Burnout can have a number of deleterious effects on one's physical, psychological, social, and occupational functioning. It has been found to relate to low worker morale, impaired work performance, reduced productivity, absenteeism, adverse interpersonal relations with clients, negative attitudes toward work/lower job satisfaction, high job turnover, lower quality of life, and poorer health and psychological well-being (Maslach, 1979; Maslach & Jackson, 1981a; Rabin, Feldman, & Kaplan, 1999).

In a comprehensive review of the empirical research on the symptoms of burnout, Kahill (1988) identified five categories of symptoms: physical (e.g., fatigue, sleep difficulties, somatic problems, gastrointestinal disturbances, colds and flu), emotional (e.g., irritability, anxiety, depression, emotional numbness, guilt, boredom, and cynicism), behavioral (e.g., aggression, callousness, pessimism, increased alcohol and drug use), work-related (e.g., resigning from work, poor work performance, absenteeism, tardiness, misuse of work breaks), and interpersonal (e.g., inability to communicate effectively,

withdrawal from clients or colleagues, dehumanized and intellectualized interactions). A number of medical (e.g., ulcers, gallbladder, cardiovascular, and kidney disorders) and psychiatric (e.g., depression and anxiety) conditions have also been linked to burnout (Kahill, 1988; Horstman & McKusick, 1986; Bellani et al., 1996; Dorz, Novara, Sica, & Sanavio, 2003). Further consequences of ongoing occupational stress and burnout among health professionals include reduced quality of care and high reports of mortality (Gray-Toft & Anderson, 1981). Aside from the detrimental effects of burnout within the workplace, these effects can spill over into the professional's personal life, thus affecting his or her social/family functioning.

Collectively, these findings suggested that occupational stress and burnout, if left unchecked, can negatively impact professional well-being and may lead to professional impairment. Burnout has been identified as a significant problem in health care professionals who work in chronic and critical care (Gueritault-Chalvin et.al, 2000), such as HIV, oncology, surgery, and intensive care (Miller, 1995; Visitini & Campanini, 1996; Bennett et al., 1991; Kleiber, Enzmann, & Gusy, 1993; Catalan et al., 1996). Even more so, it is a significant problem facing mental health professionals because of the very nature of their work in dealing with emotionally troubled persons often over extended periods of time (Moore & Cooper, 1996).

2.4.3 Occupational stress and burnout among mental health professionals

It is well known that mental health professionals work in emotionally demanding environments, making them vulnerable to occupational stress and burnout. The interpersonal contact characterized by mental health work is often emotionally charged with feelings of tension, anxiety, hopelessness, embarrassment, fear and sometimes even hostility (Rabin & et. al, 1999). There is growing evidence to indicate that mental health professionals by the nature of their work have particular vulnerabilities to stress, with prolonged stress having the potential to cause detrimental effects that can negatively impact

service delivery and quality of care. Mental health professionals are represented by a number of disciplines, including psychiatrists, psychologists, counselors, mental health social workers, psychiatric nurses, and occupational therapists (Leiter & Harvie, 1996), as well as those who specialize in the area of psychotherapy (Rabin et.al, 1999).

As the definition of mental health expands, more human service providers may be considered to provide mental health services (Leiter & Harvie, 1996). Although the burnout experience is an occupational hazard specific to a variety of human service occupations (Cox & Leiter, 1992; Maslach & Jackson, 1986), mental health professionals may face an additional burden beyond organizational stressors when compared with other health professionals. The severe emotional exhaustion and psychological tension that are often experienced are also believed to be qualitatively different from that associated with other organizational stressors (Moore & Cooper, 1996). Overriding common factors leading to burnout in mental health professionals are their constant dealing with the emotional pain of others, their ongoing challenges of setting appropriate boundaries in their professional interactions, as well as their non- reciprocated constant attentiveness to clients' problems and needs (Rabin et. al, 1999).

Pines and Maslach (1978) evaluated the characteristics of staff burnout among 76 staff members in various mental health facilities. Participants included psychiatrists, psychologists, nurses, social workers, attendants, and volunteers. Their preliminary studies suggest that the incidence of burnout is often very high in health and social services professions. They found that heavy workloads and higher percentage of patients with schizophrenia in the clinic population correlated with mental health staff's heightened job dissatisfaction. Staff members who participated in this survey also spent more time in administrative duties and recommended pharmacological rather than psychological interventions for such problems as suicide attempts by patients, both of which suggest the use of avoidance strategies. Pines and Maslach found that, in general, staff members who had been working in the mental health field longer also experienced less enjoyment

working with patients, felt less successful with them, and had less humanistic attitudes toward mental illness. These findings suggested clear indications of burnout. When staff members had less seriously ill patients and fewer work hours, they expressed more positive attitudes about the institution as a whole, enjoyed their work more and felt successful at it, and listed self-fulfillment as their primary reason for being in a mental health field. Similarly, Shinn, Rosario, Mørch, and Chestnut's (1984) surveyed of mental health practitioners found that the job stressor most frequently identified across various institutions was poor job design, involving conditions such as excessive workload and role conflict. The lack of positive reinforcement or recognition for good work was reported by 44% of the mental health professionals in this survey as a source of job dissatisfaction and stress. Collectively, these studies suggest that the experience of occupational stress and burnout in mental health professionals appear to be most evident in work situations that inhibit mental health professionals' capacity to realize their value through their work.

Studies to date have found high occupational stress and burnout levels in specific mental health professional groups, including psychiatrists, psychologists, social workers, psychiatric nurses, and case managers .

2.4.4 Burnout among psychologists

Studies have found that the level of stress and dysfunction among clinical psychologists is high. (Ackerley & et. al 1988) examined the extent of burnout and its correlates in a national sample of 562 licensed, doctoral-level, practicing psychologists employed primarily within human service settings using the MBI. They found that more than one third of the sample reported experiencing high levels of both emotional exhaustion and depersonalization.

This is consistent with the findings of Snibbe, Radcliff, Weisberger, Richards, and Kelly (1989). The modal burned-out clinician in Ackerley et al's sample was young, had a low income, engaged in little individual psychotherapy, experienced feelings of lack of

control in the therapeutic setting, was seeing many clients with challenging issues (e.g., medical problems, victims of sexual abuse or rape, sexual dysfunction, psychotic clients, dealing with legal issues or court appearances), and felt overcommitted to clients.

Nevertheless, about 95% of the sample was in the low or less than low burnout range with regard to personal accomplishment, indicating feelings of competence, satisfaction, and success in their work. Additionally, with regard to career satisfaction, about 75% of the sample indicated that they would choose the same area of psychology if they had their lives to live over.

In his attempt to determine the level of burnout among clinical psychologists who were members of a large state psychological association, Farber (1985) found that 36% of the sample reported being moderately affected or emotionally drained by their work, while 6.3% indicated being strongly affected. However, in reference to working directly with people, 61.2% indicated that it was in no way too stressful. In another survey of licensed psychologists, Hellman, Morrison, and Abramowitz (1986) found that 78% their sample indicated that they were very comfortable with the practice of individual psychotherapy.

2.4.5 Burnout among social workers

Social workers are considered to be an occupational group with above-average risks of burnout (Söderfeldt & et. al, 1995). One study comparing burnout among different groups of health and mental health professionals found that psychiatrists and social workers were susceptible to high emotional exhaustion and depersonalization (Snibbe & et. al, 1989).

Similarly, Lloyd and King (2004) found that social workers experienced high levels of burnout in the areas of emotional exhaustion and moderate levels of depersonalization, but this was offset by high personal accomplishment. A systematic review of research articles dated from 1966 to 2000 on stress among mental health social workers concluded that social workers experienced relatively high levels of occupational

stress and burnout, and less satisfaction with their work when compared to normative populations and workers in other mental health professions (Coyle, Edwards, Hannigan, Fothergill, & Burnard, 2005). However, in another review that consisted of 18 burnout studies that used the MBI, Söderfeldt & et. Al, (1995) concluded that the results of these studies could not be generalized to social workers as a group due to different study limitations in each of these studies. As such, it is unclear whether social workers indeed suffer excessive burnout. Despite the shortcomings, many studies have identified the correlates for burnout among social workers. These correlates were primarily related to the job situation and to different aspects of the work organization, rather than to individual personality factors or type of clients (Söderfeldt & et. al, 1995).

2.4.6 Burnout among case managers

Research examining the relationship between occupational stress and burnout in mental health case managers are limited. The current research appears to support that mental health case managers experience increased burnout and distress in response to occupational stress. McCarthy (2000) found that case managers serving severely mentally ill (SMI) adults in the community reported higher levels of distress than a general population sample and higher levels of depersonalization than other mental health workers. Excessive workload and client-related difficulties were reported to be the most commonly encountered stressors, and exposure to these types of stressors was significantly related to case managers' well-being. Similarly, Turner (1997) assessed the relationships between the role stress experienced by mental health case managers and their respective levels of burnout and job performance factors (e.g., absenteeism, turnover intentions, job satisfaction, and affective commitment to the organization). Case managers who perceived increased levels of role stress were found to experience increased burnout and turnover expectations, while those who perceived decreased role stress reported increased job satisfaction and affective commitment to the organization. Additionally, participatory

decision making and locus of control were significantly related to job satisfaction and self-efficacy. Contrary to these findings, Carney et al.'s (1993) longitudinal study examining the incidence of burnout among case managers in a New York City Intensive Case Manager (ICM) Program found a lower incidence of burnout compared to the national norms for mental health workers that were established by Maslach and Jackson (1981b). However, because this ICM Program was completing its first year of operation, the relatively low levels of burnout in this group of case managers could have been attributed to the program's novelty and to the enthusiasm that generally accompanies new programs (Carney & et. al, 1993). Despite the limited research, the current empirical findings suggest that mental health case managers, like other mental health professionals, are vulnerable to burnout and its adverse consequences (e.g. personal distress, reduced job satisfaction, decreased job performance, poor service delivery, and reduced quality of care).

2.4.7 Burnout among psychotherapists

Research on stress and burnout has been conducted for mental health professionals specializing in psychotherapy and counseling. Collectively, these studies suggested that psychotherapists experience high levels of occupational stress and burnout. Most people who seek help through psychotherapy are often troubled, and a psychotherapist is constantly confronted with other people's maladjustments (Raquepaw & Miller, 1989). The interactions within a psychotherapeutic setting are often charged with strong emotions. When a psychotherapist is faced with a large number of these stressful interactions, he or she may begin to experience symptoms of burnout (Maslach, 1978).

According to Rabin et al. (1999), psychotherapists have their particular satisfactions and stressors which make them vulnerable to occupational stress and burnout. While psychotherapy can be rewarding, it is often demanding and lonely, filled with excessive expectations and a lack of gratification. Dealing with the emotional suffering of others can lead to compassion fatigue, depletion of emotional resources and subsequent burnout for

the psychotherapist. Similar to psychotherapy, counseling has also been identified as a type of person-oriented occupation that is susceptible to occupational stress and burnout. Ross, Altmaier, and Russell (1989) found that the counselors in their study experienced a wide variety of stressful events in their work, and the number of stressful events was predictive of burnout.

In a Featured study, Farber and Heifetz (1982) conducted a study on the phenomenon of therapist burnout on a heterogeneous group of psychotherapists comprised of psychiatrists, psychologists, and social workers. High levels of stress, burnout, and disillusionment were found in this specialized group of mental health professionals. The primary source of stress for this sample of psychotherapists was a lack of therapeutic success, or more specifically, the inability to promote positive change in their clients. The primary factor underlying burnout was identified to be the non-reciprocated attentiveness and giving that are inherent within the therapeutic relationship. Although psychotherapists expected their work to be difficult and even stressful, they also expected their efforts to be compensated.

In sum, the authors of this study suggested that the primary difficulties faced by psychotherapists were those relating to the therapeutic role (e.g., requirements of attentiveness, responsibility, detached concern), therapeutic process (e.g., the slow, often erratic pace of therapeutic progress), as well as working conditions (e.g., excessive work load, organizational politics). It is when the psychotherapeutic work is particularly frustrating and only minimally successful that disillusionment and burnout are likely to occur. Put another way, constant giving without the compensation of success likely produces burnout. This may often be the case when one is overworked or dealing with challenging clients such as those who are suicidal, homicidal, depressed, or especially resistant.

However, psychotherapeutic work also engenders considerable satisfaction as well. In particular, therapeutic work appears to be most satisfying when psychotherapists

themselves can learn and grow while being helpful and involved with others (Farber & Heifetz, 1982).

In their study of a sample of randomly selected practicing psychotherapists comprised of psychologists and social workers, Raquepaw and Miller (1989) found low to moderate levels of burnout when compared to the MBI norms, and no significant group differences were found between psychologists and social workers. Demographic variables and treatment orientation were not found to be accurate predictors of psychotherapist burnout, and psychotherapists who worked for agencies were found to have more symptoms of burnout than did colleagues who worked solely in private practice. Additionally, psychotherapists' satisfaction with their caseload was associated with burnout, rather than their actual caseload. Specifically, those who indicated that their ideal caseload would be smaller than their current caseload were more burned-out than those who were satisfied with their caseload. Burnout was also predictive of the psychotherapists' reported intentions to leave psychotherapy within the next five years for other professions. The findings of this study support Maslach's (1976) speculation that the source of burnout lies in social or situational factors, rather than in people who experience burnout. Raquepaw and Miller further noted that their findings were reminiscent of Lazarus and Folkman's (1984) conception that an individual's appraisal of a potential stressor is a substantial determinant of whether stress actually results.

2.4.8 Burnout among other mental health professionals

Psychiatrists and mental health nurses are two professional groups that have also been found to be vulnerable to occupational stress and burnout. Snibbe et al. (1989) compared burnout among 276 primary care physicians, 15 psychiatrists, 23 social workers, and 13 psychologists in large outpatient Health Maintenance Organization using the MBI. Psychiatrists and social workers were found to be susceptible to high emotional exhaustion and depersonalization.

Primary care physicians showed only moderate burnout and retained their personal coping strategies. Except for psychologists, all the providers in this study scored significantly higher on all burnout subscales than the Maslach (1986) normative population of physicians and mental health professionals. Among the mental health professionals, social workers had significantly higher scores on emotional exhaustion than psychiatrists or psychologists, and social workers and psychiatrists had significantly higher scores on depersonalization than psychologists. There were no significant differences between these groups in personal achievement.

With regard to mental health nurses, Fagin et al. (1996) presented data from three studies on stress, coping, and burnout. They found that for the sample as a whole, about 31% of the ward nurse's experienced significant psychological distress. Out of the three studies, study three nurses reported the highest rate of psychological distress.
These nurses also had significantly higher alcohol consumption and had taken more sick days.

The main stressors that these nurses faced were related to staff shortages, health service changes, poor morale, and not being notified of changes before they occurred. Furthermore, differences in coping skills were found across studies, consistently showing the group with the highest stress scores also having the lowest coping skills scores. All three studies presented by Fagin et al. confirmed that stress is a problem for ward-based mental health nurses.

2.5 Islam view in relation to stress

Although we all talk about stress, but still it is not clear to many people what stress is really about. Psychology books talk about stress as an emotional and physical reaction to change. It is normal physical and emotional responses to events that make the person feel threatened or upset his/her balance in some way. Along with, stress, in psychology books, it has also been defined as an unpleasant state of emotional and physiological arousal that

people experience in situations that they perceive as dangerous or threatening to their well-being. Moreover, the word stress itself means different things to different people. Some people define stress as events or situations that cause them to feel tension, pressure, or negative emotions such as anxiety and anger. Others view stress as the response to these situations. This response includes physiological changes—such as increased heart rate and muscle tension—as well as emotional and behavioral changes. However, most psychologists regard stress as a process involving a person's interpretation and response to a threatening event (Microsoft Corporation, 2000). Stress and coping are interrelated words, when psychologists talk about how people respond to stress; they generally use the word cope. Coping refers to the cognitive, behavioral, and emotional ways that people deal with stressful situations and includes any attempt to preserve mental and physical health even if it has limited value (Moss-Morris & Petrie, 1996). Coping is a dynamic process, not a one-time reaction—it is a series of responses involving ones interactions with the environment. The concepts of stress and coping are neutral. Although people commonly see stress as negative and coping as positive, the relationship is not that simple. Stress can be psychologically positive or negative, and the means of coping can be effective or ineffective in meeting the challenge presented by the stressful situation. The vocabulary of modern science and religion are differ markedly in defining many psychological terms related to human behavior, but they might be agreed with the term of stress and coping as unlikable state of emotions that people experience. Islamic view is not far from the above, to be more clearly let us see to gather stress and coping in Quran.

2.5.1 The Usages of Stress in Quran

When the term stress was mentioned in the Quran, it was more related to what people are experiencing in this life. It is the nature of this life that people will suffer from worries and stress, because this world is the place of disease, hardship and suffering. Hence

among the things that distinguish Paradise from this world is the fact that there is no worry or stress there: "لاَ يَمَسُّهُمْ فِيهَا نَصَبٌ وَمَا هُم مِّنْهَا بِمُخْرَجِينَ" (الحجر، آية 48)

"No sense of fatigue shall touch them, nor shall they (ever) be asked to leave" (Al-Hijr: 48).

Stress is only found on this life, because life is full of stressors; stress is anything that causes mental, physical, or spiritual tension. There is no way people can run from it. All those matters are how one deals with worries and tensions. No doubt that stress is the most common aliment of modern age. It has been implicated in the causation of different diseases as ulcer, heart, depression, hypertension, diabetes and even cancer. Common medical problems like tension headache, insomnia, and obesity are also attributed to unusual stress. None of us are free from stress but some deal with it better than others.

Many scholars agreed that stress results from fear of the unknown and trying to see through and control the destiny, losses in our life for people and things treasured to us and to our inability to recover those losses. And finally, inner conflict between our heart and mind between what is known to be the truth and our failure to accept it as truth.

Let us examine how Quran deals with such situations. But before we go into that point, I would like to highlight the mystic that Islam had made as an intensive study of stress and it is terminology for the term stress. They used words like "*Qalaq*" (worry), "*Ya's*" (despair), and "*Qunut*" (helplessness) to explain the psychological term of "stress." Now the question is why these three words are used for the explanation of the term stress? What are the differences between them? And how are they related to one another? To answer all these questions let us see together in detail the meaning of those words first. The first word for the term stress in the holy Quran is "Worry *(Qalaq)"*. It is a universal human experience, a normal concomitant of living in a world which threatens existence and which struggle against environment, both internal and external, is part of man's lot. Thus it is conditioned response to fear (Almothwahi, 1990): "وَلِمَنْ خَافَ مَقَامَ رَبِّهِ جَنَّتَانِ" (الرحمن: آية 46)

"But for such as fear the time when they will stand before (the judgment seal of) their Lord, there will be two Gardens" (Ar-Raḥmān: 46)

Whatever the type of fear is, it is always connected with worry. This worry will disappear by the time, if it does not disappear the stress will occur and the person will fail to get the certainty of its life. The second word for stress in Islam is "Despair (Ya's)". Despair not only directs man on the wrong path, but also affects the powers of the mind, and weakens them gradually, to the point of their destruction (Hussain, 1984). To make this point clearer, let us see what Allah (swt) said in the holy Quran. In surah Yusuf Allah (swt) said:

"يَا بَنِيَّ اذْهَبُواْ فَتَحَسَّسُواْ مِن يُوسُفَ وَأَخِيهِ وَلاَ تَيْأَسُواْ مِن رَّوْحِ اللّهِ إِنَّهُ لاَ يَيْأَسُ مِن رَّوْحِ اللّهِ إِلاَّ الْقَوْمُ الْكَافِرُونَ" (يوسف: آية 87)

"And despair not of Allah's mercy; surely none despair of Allah's mercy except the unbelieving people" (Yusuf: 87).

A person, who is in the state of disorder and illness, is one from who good is not expected. Allah fearing man, who is mobbed on all sides by the calamities, and misfortunes, and does not find any way out of them, he does neither loose heart, nor does he feel desperate. He rather takes the situation as an outcome of physical and material exigencies; he does not allow the inferiority complex to enter his mind. He is the man who never gets desperate of Allah's mercy, and who is sure that his share in life is attainable. On the other hand, a man of materialistic concept of life, who finds himself in such a situation, loses heart, and gets totally frustrated; he often commits suicide, for seeing no value in life. He totally depends on the material or external causes and means of life. So, when he loses everything, he is frustrated. But the possibilities of human mind have no bounds. Thus a man believes in the gift of the divine mercy, never thinks that he can do nothing now. This, in fact, is the abnegation of his own self. Man should never bow to the exigencies of material conditions (Hussain, 1984). Allah (swt) said:

"إِن يَمْسَسْكُمْ قَرْحٌ فَقَدْ مَسَّ الْقَوْمَ قَرْحٌ مِّثْلُهُ وَتِلْكَ الأيَّامُ نُدَاوِلُهَا بَيْنَ النَّاسِ وَلِيَعْلَمَ اللّهُ الَّذِينَ آمَنُواْ وَيَتَّخِذَ مِنكُمْ شُهَدَاء وَاللّهُ لاَ يُحِبُّ الظَّالِمِينَ" (آل عمران: آية 140)

“Such days (of varying fortunes) we give to men and men by turns” (Al-E-Imran: 140)

The last word for the term stress in Islam is “Helplessness (Qunut)”. The man experiences “helplessness” when he or she gets totally frustrated, and has no hope of getting anything good done in their life. As Allah (swt) said in the holy Quran:

"قُلْ يَا عِبَادِيَ الَّذِينَ أَسْرَفُوا عَلَى أَنفُسِهِمْ لَا تَقْنَطُوا مِن رَّحْمَةِ اللَّهِ إِنَّ اللَّهَ يَغْفِرُ الذُّنُوبَ جَمِيعًا إِنَّهُ هُوَ الْغَفُورُ الرَّحِيمُ"

(الزمر: آية 53)

“Say: O my servants who transgress against their souls; despair not of the mercy of God: for God forgives all sins; he is oft-forgiving, most merciful. Turn ye to your lord (in repentance) and bow to his (will), before the penalty comes on you; after that you will not be helped” (Az-Zumar: 53)

2.5.2 The Stress during Prophet's Mohammad Peace be upon him (PBUH):

The Prophets had felt stress in different occasion during his Da’awah. And it was mentioned in the book of Serah, there was a time when his people disbelieved his account of his Night Journey (Israa'). It was difficult for him to tell the truth, and people do not believe. Abu Hurayrah told us that the Messenger of Allah said**:** “I found myself in the Hijr (an area in the Haram in Makkah, near the Ka'bah), and Quryash were asking me about my Night Journey, questions about Bayt al-Maqdis that I was not sure of. I felt more distressed and anxious than I had ever felt, and then Allah raised it for me so that I could see what they were asking me about and answer all their questions…”

Based on the above, our prophet was not free from stress, so how about us a normal people whom always having problems. Sure men are not free from stress; they face different kind of stresses in this life. It is usual to see a person who is worry about his/her daily hassles as

health problems, financial security, physical safety, social acceptability, performance at work and so on. This pressure with the self is probably one of the most serious forms of worry because it prevents individuals from living stress free conditions. However, you might also see an individual who feels despair of everything in life, he/she feels difficulty to success in an education or in a job, and even winning possessions is difficult to them. Furthermore, seeing a hopelessness individual is another issue. You may see a person who loses the hopes in anything and believes that he/she is trapped in misery with no expectation of things ever getting better. Now is the question how to cope with all those types of stress? How dose our prophet Mohammad (PBUH) cope with his stressors? What Islam says about stress management? As being Muslim scholars we need to answer all those questions in order to help the Muslims Ummah find the best coping mechanisms.

2.5.3 Ways to cope with stress: An Islamic point of view

People often rely on clinical means to deal with stress; nonetheless there are many other natural ways of dealing with it as well. Some Islamic or Quran based tips to deal with stress can be useful. According to Almothwahi (1990), our prophet's Mohammad (PBUH) advice was the best to be explained at this point. Our prophet (PBUH) said:

“Leave what makes you suspicious to what makes you not”.

Almothwahi (1990) added that *Salat* and *dhiker* are the best way to prevent such feelings like worry. Therefore, Allah said:

"الَّذِينَ آمَنُواْ وَتَطْمَئِنُّ قُلُوبُهُم بِذِكْرِ اللّهِ أَلاَ بِذِكْرِ اللّهِ تَطْمَئِنُّ الْقُلُوبُ" (الرعد: آية 28)

“For those who believe and work righteousness, is (every) blessedness, and a beautiful place of (final) return” (Ar-r'aed:28).

According to Karim (1984), the best way that Islam chooses to treat it is Ummah in the generation of chemicals through the mediation of dhikr “ stag”, the tasbih “magnification,” and the Salat “prayer” for mental stability and for curing the mentally ill. He also added, religious basis was recognized by the Prophet (saw) and confirmed by the latest work,

where Allah generates in man a tremendous spiritual energy, which changes his attitude toward life and alters his attitude toward the world. From looking inwards he begins to look outwards and thus he enters society (Karim, 1984). It is this faith, which the Quran alludes to the prophet (saw) knew that the emotions have a profound effect upon health, which is evident from the Hadith, that when a man came for advice, he was told never to be angry. This is confirmed in the Quran where "those who restrain their anger" are promised the rewards of paradise.

"الَّذِينَ يُنفِقُونَ فِي السَّرَّاء وَالضَّرَّاء وَالْكَاظِمِينَ الْغَيْظَ وَالْعَافِينَ عَنِ النَّاسِ وَاللّهُ يُحِبُّ الْمُحْسِنِينَ" (آل عمران: آية 134)

"Who spend [in the cause of Allah] during ease and hardship and who restrain anger and who pardon the people - and Allah loves the doers of good" (Al-'imran: 134)

The act of wudu' "ablution" and the salat "prayer," plus the mental preparation and participation, lead to the development of one‟s state of calmness, peace, and relaxation, since it entails forbearance, tolerance, and forgiveness and nobility. *The Special Issue on*

The Prophet (PBUH) also prescribed unique remedies for the treatment of sorrow, apprehension and fear, the major components in stress. He prescribed the reading of the holy Quran specially the Muwathatayn (surat al-Nas and al-Falaq), which teach man how to seek refuge in Allah and ask his protection. These are anchors in the present-day treatment of the neurosis that base is in security and helplessness (Karim, 1984). Of the Islamic rituals the most important is the salat. The salat engenders a state of homeostasis in the body, since the period of work stress is interrupted to allow the body to come to rest again. It has been found that during stress, hormones are released which are of the corticosteroid group responsible for hypertension with its sequel of heart attacks and cardiac failure, gastric ulcers, and nervous disorders. In mental sphere, salaat, which requires a reliance on one's creator, will prevent and cure most of neuroses, depression, and major psychosis (Karim, 1984). It is agreed in Islamic books that salat has physical benefits as well as psychological benefits. Psychologically, the salat promotes mental stability and calmness; it also leads to the mental relaxation and emotional well-being. Moreover, the function of the

salat is to prevent the person from Al-Fahsha' (i.e. great sins of every kind, unlawful sexual, and other bad behavior). It also makes the person behave well in all matter of life. Physically, the salat leads to good health as person exercise while performing the prayer five times a day.

2.6 Burnout and social support

Research shows that burnout could play an important role in reducing burnout. In the following paragraphs the concept of social support, the forms of Social support, the social support theories and relationship with burnout is presented.

2.6.1 Social support

Different researchers have differently defined social support. For example, Hagihara, et al (1998) defined social support as "the provision and receipt of tangible and intangible goals, services, and benefits (such as encouragement and reassurance) in the context of informational relationships (e.g., family, friends, co-worker and boss)." It has been argued that social support is too complex to be limited to a single theoretical concept (Vanx, 1988), as a result comprehensive models that incorporate the major elements of most current conceptualization of social support have been developed (Cutronor and Russell, 1987).

In another study, Hupcey (1998) described social support as well intentioned action, willingly given to a person with whom one has a personal relationship, which produces a positive response in the recipient. Social support has also been defined as the physical and emotional comfort given to us by our family, friend, coworker and others. It knows that we are part of a community of people who love and care for us, valued and think well of us. It is the "sum of the social emotional and instrumental exchanges with which the individual is involved having the subjective consequence that an individual sees him or herself an object of continuing valued in the eyes of significant other" (Gordy, 1996).

The researcher was briefed on the study of (Sarason & et. Al, 1990) define it as the "existence or availability of people on whom we can rely, people who let us know that they care about, value, and love us" Saranson et al. claim that direct assistance, advice, encouragement, companionship, and expressions of affection have all been associated with positive outcomes for persons facing life's various strains and dilemmas. Typically support would be would be expected to come from family, friends, and/or fellow workers.

In another study, Kahn (1985) describes social support as interactions that include one or more of the following: the expression of positive affect of one person toward another; the endorsement of another person's behaviors, perceptions, or expressed views; and/or the giving of symbolic or material aid to another.

In a featured study, Cobb presented a paper (1976) which emphasized the highly subjective natured of social support. Cobb said it was information which leads a subject to believe that he/she (1) is cared for and loved (2) is esteemed and valued and/or (3) belongs to a network or communication and mutual obligation. So it did not just that assistance is offered in an interaction, it is necessary that the recipient believe something about the offer. This idea makes very good sense. If an interaction take place which offers help and the receiver of the offer does not believe it, then that individual cannot feel much supported. This is the case with all sorts of communicative messages. No matter what was said, it is what was understood that ends up being communicated and making the difference.

In another study, Hupcey (1998) summed up all of the theoretical definitions in the following way as including all or part of the previous concerns and emphases: (a) the act of providing a resource, (b) the result of which is that the recipient has a sense of well-being or of being cared for, (c) there is an implied positive outcome, and (d) there is an existing relationship between the recipient and provider.

In identifying those components as essential to the definition, Hupcey leaves out some aspects that others have included and thought important such as (a.) social climate or environment, (b.) personal charateristics of either the provider or recipient, (c.) network

resource, (d.) negative support (such as "tough love"), (e.) reciprocity (a kind of "payback"), and (f.) the costs and benefits of giving and receiving support.

2.6.2 The Forms of social support

Let us say that one person has offered support to another person. What are the various forms which that support may take? Although there are various ways of making offers, some of them with multiple or overlapping purposes, they are only six categories. These are emotional, instrumental, informational, appraisal, network and companionship. There are defined as follows:

1) Emotional support consists of comfort and security from others leading the effected person to believe that he/she is cared for by others (Sarason et al, 1990). Emotional support conveys the idea that a person is valued for his or her own worth and is accepted. This kind of support may result in the enhancement of self-esteem. (wan, Jaccard & Ramey,1996).

2) Instrumental support refers to acts such as loaning money or giving of one's time. It is also called "tangible support" because it involves the giving of material resources or services (Wan, Jaccard & Ramy, 1996).

3) Informational support consists mainly of advice and counsel. While this might be helpful, it is my experience that oftentimes people ask for advice when all they want is for someone to listen to them. If you are a good listener, the person may believe that you have given them good advice when what is actually the case is that they feel understood.

4) Appraisal support refers to evaluative feedback (Tardy, 1992). We all need feedback whether we want it or not. Sometimes the person who provides this is "reality check" who confronts rationalizations or other escape mechanisms.Sometimes this takes the form of encouragement. Typically, we need positive as well as negative feedback.

5) Network support refers to being a member of a group or being put in touch with a group with common interests and concerns (Saranson & et. al, 1990). These are usually more than casual acquaintanceships or shared recreation. You might view the AA as one of these

groups, or a breast cancer survivor group, or a gay/lesbian support group. It is not unusual for people to say that support groups they are members of are extremely important to them, 6) Companionship support means having someone to share life's experiences with. It distracts people from their problems and provides feelings of belongingness (Wan, Jaccard & Ramy, 1996) Non-intimates as well as intimates can be companions (Tardy, 1992).

2.6.3 Factors related to social support:

Many studies have demonstrated that being integrated into social networks and receiving high levels of social support are important for mental health and well-being particularly for women (Kessler and Mclead, 1995; Alarie, 1996). The number of social contacts, both close and not too close, is related to higher levels of well-being. Within relationships, different types of support from different sources may benefit health-such as emotional, practical and informational support (House and Kalin, 1995). Stansfeld and Sprooton (2002); Alarie (1996) in their different studies observed that, on the other hand, close relationship may be stressful as well as stress relieving, and high levels of negative interaction within relationship increase the risk of mental ill health.

Two pathways for the influence of social support on health have been postulated. These are the "direct" effects and "buffering" effects. The direct pathway implies that levels of social support and social contact act to improve levels of well-being, or enhanced self-appraisal and self-esteem, positively influencing mental health (Cohen, 1985), while the buffering hypothesis implies that social support only influences health in the context of exposure to acute or chronic stressor (Alloway and Bebbington, 1987). In this situation, persons exposed to stressors are helped, either in reappraising the threat implicated in the stressor, or in coping with the consequence of the stressor or through emotional, informational or material support.

Studies have equally demonstrated that lack of social support has been etiologically linked to common mental disorder. Stansfeld and Strooton (2002) argued that it is possible that differing patterns of support might contribute to the explanation of differences between

ethnic groups in rates of mental disorder. For example, it has been suggested that the fact that south Asian people in the UK show relatively low rates of common mental disorder, in spite of the high levels of social disadvantage faced by ethnic minority groups, is a consequence of the extended social support networks characteristic of Asian culture, which may be protective of mental health (Cochrane and Bal, 1989, Halpern, 1993). Others have, however, criticized the stereotyped basis of this theory (Sashidaran, 1993). Close relationships are not always beneficial to health, as there may be scope for conflict as well as support (Stansfeld and Sprooton, 2002). Analyses of immigrant mortality statistics show that mortality rates from suicide are higher among young women of south Asian origin, and that this is particularly the case for young women age 15 to 24 where the rate is two to three times the national average (Soni, Bulusu and Balajaran, 1990). Soni and Balajaran (1992) concluded that, "it is possible that intense close relationships in these families coupled with intergenerational cultural conflicts might increase suicide risk in these young women.

Some recent studies had also proved that the presence of a socially supportive person reduces cardiovascular reactivity in socially threatening situation (Quigley, 2003). It was noted that males and females had different preferred source of social support. Brondolo, argued that men may benefit more than women from coworker support because close social relationships may sometimes be a source of stress or demand for women. Kendler (2005) in a study observed that women are" often socialized to develop their sense of self from their relationships or the quality of their relationship" .As a result when women feel that their relationships are poor, this has enormous influence on their emotional well-being. He further noted that support from family and spouse appears to mean somewhat more to women than men.

And for Examples of relevant studies, Green (1993) argued that there is clear causal direction in the relationship between social support and health, that it is possible that good social support promotes psychological well-being which in turn promotes good health. He however, admitted that it is possible that those with good health find psychological

adaptation easier, which then attracts a wider support .In another study, it has been postulated that high levels of social support were associated with faster and more extensive recovery of function after a stroke, and that social support may be an important prognostic factor in recovery (Gordly, 1996). Pines, Aronson and Kafry (1981) observed that social support has been well documented as a highly effective intervention for coping with burnout. Hansen, Isacsson and Janzen (1990), Lought and Shank (1996), argued that the relationship between physical health and social support for women is complex and not well established. Therefore, due to conflicting result in various studies, Pender (1996) called for further investigation of how social support impacts health promoting lifestyles of women.

In another study, Aaronson (1989) found that perceived and received support contributes to a pregnant woman sustaining good health practice and recommended health behaviours. In a study investigating health status and social support of the older women, the result showed that the perception of positive health status and social support do not decline with age (Lough and Shank, 1996). Social support was viewed as beneficial in both smoking cessation programmes and decreasing symptoms related to premenstrual syndrome (Hansen, Isacsson, and Janzon, 1990; Morse, 1997). A study that compares the health practices of rural women with those of a large metropolitan area, it was found that rural women adopted more health practices overall than their urban counterparts. Younger women in both groups exhibited more awareness of health promotion.

2.6.4 The relationship between social support and burnout

The literature asserts that health care professionals who experience a sense of isolation, have minimal contact with others who are exposed to similar problems, and lack opportunities to express emotionally charged feelings, are likely to be more prone to developing burnout (Ross, 1993). Researchers have consistently found that persons who have high levels of social support are in better physical and mental health, and it has been identified as a resource that enables people to cope with stress (Ross & et. al, 1989).

The majority of research has found social support, in general, to be negatively related to burnout (Leiter & Maslach, 1988; Ross &et. al, 1989; Slagle, 1996; Mueller, 1997; Kee & et. al, 2002).

Lack of social support has also been found to be a significant predictor of burnout even after controlling for the effects of anxiety (Brown, Prashanham, & Abbott, 2003). However, the measurement of social support is complex due to the great degree of variability in the definitions that have been used to measure it.

Various forms of social support have found distinct relationships with the dimensions of burnout. Perceived social support was strongly related to emotional exhaustion and depersonalization, but not with reduced personal accomplishment (Brown & et. al, 2003).

This is contrary to Leiter's (1991a) assertions that, in general, social support tends to be more closely related to the personal accomplishment dimension of burnout. When measured as pleasant contact with different sources of social support, pleasant contact with supervisors was negatively related to emotional exhaustion, while pleasant contact with co-workers was positively related to personal accomplishment (Leiter & Maslach, 1988). Alternatively, personal conflicts with co-workers, supervisors, or service recipients were more related to increased emotional exhaustion (Leiter, 1991a). Cianfrini (1997) found that support from friends, family, and co-workers were related to all three dimensions of burnout, with higher levels of support correlating with higher levels of personal accomplishment and lower levels of emotional exhaustion and depersonalization. This is generally consistent with the review by Leiter and Harvie (1996) who found that support from family members was inversely related to both emotional exhaustion and depersonalization in mental health professionals. In addition to support from supervisors and co-workers, social support from family may also serve as an important resource for human service providers by building their capacity to manage the emotional demands of work. However, difficulty in managing the boundary between work and family has been

identified as a contributor to emotional exhaustion and depersonalization (Leiter, 1990; Leiter & Durup, 1996).

Much of the research on social support and burnout found that persons with limited supportive social relationships tend to be more vulnerable to the effects of stress.

Although a direct relationship between social support and burnout has been documented, the empirical evidence with regard to the buffering hypothesis in the stress-burnout relationship is mixed (Ross e al., 1989).

It has been found that strong social support enables human service providers to manage more severe demands at work; thus, buffering against the negative effects of occupational stress (Cohen & Willis, 1985; Kirmeyer & Dougherty, 1988; Fagin et al., 1996).

This suggests that demands and social interactions at work are relevant to the development and alleviation of burnout (Maslach & et.al, 1996), and this has been documented in studies involving burnout in mental health professionals (Coyle & et.al, 2005; Cianfrini, 1997). However, not all studies found support for the buffering role of social support against burnout in mental health professionals (Ross & et.al, 1989; McCarthy, 2000; Ankarlo, 1999). It has been argued that the buffering effects of social support will only be found when specific types of social support are examined with relation to the specific stressor being investigated (Ross & et.al, 1989).

Nevertheless, social support at work (i.e., supervisor and co-worker support) has positive effects on the physical and mental health of workers (Ross & et.al, 1989). Increasing social support has been well documented as a highly effective intervention for coping with burnout (Pines, Aronson, & Kafry, 1981).

Chapter Three

Literature Review

The Literature Review

Introduction

The burnout is a common phenomenon for staff in the human service professions, particularly in teaching, medical services, counseling, and social work. The number of workers in human services has increased fourfold since the late 1880's, thereby increasing the potential for more burnout in the human service workforce. One reason such workers burn out easily is their humanitarian attitude (Elamassi, A. 2007). Those personality characteristics contributing to these workers' desire to care for people seem to place them at a higher risk of burnout. So I will explore all the related literature as follow:

1- **Bawih N. (2012): The level of burnout students of social sciences department at the University of Ouargla**.

The study objective: in study to identify the psychological burnout's level among the students of social sciences department at the university of Ouargla « Kasdi Marbah ». taking into consideration the following variation as gender, specialties (Psychology, Educational), lifestyles (internal, external) and the effect of these later on the burnout's level.

Target group of the study: the researcher has used the module of the burnout designed to gather the information to this study where she applied it on an amount of fourth year student of the psychological department from the university of Ouargla, the informants are 170 , they were chosen at random, and it was relied on the statistics, treatment of the shows on the repetition , the percentages and the calculation's averages also the value « **T** » to supply the differences.

The study result: the study resolute the following results : 1- There's no differences show statistically between the student's averages following the variation of gender (male. Female), 2- The increase of the burnout level among the students. 3- There's no differences

shown statically between the student's averages following the variation of lifestyles (internal, external). 4- There's no difference shown among the student's averages following the variation of specialties (psychology, educational).

2- **Segal S. & et.al (2010):Self-Help and community Mental Health Agency outcomes for persons with serious mental illness.**

The study objective : in study to determine the effectiveness of combined SHA (Self-help agencies) and community mental health agency (CMHA) services in assisting recovery for persons with serious mental illness.

Target group of the study: A weighted sample of new clients seeking CMHA services was randomly assigned to regular CMHA services or to combined SHA-CMHA services at five proximally located pairs of SHA drop-in centers and county CMHAs. Member-clients (N=505) were assessed at baseline and at one, three, and eight months on five recovery-focused outcome measures: personal empowerment, self-efficacy, social integration, hope, and psychological functioning. Scales had high levels of reliability and independently established validity.

The study result: Outcomes were evaluated with a repeated-measures multivariate analysis of covariance. The study found that combined SHA-CMHA services were significantly better able to promote recovery of client-members than CMHA services alone.

3- **Abu masood S., (2010): Job burning phenomenon among administrative staff in the Ministry of Education and Higher Education in the Gaza Strip - causes and treatment.**

The study objective :in study aimed to recognizing the extent to which burnout spread out and its causes among administrative employees at Ministry of Education and Higher Education and the directorates of education belongs to it in Gaza strip and finding out the

relationship between the level of burnout and number of demographic variables (sex, age, experience, marital status, managerial level , salary , educational level).

Target group of the study: The study population consisted of 821 employees a sample (n 258) was chosen randomly the response percentage was 86%. The researcher used a questionnaire consisted of three parts the first examined the personal characteristic, the second measured the level of burnout (the researcher used here Maslach Burnout Inventory after be changed to be suitable to the study), the third part consisted of the causes of burnout. The researcher used the statistical program SPSS to analyze the information collected and to get the results of the study.

The study result: The main results of the study was that the administrative staff at the Ministry of Education in Gaza Strip suffer from the average Level of burnout at the (Emotional exhaustion & Depersonalization) dimensions, and low level at the third dimension of burnout (personal accomplishment),the findings also showed that there was a negative significant correlation between (lack of positive reinforcement , low level of control and the level of burnout at its three dimensions. But there was a positive significant correlation between (work load –values conflict – and lack of social relationships) and the level of burnout at its three dimensions, the findings also showed that differences were significant between (age, experience, marital status, managerial level, educational level) and the level of burnout at its three dimensions.

4- Paris M. and Hoge M., (2009):Burnout in the Mental Health Workforce.

The study objective: in study to provide such a review by examining the construct of burnout, methodological and measurement issues, its prevalence in the mental health workforce, correlates of burnout, and interventions to decrease it.

Target group of the study: A review of the relevant menial health literature from 1990 to 2009 was conducted. Numerous databases, such as PsycINFO, MEDLINE, CINAHL, BIOS1S, AMED, Cochrane Database of Systematic Reviews, Web of Science, Infotrac,

Global Health, PubMed, and EMBASE, were utilized, yielding 145 articles related to issues of burnout in behavioral health. It is of note that 87 of the articles focused exclusively on international findings (particularly the UK), while 16 combined US and international findings. Only 38 focused solely on the USA.

The study result: The study found that Burnout was first introduced in the literature by Herbert J. Freudenberg as a concept related to frontline human service workers. Through his experiences working in a free clinic, he articulated a set of symptoms commonly associated with burnout, identified the types of individuals who were and other human services fields in burnout and its relationship to variables, such as turnover, absenteeism, and the psychological and physical health of employees. Due to the potential negative impact of burnout, a number of researchers developed measures that have further defined this construct. The most commonly cited measures include the Staff Burnout Scale for Health Professionals, the Burnout Measure, and the Maslach Burnout Inventory.

5- **Kermode M. & et.al (2009): Attitudes to people with mental disorders: a mental health literacy survey in a rural area of Maharashtra.**

The study objective: in study used a cross-sectional mental health literacy survey.

Target group of the study: A questionnaire was administered to 240 systematically sampled community members and 60 village health workers (VHWs). Participants were presented with two vignettes describing people experiencing symptoms of mental disorders (depression, psychosis); they were asked about the causes of the problems and the vulnerabilities of community sub-groups. Additionally, the General Health Questionnaire (GHQ12) was administered to assess prevalence of possible common mental disorders.

The study result: The most commonly acknowledged causes of the problems were a range of socioeconomic factors. Supernatural and biological explanations were not widely endorsed. Women, the unemployed and the poor were judged as more likely to develop mental disorders, while both young and older people were perceived to be less vulnerable.

Results of the GHQ12 indicated that 27% had a possible common mental disorder and that the elderly were at increased risk, contrary to community perceptions. The study Concluded that enhancing mental health literacy of both VHWs and community members using approaches that are sensitive to local conceptualizations of mental health and illness will contribute to improved treatment and care for people with mental disorders. Further investigation of mental health among the elderly in this community is indicated.

6- **La salvia A. & et.al (2009): Influence of perceived organizational factors on job burnout: survey of community mental health staff**.

The study objective: in study to explore the relative weight of job-related characteristics and perceived organizational factors in predicting burnout in staff working in community-based psychiatric services.

Target group of the study: A representative sample of 2000 mental health staff working in the Veneto region, Italy, participated. Burnout and perceived organizational factors were assessed by using the Organizational Checkup Survey.

The study result :Overall, high levels of job distress affected nearly two-thirds of the psychiatric staff and one in five staff members suffered from burnout. Psychiatrists and social workers reported the highest levels of burnout, and support workers and psychologists, the lowest. Burnout was mostly predicted by a higher frequency of face-to-face interaction with users, longer tenure in mental healthcare, weak work group cohesion and perceived unfairness. It concluded that improving the workplace atmosphere within psychiatric services should be one of the most important targets in staff burnout prevention strategies. The potential benefits of such programmed may, in turn, have a favorable impact on patient outcomes.

7- **Ean L., (2007): Study on the job satisfaction and burnout among medical social workers in government hospitals in Malaysia**

The study objective: in study to find the association between the individual / demographic factors of the medical social workers to the Human Service Job Satisfaction.

Target group of the study: Questionnaire scores (HSJSQ scores), and it identified other important factors which influenced the medical social workers' job satisfaction and burnout levels. The respondents were 143 social workers who worked in 58 hospitals. Data was collected by questionnaire and the instrument used was the Human Service Job Satisfaction Questionnaire (HSJSQ). The questionnaire had two open ended questions which asked the social workers to explain (1) why they were satisfied or dissatisfied and (2) why they suffered or did not suffer from burnout with their jobs.

The study result: Findings showed that overall the social workers were satisfied with their jobs. The demographic variables of the medical social workers did not have significant associations with the HSJSQ scores. The individual / demographic factors were the main reasons for them being satisfied whereas the organizational factors were the main reasons for them suffering from burnout.

8- **Elamassi A., (2007): psychological factors Associated with burnout among nurses.**

The study objective : to assess the psychological factors associated with Burnout among nurses.

Target group of the study : In order to test the hypotheses the descriptive analysis style followed, the sample consist of 122 nurse distributed in 5 hospitals, The selected Nursing are classified under the various types of work fields like Neonatal intensive care unit, The artificial kidney unit, The cancer unit, The female medical department, chest unit department, emergency department, burn intensive care unit, obstetric department, medical child departments, ophthalmology hospital, and others. The tools used in the study: Burnout inventory checklist, Work stress checklist, Social support checklist, Personal data sheet

(sex, age, years of experience, place of work).Statistical methods which followed in the study were: Frequencies and Percentile, Alpha- Cronbach Test for measuring reliability of the items of the questionnaires, Person correlation coefficients for measuring validity of the items of the questionnaires, Spearman– Brown Coefficient ,One sample t test, Independent samples t test, One way ANOVA.

The study result : The results of the study: the total score of burnout percentage is 50%,the work stress was 72%, the social support was 70%, the did total score of burnout percentage did not affected by the variables like sex, age, educational level, place of work, nurses experience at significant level (a == 0.05).

9- **Evans SH. & et.al (2006): Mental health, burnout and job satisfaction among mental health social workers in England and Wales**.

The study objective: in study to examine the prevalence of stress and burnout, and job satisfaction among mental health social workers (MHSWs) and the factors responsible for this.

Target group of the study: It used A postal survey incorporating the General Health Questionnaire, Maslach Burnout Inventory, Karasek Job Content Questionnaire and a job satisfaction measure was sent to 610 MHSWs in England and Wales. Results of this study was Eligible respondents (n= 237) reported high levels of stress and emotional exhaustion and low levels of job satisfaction.

The study result: (47%) showed significant symptomatology and distress, which is twice the level reported by similar surveys of psychiatrists. Feeling undervalued at work, excessive job demands, limited latitude in decision-making, and unhappiness about the place of MHSWs in modern services contributed to the poor job satisfaction and most aspects of burnout. Those who had approved social worker status had greater dissatisfaction. The study concluded that Stress may exacerbate recruitment and retention

problems. Employers must recognize the demands placed upon MHSWs and value their contribution to mental health services.

The burnout syndrome may be defined as a complex phenomenon which is characterized by three components: emotional burnout (physical and psychical exhaustion, incapability to carry on requirements), depersonalization (cynical attitude towards performed work, duties, cold or negative reaction to the patients), and lowered efficiency (reflected by the sense of incompetence, the lack of efficiency and achievements). This process is progressing slowly for a long time and is characterized individually by various psychical and physical symptoms of different intensity.

10- Vimantaite R. & Seskevicius A.,(2006): The burnout syndrome among nurses working in Lithuanian cardiac surgery centers.

The study objective: The study examine the manifestation of burnout syndrome and to estimate the influence of the syndrome on the behavior and practice of the nurses in cardiac surgery units of Lithuania (to evaluate physiological and psychological symptoms of the burnout).

Target group of the study: This study was performed using a questionnaire. A total of 180 questionnaires completed by nurses in Lithuanian cardiac surgical centers (Vilnius, Kaunas, and Klaipeda) were analyzed.

The study result: The study revealed that 72.8% of nurses had an excess of workload (exceeding full-time job). Most of the respondents (84.4%) pointed out the emotional stress, unevaluated work and underpayment. Three-fourths of the nurses (75%) indicated that they felt physical fatigue after their work. More than half of nurses (67.2%) felt general fatigue, 63.3% reported the leg pains after the work, and 32.2% feel splitting headaches. Psychological fatigue was stressed by 86.1% of specialists. The main causes of psychological stress are as follows: the communication with the doctors in 57% of the cases, communication with the patient's relatives in 52% of cases, communication with the

nursing administration in 49% of cases, and communication with the patients in 40% of cases. The study concluded that the majority of the nurses working in the centers of cardiac surgery experience physical and psychological fatigue, emotional stress. All this determinates the dissatisfaction in the work, conflicts rising between the nurse and job environment. Above-mentioned symptoms show the progression of the burnout syndrome.

11- **Piko BF., (2006): Burnout, role conflict, job satisfaction and psychosocial health among Hungarian health care staff: a questionnaire survey.**

The study objective: study investigated the interrelationships among burnout, role conflict and job satisfaction in a sample of Hungarian health care staff. The study also investigated how these indicators of psychosocial work climate influence respondents' frequency of psychosomatic symptoms.

Target group of the study: A questionnaire survey (anonymous questionnaires) has been carried out to detect these interrelationships. Questionnaire contained items on work and health-related information (i.e., burnout, job satisfaction, role conflict, and psychosomatic symptoms) and on some basic socio-demographics. Beyond descriptive statistics, correlation and multiple regression analyses were computed. Questionnaires were distributed to 450 health care staff among whom 55.7% were registered nurses. Altogether, 201 questionnaires were returned and analyzed, giving a response rate of 44.6%. Findings show that emotional exhaustion and depersonalization scores were higher, while scores on personal accomplishment was lower as compared to Canadian, Norwegian or US samples. Burnout, particularly emotional exhaustion ($p<.001$), was found to be strongly related to job dissatisfaction. Schooling was inversely related to satisfaction with the job ($p<.05$). While job satisfaction was a negative predictor of each type of burnout subscale ($p<.001$), role conflict was a factor contributing positively to emotional exhaustion ($p<.001$) and depersonalization scores ($p<.001$).

The study result: The study results underline the importance of the role of psychosocial work environment and the interrelationships among burnout, role conflict, job satisfaction and psychosomatic health among Hungarian health care staff.

12- Zhu, et.al (2006): Job burnout and contributing factors for nurses.

The study objective: in study to investigate the degree of job burnout and contributing factors for nurses.

Target group of the study: A total of 495 nurses from three provincial hospitals were randomly selected. The MBI-GS, EPQ-RSC and OSI-R were administered to measure job burnout, personality traits and occupational stress, respectively.

The study result: The study results revealed that medical and surgical nurses had significant greater scores of job burnout than others ($P < 0.05$). The poorer educational background was correlated with lower professional efficacy. The younger nurses had stronger feeling of job burnout. The scores of job burnout changed with different personality traits. The main contributing variables to exhaustion were overload, sense of responsibility, role insufficient and self-care ($P < 0.05$). The main contributing variables to cynicism were role insufficiency, role boundary, sense of responsibility and self-care ($P < 0.05$). The main contributing variables to professional inefficacy were role insufficiency, social support and rational/cognitive coping ($P < 0.05$). The study concluded that Job burnout for nurses can be prevented by reducing or keeping moderate professional duties and responsibility, making clearer job descriptions, promoting leisure activities, and enhancing self-care capabilities.

13- Deborah E. & et.al (2006): Clinical supervision and burnout: the influence of clinical supervision for community mental health nurses.

The study objective: in study to establish the degree to which clinical supervision might influence levels of reported burnout in community mental health nurses in Wales, UK.

Target group of the study: The research instruments used were the Maslach Burnout Inventory and the Manchester Clinical Supervision Scale. At the time of the survey 817

community mental health nurses were reported to work within Wales. Two hundred and sixty (32%) community mental health nurses working in 11 NHS Trusts responded to the survey.

The study result: The results show that One hundred and eighty-nine (73%) community mental health nurses had experience of clinical supervision in their present posts and 105 (40%) in their previous posts. The findings from the Maslach Burnout Inventory indicated high levels of emotional exhaustion for 36%, high levels of depersonalization for 12% and low levels of personal accomplishment for 10% of the community mental health nurses surveyed. Univariate analysis showed that those community mental health nurses who were younger, male and who had not experienced six or more sessions of clinical supervision were more likely to report cold negative attitudes towards their clients as indicated by higher scores on the depersonalization subscale of the Maslach Burnout Inventory. One hundred and sixty-six community mental health nurses had experienced six or more sessions of clinical supervision and had completed the Maslach Burnout Inventory. Higher scores on the Manchester Clinical Supervision Scale were also associated with lower levels of measured burnout, with significant negative correlations between the total Manchester Clinical Supervision Scale score and the emotional exhaustion subscale ($r = -0.148$, $P = 0.050$) and the depersonalization subscale ($r = -0.220$, $P = 0.003$) of the Maslach Burnout Inventory. These findings suggest that if clinical supervision is effective then community mental health nurses are likely to report lower levels of emotional exhaustion and depersonalization. The findings from this study suggest that if clinical supervision is effective then community mental health nurses report lower levels of burnout. Further research is required to determine the long-term benefits of implementing clinical supervision and to determine which other factors have an influence on levels of burnout for this group of nurses. Health service organizations have a responsibility for ensuring that all individual practitioners have access to effective clinical supervision and the Nursing and

Midwifery Council could extend the registered nurses personal accountability to include - seeking clinical supervision as and when necessary.

14- **Swoboda H. & et.al (2005): Job satisfaction and burnout in professionals in Austrian mental health services**.

The study objective: In study to explore job satisfaction, professional role and burnout among community mental health staff in Austria.

Target group of the study: It used the Minnesota Job Satisfaction Questionnaire, the GHQ-12, the Maslach Burnout Inventory and a questionnaire exploring staff's professional role and team identity were administered to 195 community-based mental health professionals in two Austrian regions. Staff's job perception was assessed in open questions. Predictors of burnout scores were identified in multivariate analyses.

The study result: The study results shows that while the mental health professionals had elevated scores on the GHQ-12, their levels on the three burnout subscales were low. Social workers and psychologists showed the lowest job satisfaction, social workers also had low role identity scores. Being in the current job for a short time and disposing of psychosocial skills were predictors of high job satisfaction. High burnout scores were predicted by the lack of basic psychosocial competence and a lack of general knowledge in mental health care. The effect of caseload on psychological well-being was positive as well as negative. It concluded that even if the mental health professionals in our study show high levels of general stress, they seem to have less emotional problems resulting from extensively dealing with troubled individuals. Improving basic psychosocial competence and general expertise in mental health care might have a protective effect against developing a burnout syndrome.

15- **Vahey & et.al (2004): Nurse burnout and patient satisfaction.**

The study objective: in study examines the effect of the nurse work environment on nurse burnout, and the effects of the nurse work environment and nurse burnout on patients' satisfaction with their nursing care.

Target group of the study: They conducted cross-sectional surveys of nurses (N=820) and patients (N=621) from 40 units in 20 urban hospitals across the United States. Nurse Surveys included measures of nurses' practice environments derived from the revised Nursing Work Index (NWI-R) and nurse outcomes measured by the Maslach Burnout Inventory (MBI) and intentions to leave. Patients were interviewed about their satisfaction with nursing care using the La Monica-Obverts Patient Satisfaction Scale (LOPSS).

The study result: The study results shows that Patients cared for on units that nurses characterized as having adequate staff, good administrative support for nursing care, and good relations between doctors and nurses were more than twice likely as other patients to report high satisfaction with their care, and their nurses reported significantly lower burnout. The overall level of nurse burnout on hospital units also affected patient satisfaction. The study concluded that improvements in nurses' work environments in hospitals have the potential to simultaneously reduce nurses' high levels of job burnout and risk of turnover and increase patients' satisfaction with their care.

16- **Schaufeli W. and Bakker A., (2004): Job demands, job resources, and their relationship with burnout and engagement: a multi-sample study**.

The study objective: in study focused on burnout and its positive antipode—engagement.

Target group of the study: A model is tested in which burnout and engagement has different predictors and different possible consequences. Structural equation modeling was used to simultaneously analyze data from four independent occupational samples (total N= 1698).

The study result: Results confirm the hypothesized model indicating that: (1) burnout and engagement are negatively related, sharing between 10 per cent and 25 per cent of their variances; (2) burnout is mainly predicted by job demands but also by lack of job resources, whereas engagement is exclusively predicted by available job resources; (3) burnout is related to health problems as well as to turnover intention, whereas engagement is related only to the latter; (4) burnout mediates the relationship between job demands and health

problems, whereas engagement mediates the relationship between job resources and turnover intention. The fact that burnout and engagement exhibit different patterns of possible causes and consequences implies that different intervention strategies should be used when burnout is to be reduced or engagement is to be enhanced.

17- **Haejung L. & et.al (2003): A comprehensive model for predicting burnout in Korean nurses.**

The study objective: in study purposed to understand the phenomenon of burnout among Korean nurses.

Target group of the study: A comprehensive model of burnout was examined to identify significant predictors among individual characteristics, job stress and personal resource, with the intention of providing a basis for individual and organizational interventions to reduce levels of burnout experienced by Korean nurses. A cross-sectional correlation design was used. A sample of 178 nurses from general hospitals in southern Korea was surveyed from May 1999 to March 2000. The data were collected using paper and pencil self-rating questionnaires and analyzed using descriptive statistics, Pearson correlations, and hierarchical multiple regression.

The study result: The study results shows that Korean nurses reported higher levels of burnout than nurses in western countries such as Germany, Canada, the United Kingdom and the United States of America. Nurses who experienced higher job stress, showed lower cognitive empathy and empowerment, and worked in night shifts at tertiary hospitals were more likely to experience burnout. The study concluded that identifying a comprehensive model of burnout among Korean nurses is an essential step to develop effective managerial strategies to reduce the problem. Suggestions to reduce the level of burnout include enhancing nurses' cognitive empathy and perceived power, providing clear job descriptions and work expectations, and exploring nurses' shift preferences, especially at tertiary hospitals. In future research we recommend recruiting nurses from broader geographical areas using random selection in order to increase the generalizability of the findings.

Comments on the Literature Review:

From the previous literature review one notice that burnout syndrome is a psychological problem the mental health workers suffered all over the world, cause serious problems which affects the acts of the nurse in his job.

As we read, the researcher notice that all the studies share in focus on persons with serious mental illness-especially burnout-, such as: Evans, Sh. and etc. (2006) study, and Bhui, k. and etc. (2006) study, Kermode, M. and etc. (2009) study, and Leiter, M. and etc. (2009) study. And most of it depended on previous studies to explain or to investigate the relationships between burnout and the other variables.

Previous studies showed the use of different methods (questioners, a multidimensional model, etc.) to collect data and to highlight results. It also showed the application of studies on different societies and on different samples.

Also the researcher summarized the results of previous studies as follow:

- Burnout was significantly negatively correlated with age, professional experience, intrinsic and extrinsic work conditions, and social support from colleagues within the organization and from the agency head.
- Burnout was first introduced in the literature by Herbert J. Freudenberg as a concept related to frontline human service workers.
- Due to the potential negative impact of burnout, a number of researchers developed measures that have further defined this construct. The most commonly cited measures include the Staff Burnout Scale for Health Professionals, the Burnout Measure, and the Maslach Burnout Inventory.
- High levels of job distress affected nearly two-thirds of the psychiatric staff and one in five staff members suffered from burnout. Psychiatrists and social workers reported the highest levels of burnout, and support workers and psychologists, the lowest. Burnout was mostly predicted by a higher frequency of face-to-face interaction with users, longer tenure in mental healthcare, weak work group cohesion and perceived unfairness.

- overall the social workers were satisfied with their jobs. The demographic variables of the medical social workers did not have significant associations with the HSJSQ scores. The individual / demographic factors were the main reasons for them being satisfied whereas the organizational factors were the main reasons for them suffering from burnout.
- There are a high levels of stress and emotional exhaustion and low levels of job satisfaction.
- There are a high percent of nurses had an excess of workload (exceeding full-time job). Most of the respondents pointed out the emotional stress, unevaluated work and underpayment.
- The main causes of psychological stress are as follows: the communication with the doctors, communication with the patient's relatives, communication with the nursing administration, and communication with the patients.
- There are a medical and surgical nurses had significant greater scores of job burnout than others ($P < 0.05$).
- The mental health professionals had elevated scores on the GHQ-12, their levels on the three burnout subscales were low. Social workers and psychologists showed the lowest job satisfaction, social workers also had low role identity scores.
- The Korean nurses reported higher levels of burnout than nurses in western countries such as Germany, Canada, the United Kingdom and the United States of America. Nurses who experienced higher job stress, showed lower cognitive empathy and empowerment, and worked in night shifts at tertiary hospitals were more likely to experience burnout.

The importance of previous studies to me comes from the fact that research in the field is accumulative in its nature. Specifically, this literature helped me to plan and use my research tool and define research hypotheses.

Chapter Four

Methodology

4.1 Introduction

Not only that research journey is exhausting but also it's interesting, the researcher must be alert in all the research stages from any deviation or mistake. The research was conducted in many stages as follow:

4.2 Study Design

Research design is analytic descriptive for obtaining answers to the questions being studied. It is a method for getting from "here" to "there" where "here" may be defined as the initial set of questions to be answered, and "there" is some set of conclusion or answers about these questions. Between "here" and "there" a number of major steps may be found including the collection and analysis of relevant data (Naoum, 1998). The research design normally specifies which type of the various types of research approaches to be considered and how the researcher plans to implement scientific control over the factors.

The first phase of the research thesis proposal included identifying and defining the problems and establishment objective of the study and development research plan. The second phase of the research included a summary of the comprehensive literature review. The third phase of the research included a field survey which was conducted with Burnout checklist. The fourth phase of the research focused on the modification of the questionnaire design, through distributing the questionnaire to pilot study. The purpose of the pilot study was to test and prove that the questionnaire questions are clear to be answered in a way that help to achieve the target of the study. In addition, it was important to ensure that all information received from samples (mental health workers in Gaza Strip) would be useful in achieving the research objective. The questionnaire was modified based on the results of the pilot study. The fifth phase of the research focused on distributing questionnaire. This questionnaire was used to collect the required data in order to achieve the research objective.

The structured questionnaire is probably the most widely used data collection technique for conduction surveys to find out facts, opinion and views (Naoum, 1998). The main advantage of structural questionnaire (Naoum, 1998):

1- The answer can be more accurate.
2- The response rate is relatively high (approximately 60-70 %).
3- The answers can be explored with finding out "why" the particular answers are given.

In this research, a structural questionnaire is designed to gather data, and investigate the main variables to estimate Burnout among mental health workers in Gaza Strip.

The sixth phase of the research was data analysis and discussion. Statistical Package for the Social Sciences, (SPSS) was used to perform the required analysis. The final phase includes the conclusions and recommendations.

4.3 Study design\approach

The research used analytical study descriptive to was carried in the mental health centers in Gaza city, like west of Gaza Clinic, Abu Shbak Clinic for Mental Health, Alsoarani Clinic – Gaza, Psychiatric Hospital, Martyrs Nusseirat Center for Mental Health, Khan Yunis clinic for mental health, and Rafah clinic for mental health.

4.4 Study Population

The study society is all workers in the Department of mental health in Gaza Strip. which include (118) mental health workers.

4.5 Study sample

The study sample was consist of all study population that include (118) mental health doctors, nurses, Psychologists, and social workers who are works in the mental health centers.

The percentage of study sample male is 56.6%, whereas the percentage of study sample female is 43.4%.

The researcher was choose the sample in form as purposive sampling, also known as judgmental, selective or subjective sampling, is a type of non-probability sampling technique. Non-probability sampling focuses on sampling techniques where the units that are investigated are based on the judgment of the researcher.

Pilot Study

The pilot study is necessary during the construction of the questionnaire, and it's advisable to conduct a pilot study before you collect the final data for the whole sample. A pilot study provides a trial run for the questionnaire, which involves testing the wording of the questions identifying ambiguous questions, testing the technique that used to collect the data, measuring the effectiveness of your standards invitations to respondents (Naoum, 1998).

A pilot study for this study-number of pilot study =40 of mental health workers-was conducted before starting collecting data to test the meaning of the questions and making sure that the questions are clear and understandable, with no duplications in the meanings. It was conducted by distributing the prepared questionnaire to two panels of experts -having experience.

Study instrument:

According to the review of literature and after interviewing experts who were dealing with the subject at different levels, all the information that could help in achieving the study objectives were collected, reviewed and formalized to be suitable for the study survey and after many stages of brain storming, and reviewing executed by the researcher with the supervisor, a questionnaire was developed with closed questions.

The questionnaire was designed in the Arabic language as most members of the target population were unfamiliar with the English language and to be more understandable. An English version was attached in (Annex 1).look P.121

Unnecessary personal data, complex and duplicated questions were avoided. The questionnaire was provided with a covering letter which explained the purpose of the study, the way of responding, the aim of the research and the security of the information in order to encourage high response.

The questionnaire develops as follows: it was presented to judges. They made some modifications, the researcher modify paragraphs to become in its final form.

The questionnaires design was composed of one tool to accomplish the aim of the research, as follows.

Questionnaire Design and Content to the tool:

1) **Socio demographic:** The first section contained information about the sample to include: (The sex, the age, housing area (address), marital status, number of children - if married -, monthly income, specialization, the level of education, the number of years spent in the work in employment, the Number of working hours)
2) The scale: contain from three subsections:
    - The first subsection (field) was about the Emotional Exhaustion/ Depersonalization (EE+DP), paragraph no (1, 2, 3, 4, 5, 6, 7, 8. 9, 10, 11, 12, 13, 14 ,15).
    - The second subsection (field) was about the Physical Exhaustion (PE), paragraph no (16,17,18,19,20,21,22,23,24,25,26,27).
    - The third subsection (field) was about the Personal Accomplishment (PA), paragraph no (27, 28, 29, 30, 31, 32, 33, 34, , 35 ,36, 37, 38, 39, 40, 41, 42, 43, 44, 45,46,47,48,49)

Psychometric properties of the questionnaire:

In order to validate the instrument, validity and reliability tests were performed correlation coefficients between the realize construct were examined.

Validity:

To establish construct related evidence, the prepared questionnaire was distributed to two panels of experts having experience in the same field of the research to have their remarks on the questionnaire. The first panel, which consisted of five experts, was asked to verify the validity of the questionnaire topics and its relevance to the research objective. The second panel, which consists of one expert in statistics, was consulted to check if the research tool is well- designed to provide answers related to research questions.

Expert comments and suggestions were collected and evaluated carefully. All the suggested comments and modifications were discussed with the supervisor before taking them into consideration. At the end of this process, some minor changes, modifications and additions were introduced to the questions and the final questionnaire was constructed.

To get evidence for the internal consistence validity of the questionnaire, correlation coefficients were used as follows. This is shown in tables 1,2,3,4

- Correlation between each item and total score of emotional exhaustion
- Correlation between every item and total score of depersonalization
- Correlation between every item and total score of low personal accomplishment
- Correlation between total score of each dimension and overall total score

Table 1: Correlation between each item and total score of emotional exhaustion

Item	Value R	Value SIG.
I feel the pressure that I'm having in my work is the reason I suffer from physical troubles	.453	.006**
I deal with high efficiency with the problems of patients who treat	.033	.848
I feel constant fatigue when I wake up from my sleep	.492	.002**
I have accomplished many things important to my career	.206	.227
I feel stress because of my practice for my career	.428	.009**

Item	Value R	Value SIG.
I deal calmly with emotional problems for patients	.389	.019*
I'm embarrassed to sacrifice time palms	.483	.003**
I feel exhausted because of my practice for my work	.656	.000**
I feel energetic when practicing my profession	.009	.960
I feel that I am working in this profession a great stress	.651	.000**
Dealing with patients throughout the day causes me stress and fatigue	.563	.000**
I feel that it is hard to be calm & felt relaxed after the day when I treat patients	.569	.000**
Hours practical stretch for long periods	.601	.000**
Often he had to stay in the work place until after the end of working hours	.622	.000**
I suffer bouts of headaches from time to time during my work	.567	.000**

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

Table 1 illustrates the correlation between items and factor emotional exhaustion. The results reveal that some items are significant at the 0.01 and 0.05 level 2-tailed except q1, q4, q9.

Table 2: Correlation between every item and total score of depersonalization

Item	Value R	VALUE SIG.
I find it difficult to control my emotions as a result of practicing my profession	.475	.003**
Dealing directly with patients causes me severe psychological pressure	.548	.001**
I Lose patience when patients do not respond to ask them	.566	.000**
I feel happy when helping patients	.183	.286
I do not care when do not perform work on her face right	.501	.002**
I feel I am dealing with some patients as if they were inanimate not humans	.798	.000**
I do not care what happens with patients of problems	.678	.000**
I feel concerned that this profession increases the insensitivity and cruelty of my emotions	.739	.000**

Item	Value R	VALUE SIG.
I feel I have become more severe with people after I joined the professions	.753	.000**
I am concerned because this function petrified my emotions	.752	.000**
I feel that patients throwing the responsibility for some of the problems they face	.666	.000**
Love and hate became one	.670	.000**

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

Table 2 illustrates the correlation between items and factor depersonalization. The results reveal that some items are significant at the 0.01 and 0.05 level 2-tailed except q19.

Table 3: Correlation between every item and total score of low personal accomplishment

Item	Value R	VALUE SIG.
I feel annoyed when discussing patients in a particular subject area	.390	.019*
I feel unnatural relationship with patients during my work career	.175	.308
I feel low motivation towards practical	.265	.118
Easy I have to create a relaxed atmosphere with patients	.227	.182
I feel frustrated by the practice of the profession	.372	.025*
I feel that the actions of patients exceeding the pressures of work	.575	.000**
I feel that I have a positive influence in the lives of many people through my practice of the profession	.080	.644
I feel inhibitor determination because of my job	.391	.019*
I feel the absence of material and moral incentives from others	.426	.010**
I feel the lack of a safe and suitable environment to solve the problems faced by workers	.672	.000**
I feel that there is no job title	.748	.000**
I feel afraid in my work and the lack of appropriate security measures	.799	.000**
I'm having a large workload throughout the day	.490	.002**

Item	Value R	VALUE SIG.
I am concerned the absence of drugs	.470	.004**
I'm having a shortage in the availability of resources and the appropriate preparations to deal with the patient	.648	.000**
I feel the absence of appropriate opportunities for promotions	.748	.000**
I am concerned political instability	.381	.022*
suffer from physical abuse from the patient or his family	.580	.000**
I suffer from the wrong behaviors of the patient or his family	.634	.000**
I suffer from psychological abuse from the patient or his family	.707	.000**
I feel no matter how accomplished in the work place, the result is the same	.805	.000**
Direct officials not assess practical from time to time	.696	.000**

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

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

Table 3 illustrates the correlation between items and low personal accomplishment. The results reveal that some items are significant at the 0.01 and 0.05 level 2-tailed except q29, q30, q31, q34. So the validation of instrument is high, hence the instrument is acceptance except questions 1,4,9,19,29,30,31,34 are no significance, however researcher must rewrite these questions to enhance the instrument.

Table 4: Correlation each dimension and overall burnout score

Questionnaire dimensions	Total score
emotional exhaustion	0.771 **
Depersonalization	0.780**
personal accomplishment	0.804**

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

Table 4 illustrates the correlation among factors and overall burnout among mental health workers. The results reveal that some factors are significant at the 0.01 level 2-tailed. The validation of instrument is high, hence the instrument is acceptance.

The researcher obtained construct related evidence through comparing the score of those who have high score in emotional exhaustion, depersonalization and low personal accomplishment with those who obtained low score. Results show significant differences which validates the developed instrument. See the following table.

Table 5: Comparison between high and low burnout scores

Factor	Degree	N	Mean	Std. Deviation	T value	Sig. (2-tailed)
Emotional exhaustion	High 30%	11	4.9939	.60182	7.555	.000**
	Low 30%	11	3.4909	.27043		
Depersonalization	High 30%	11	4.3636	.60584	11.321	.000**
	Low 30%	11	2.1667	.21731		
Low personal accomplishment	High 30%	11	5.2355	.34367	11.121	.000**
	Low 30%	11	3.1612	.51441		
Total	High 30%	11	4.6472	.38551	10.455	.000**
	LOW 30%	11	3.1081	.29963		

* = significant at the 0.05 level (2-tailed). **= significant at the 0.01 level (2-tailed).

Reliability

The reliability of an instrument is the degree of consistency which measures the attribute; it is supposed to be measuring (Polit & Hunger, 1985).

The less variation an instrument produces in repeated measurements of an attribute, the higher its reliability. Reliability can be equated with the stability, consistency, or dependability of a measuring tool. The test is repeated to the same sample of people on two occasions and then compares the scores obtained by computing a reliability coefficient (Polit & Hunger, 1985).

Internal consistency measures were used to get reliability evidence. Cronbach's alpha and split-half estimates were assessed for each dimension (factor). Table 6 shows that good reliability estimates.

Table 6: Reliability estimates

Factors	N of items	Cronbach's Alpha	Split- half
Emotional exhaustion	15	0.728	0.665
Depersonalization	12	0.843	0.814
Low personal accomplishment	22	0.874	0.752
Total Survey	49	0.901	0.700

Inclusion criteria

The questionnaire was applied to the following categories: mental health doctors, nurses, Psychologist, and social worker who are works in the mental health centers.

Exclusion criteria

The questionnaire was excluded the following categories: mental health Administrative, pharmacist, and worker hygiene (cleaner) who are works in the mental health centers.

Statistical analysis

To achieve the research goal, researcher used the Statistical Package for the Social Science (SPSS) version (18) for Manipulating and analyzing the data. The type of study is descriptive analytic style.

Statistical methods:

To answer the study questions and hypotheses, the researchers used the following statistical methods:

- Frequencies and Percentages: used to help the researcher to describe the study sample.
- Mean, Standard deviation and percentage mean for describing the dimensions.

- Pearson’s Correlation Coefficients to measure the degree of correlation as well to study the relation between variables.
- Cronbach’s alpha coefficient and Split-half coefficient to determine the constancy of questionnaires' items.
- T-Test to determine the difference between the categories of the categorical variables (two categories).
- One-Way ANOVA to study the difference between the categories of the categorical variables (three or more categories).

Difficulties faced the researcher

- The type of the population work is continuous shifting, so the choosing of sample and completing the questionnaires was so exhausting process.
- Difficulties in sharing and completing the questionnaires from the sample.
- Difficulty in choosing the sample away from bias.
- The financial heaviness of preparing the tools and the copies.
- The psychological issue of the researcher plays a role in the difficulties.

Chapter Five

Results , discussion & Recommendations

Introduction

In this chapter, the researcher displayed the result of the study in two parts. The first is the demographic characteristics of the study sample; the second is about burnout among mental health workers in and its relations to the demographic data of mental health centers in Gaza Strip.

Demographic characteristics of the study sample

The following the table shows the descriptive results of demographic variables of the mental health workers in mental health centers in Gaza Strip.

Table (7): Socio-demographic characteristic of study sample (N=113)

Variable		N	Percent %
Gender	Male	64	56.6
	Female	49	43.4
Age	18-25	7	6.2
	26-35	63	55.8
	36-45	31	27.4
	more than 46	12	10.6
Address (place)	Rafah	16	14.2
	Khan-younis	12	10.6
	Middle	30	26.5
	Gaza	37	32.7
	North Gaza	18	15.9
Marital status	Married	100	88.5
	Single	12	10.6
Number of children	one child	14	12.4
	2-5	61	54
	more than 5 child	25	22.1
	no child	13	11.5
Level of education	Diploma	8	7.1
	University	52	46
	Master	53	46.9
Income	1000-2000	36	31.9

Variable		N	Percent %
	2100-3000	63	55.8
	more than 3001	14	12.4
Hours of work	less than 8 hours	82	72.6
	8-10 hours	31	27.4
Experience of years	less than 4 years	36	31.9
	4-10 years	45	39.8
	10-15 years	16	14.2
	more than 1 years	16	14.2
Specialization (type of job)	Doctor	19	16.8
	Nurse	49	43.4
	Psychologist	20	17.7
	Social worker	25	22.1

Table (9) illustrates the distribution sample according to demographic variables such as: Gender: percent of male equal 56.6% and female equal 43.4%, and hours of work: less than 8 equal 72.6%, whereas from 8 to 10 hours equal 27.4. And the distribution sample according to experience of years showed that percent of less than 4 years is 31.9%, whereas from 4 to 10 years is 39.8%, and from 10 to 15 years is 14.2%, and more than 1 years is 14.2%. Also doctor is 16.8 %; the most of worker as nurse is 43.4; Psychologist is 17.7 and Social worker is 22.1

Main question: What is the prevalence of burnout among mental health workers in mental health centers in Gaza Strip?

The following the table shows the descriptive results of all the items and domains of burnout among mental health workers in mental health centers in Gaza Strip.

Table (8): Mean and Std. Deviation of burnout

Item	Mean	Std. Deviation
I feel the pressure that I'm having in my work is the reason I suffer from physical troubles	3.876	1.707
I deal with high efficiency with the problems of patients who treat	4.106	1.834
I feel constant fatigue when I wake up from my sleep	3.69	1.512
I have accomplished many things important to my career	4.353	1.658
I feel stress because of my practice for my career	3.831	1.642
I deal calmly with emotional problems for patients	4.132	1.688
I'm embarrassed to sacrifice time palms	3.823	1.723
I feel exhausted because of my practice for my work	3.876	1.593
I feel energetic when practicing my profession	4.000	1.402
I feel that I am working in this profession a great stress	4.176	1.599
Dealing with patients throughout the day causes me stress and fatigue	3.893	1.448
I feel that it is hard to calmer and felt relaxed after the day when I treat patients	3.707	1.522
Hours practical stretch for long periods	3.876	1.53
Often he had to stay in the work place until after the end of working hours	3.504	1.39
I suffer bouts of headaches from time to time during my work	4.017	1.439
Total score Emotional exhaustion	3.924	1.05
I find it difficult to control my emotions as a result of practicing my profession	3.964	1.631

Item	Mean	Std. Deviation
Dealing directly with patients causes me severe psychological pressure	3.99	1.854
I Lose patience when patients do not respond to ask them	3.814	1.601
I feel happy when helping patients	4.69	1.559
I do not care when do not perform work on her face right	3.212	1.114
I feel I am dealing with some patients as if they were inanimate not humans	2.831	1.336
I do not care what happens with patients of problems	2.929	1.492
I feel concerned that this profession increases the insensitivity and cruelty of my emotions	3.292	1.341
I feel I have become more severe with people after I joined the professions	3.168	1.426
I am concerned because this function petrified my emotions	3.044	1.526
I feel that patients throwing the responsibility for some of the problems they face	3.902	1.512
Love and hate became one	3.115	1.58
Total score Depersonalization	3.496	1.088
I feel annoyed when discussing patients in a particular subject area	3.415	1.516
I feel unnatural relationship with patients during my work career	3.539	1.758
I feel low motivation towards practical	3.539	1.711
Easy I have to create a relaxed atmosphere with patients	4.849	1.465
I feel frustrated by the practice of the profession	3.699	1.529
I feel that the actions of patients exceeding the pressures of work	3.955	1.655
I feel that I have a positive influence in the lives of many people through my practice of the profession	4.327	1.589
I feel inhibitor determination because of my job	3.769	1.648
I feel the absence of material and moral incentives from others	4.61	1.815
I feel the lack of a safe and suitable environment to solve the problems faced by workers	4.611	1.745
I feel that there is no job title	4.602	1.993
I feel afraid in my work and the lack of appropriate security measures	4.221	1.85
I'm having a large workload throughout the day	4.248	1.765
I am concerned the absence of drugs	4.221	1.85

Item	Mean	Std. Deviation
I'm having a shortage in the availability of resources and the appropriate preparations to deal with the patient	4.469	1.582
I feel the absence of appropriate opportunities for promotions	4.903	1.788
I am concerned political instability	4.566	1.726
suffer from physical abuse from the patient or his family	3.611	1.454
I suffer from the wrong behaviors of the patient or his family	3.54	1.482
I suffer from psychological abuse from the patient or his family	3.283	1.473
I feel no matter how accomplished in the work place, the result is the same	4.381	1.819
Direct officials not assess practical from time to time	4.142	2.03
Total score Low personal accomplishment	4.114	1.178
Total Scores of Burnout	3.845	1.048

Results show that the average mean for the total score is equal 3.8 and the weighted mean equal 54.92%. The average mean for the is equal 3.9 and the weighted mean equal 56% for Emotional exhaustion dimension and equal 3.5 and the weighted mean equal 50% for Depersonalization dimension and equal 4.1 and the weighted mean equal 59% for Low personal accomplishment. In general, results show mental health which indicates the following:

- The mental health workers suffering is most for low personal accomplishment, then emotional exhaustion, then depersonalization.
- This show that the highest mean item at low personal accomplishment domain is (I have accomplished many things important to my career) the mean is 4.353, whereas the lowest mean item at low personal accomplishment domain is (Often he had to stay in the work place until after the end of working hours) the mean is 3.504.
- Also the highest mean item at emotional exhaustion domain is (I feel happy when helping patients) the mean is 4.69, whereas the lowest mean item at emotional

exhaustion domain is (I am concerned because this function petrified my emotions) the mean is 3.044.

- Also the highest mean item at depersonalization domain is (I feel the absence of appropriate opportunities for promotions) the mean is 4.903, whereas the lowest mean item at depersonalization domain is (I suffer from psychological abuse from the patient or his family) the mean is 3.283.

Specific questions:

Questions 1: There is no significant difference at (α≤0.05 in burnout scores due to gender.

The researcher used independent t-test to investigate the differences between males and females with regard to dependent variable of burnout. The researcher fails to reject the null hypotheses and conclude that there are no significant statistical differences at (α≤0.05) in all burnout factors due to gender.

Table (9): Independent T-test comparing means of burnout according to gender

Variable	Gender	N	Mean	Std. Deviation	t-value	P-value
Emotional Exhaustion	Male	64	3.7677	1.06123	1.833	0.070***
	Female	49	4.1293	1.00953		
Depersonalization	Male	64	3.3737	1.05670	1.374	0.172***
	Female	49	3.6565	1.11902		
Low Personalization Accomplishment	Male	64	4.1094	1.23021	0.046	0.964***
	Female	49	4.1197	1.11895		
Total Scores Burnout	Male	64	3.7503	1.05965	1.098	0.274***
	Female	49	3.9685	1.02937		

*The value of t at df (111) and significance level 0.05 = 1.66
**The value of t at df (111) and significance level 0.01 = 2.36
*** No significant

From the above table, data shows that burnout among male mental health workers is similar to females in spite of the higher mean scores of burnout for females. This could be attributed to the fact that the circumstances and pressure that they both live in are similar in some way. This result is similar to (Elamassi, 2007) and (Bawih, 2012) that showed that there are no significant statistical differences at level due to gender.

Also the results inconsistent with Haejung & et.al (2003) that showed that the Korean nurses reported higher levels of burnout.

Question 2: There is no significant difference at (α≤0.05 in burnout scores due to age.

The researcher used ANOVA test to investigate the differences between the different age groups with regard to dependent variable of burnout. The researcher fail to reject the null hypothesis and conclude that there are no significant statistical differences at (α≤0.05) in all burnout factors among mental health workers due to age.

Table (10): One way ANOVA comparing burnout according to age

Variable	Source of variable	Sum of Squares	df	Mean Square	F value	Sig. level
Emotional Exhaustion	Between Groups	2.296	3	.765	.688	.561
	Within Groups	121.202	109	1.112		
	Total	123.498	112			
Depersonalization	Between Groups	3.812	3	1.271	1.075	.363
	Within Groups	128.860	109	1.182		
	Total	132.672	112			
Low Personalization Accomplishment	Between Groups	2.289	3	.763	.543	.654
	Within Groups	153.158	109	1.405		
	Total	155.447	112			
Total Scores Burnout	Between Groups	2.502	3	.834	.755	.522
	Within Groups	120.421	109	1.105		
	Total	122.923	112			

The value of F at df (3, 109) and significance level 0.05 = 2.69
The value of F at df (3, 109) and significance level 0.01 = 3.97

From the above table, data shows that burnout scores are similar for different age groups which indicate that the study sample face similar circumstances in general which lead to similar scores in burnout. The results of the study contradict with the results of (Abu masood, 2010) who indicated that differences were significant between age and the level of burnout at its three dimensions with age. It agrees with (Elamassi, 2007) , study who stated that there are no significant statistical differences at level (a == 0.05) in the burnout total score due to the age of the nurse.

Question 3: There is no significant difference at (α≤0.05) at the burnout scores dues to place of residence.

The researcher used ANOVA test to investigate the differences between the different of address variable with regard to dependent variable of burnout. The researcher fail to reject the null hypothesis and conclude that there are no significant statistical differences at (α≤0.05) in all burnout factors among mental health workers due to address of mental health workers.

Table (11): One Way ANOVA comparing burnout according to place of residence

Variable	Source of variable	Sum of Squares	Df	Mean Square	F value	Sig. level
	Between Groups	2.904	4	.726	.650	.628
	Within Groups	120.594	108	1.117		
	Total	123.498	112			
Depersonalization	Between Groups	4.992	4	1.248	1.056	.382
	Within Groups	127.680	108	1.182		
	Total	132.672	112			
Low Personalization Accomplishment	Between Groups	9.975	4	2.494	1.851	.124
	Within Groups	145.472	108	1.347		
	Total	155.447	112			
Total Scores Burnout	Between Groups	5.411	4	1.353	1.243	.297
	Within Groups	117.512	108	1.088		
	Total	122.923	112			

***The value of F at df (4, 108) and significance level 0.05 = 2.46
**The value of F at df (4, 108) and significance level 0.01 = 3.50

From the above table, data shows that burnout scores are similar for the study sample regardless where they live. It agrees with (Elamassi, 2007) and (Bawih, 2012)

study who stated that there are no significant statistical differences at level (a == 0.05) in the burnout total score due to working place.

Question 4: There is no significant difference at (α≤0.05) in burnout scores due to marital status

In order to investigate the difference in burnout between mental health workers according to marital status of the study population, the researcher used independent t-test. The following table shows that: There are no significant differences at (α≤0.05) in all burnout factors between mental health workers due to marital status.

Table (12): Independent T-test comparing means of burnout according to marital status

Variable	Marital status	N	Mean	Std. Deviation	t-value	P-value
Emotional Exhaustion	Married	101	3.9188	1.06790	.166	.869***
	Single	12	3.9722	.92571		
Depersonalization	Married	101	3.4637	1.08111	.924	.358***
	Single	12	3.7708	1.15913		
Low Personalization Accomplishment	Married	101	4.1004	1.20195	.351	.726***
	Single	12	4.2273	.99113		
Total Scores Burnout	Married	101	3.8276	1.05916	.506	.614***
	Single	12	3.9901	.97507		

The value of t at df (111) and significance level 0.05 = 1.66*
The value of t at df (111) and significance level 0.01 = 2.36**
*** No significant

From the above table, data shows that burnout scores are similar for the study sample regardless of their marital status. The results of the study is similar to (Ean, 2007) study that showed was that the demographic variables of the medical social workers did not have significant associations with the HSJSQ scores. The results of the study contradict with the results of (Abu masood, 2010) who indicated that differences were significant between marital status and the level of burnout at its three dimensions with marital status.

Question 5: There is no significant difference at (α≤0.05) in burnout scores due to number of children.

In order to investigate the difference in burnout scores among mental health workers according to number of children of the study population, the researcher used one way ANOVA. The following table shows that: There are no significant differences at (α≤0.05) in all burnout factors among mental health workers due to number of children.

Table (13): One Way ANOVA comparing burnout according to number of children

Variable	Source of variable	Sum of Squares	df	Mean Square	F value	Sig. level
Emotional Exhaustion	Between Groups	2.291	3	.764	.687	.562
	Within Groups	121.207	109	1.112		
	Total	123.498	112			
Depersonalization	Between Groups	3.459	3	1.153	.973	.408
	Within Groups	129.213	109	1.185		
	Total	132.672	112			
Low Personalization Accomplishment	Between Groups	2.524	3	.841	.600	.617
	Within Groups	152.922	109	1.403		
	Total	155.447	112			
Total Scores Burnout	Between Groups	2.695	3	.898	.815	.489
	Within Groups	120.228	109	1.103		
	Total	122.923	112			

*The value of F at df (3, 109) and significance level 0.05 = 2.69
**The value of F at df (3, 109) and significance level 0.01 = 3.97

From the above table, data shows that burnout scores are similar for the study sample regardless of the number of children they have.

Question 6: There is no significant difference at ($\alpha \leq 0.05$) in burnout scores due to level of education (Qualification).

In order to investigate the difference in burnout among mental health workers according to number of children of the study population, the researcher used one way ANOVA. The following table shows that: There are significant differences at ($\alpha \leq 0.05$) in all burnout factors among mental health workers due level of education (Qualification).

Table (14): One Way ANOVA comparing burnout according to level of education

Variable	Source of variable	Sum of Squares	Df	Mean Square	F value	Sig. level
Emotional Exhaustion	Between Groups	8.344	2	4.172	3.985	.021*
	Within Groups	115.154	110	1.047		
	Total	123.498	112			
Depersonalization	Between Groups	8.993	2	4.497	3.999	.021*
	Within Groups	123.679	110	1.124		
	Total	132.672	112			
Low Personalization Accomplishment	Between Groups	14.275	2	7.137	5.561	.005**
	Within Groups	141.172	110	1.283		
	Total	155.447	112			
Total Scores Burnout	Between Groups	10.241	2	5.121	4.999	.008**
	Within Groups	112.682	110	1.024		
	Total	122.923	112			

*The value of F at df (2, 110) and significance level 0.05 = 3.08
**The value of F at df (2, 110) and significance level 0.01 = 4.80

Post – hoc analysis was performed. It indicated that there significant differences in the dimension and total score of burnout. Results in the following table shows that the profession with educator diploma have significantly higher scores in burnout than the

profession with educator masters' degree. Moreover, profession with educator Bachelor's degree have significantly higher scores in burnout compared to profession with educator master degree.

The results of the study is different to (Bawih, 2012) study that showed was that There's no differences shown among the student's averages following the variation of specialties (psychology, educational). The results of the study similar with the results of (Abu masood, 2010) who indicated that differences were significant between educational level and the level of burnout at its three dimensions with educational level.

Table (15): Scheffe test for burnout according to level of education

Dependent Variable	(I) qualification	(J) qualification	Mean Difference (I-J)	Sig.
Emotional Exhaustion	Diploma	Master	.84591	.031**
	Bachelors	Master	.45745	.024**
Depersonalization	Diploma	Master	.81329	.046**
	Bachelors	Master	.50239	.017**
Low Personalization Accomplishment	Diploma	Master	1.25472	.004*
	Bachelors	Master	.5090	.023**
Total Scores Burnout	Diploma	Master	.97131	.013**
	Bachelors	Master	.48964	.015**

*****The mean difference is significant at the 0.05 level
**The mean difference is significant at the 0.01 level

The results could be attributed to the fact that mental health workers profession with educator diploma usually deal directly with patients, and are often subjected to different categories of patients from all segments of society, while profession with educator masters degrees deal with specific groups of patients in addition having more administrative jobs.

Question 7: There is no significant difference at (α≤0.05) in burnout scores due to income.

In order to investigate the difference in burnout among mental health workers according to income of the study population, the researcher used one way ANOVA. The following table shows that: There are no significant differences at (α≤0.05) in all burnout factors among mental health workers due to income.

Table (16): One Way ANOVA comparing burnout according to income

Variable	Source of variable	Sum of Squares	df	Mean Square	F value	Sig. level
Emotional Exhaustion	Between Groups	2.102	2	1.051	.952	.389
	Within Groups	121.396	110	1.104		
	Total	123.498	112			
Depersonalization	Between Groups	6.399	2	3.199	2.787	.066
	Within Groups	126.273	110	1.148		
	Total	132.672	112			
Low Personalization Accomplishment	Between Groups	4.103	2	2.051	1.491	.230
	Within Groups	151.344	110	1.376		
	Total	155.447	112			
Total Scores Burnout	Between Groups	3.927	2	1.963	1.815	.168
	Within Groups	118.996	110	1.082		
	Total	122.923	112			

*The value of F at df (2, 110) and significance level 0.05 = 3.08
**The value of F at df (2, 110) and significance level 0.01 = 4.80

From the above table, data shows that burnout scores are similar for the study sample regardless of their income.

The results of the study contradict with the results of (Abu masood, 2010) who indicated that differences were significant between salary and the level of burnout at its three dimensions with salary.

Question 8: There is no significant difference at (α≤0.05) in n burnout score dues to working hours.

In order to investigate the difference in burnout among mental health workers according to number of hours of the study population, the researcher used independent T-test. The following table shows that: There are significant differences at (α≤0.05) in all burnout factors between mental health workers due to number of working hours except low personalization accomplishment factors.

Table (17): Independent T-test comparing means of burnout according to working hours

Variable	Working hours	N	Mean	Std. Deviation	t-value	P-value
Emotional Exhaustion	less than 8 hours	82	4.0520	1.02662	2.133	.035**
	8-10	31	3.5871	1.05303		
Depersonalization	less than 8 hours	82	3.6565	1.07187	2.610	.010*
	8-10	31	3.0726	1.03184		
Low Personalization Accomplishment	less than 8 hours	82	4.2417	1.13714	1.898	.060
	8-10	31	3.7757	1.23588		
Total Scores Burnout	less than 8 hours	82	3.9834	1.01745	2.331	.022**
	8-10	31	3.4784	1.05413		

The value of t at df (111) and significance level 0.05 = 1.66*
The value of t at df (111) and significance level 0.01 = 2.36**

From the above table, data shows that burnout between less than 8 hours and 8-10 hours mental health workers is significant statistical differences in Emotional Exhaustion, Depersonalization, Depersonalization returned to less than 8 hours.

The results of the study agreed with the results of (Abu masood, 2010) who indicated there was a positive significant correlation between work load and the level of burnout at its three dimensions.

Question 9: there is no significant difference at (α≤0.05) in burnout scores due to experience.

In order to investigate the difference in burnout among mental health workers according to experience of the study population, the researcher used one way ANOVA. The following table shows that: There are no significant differences at (α≤0.05) all factors in burnout among mental health workers due to experience.

Table (18): One Way ANOVA comparing burnout according to experience

Variable	Source of variable	Sum of Squares	Df	Mean Square	F value	Sig. level
Emotional Exhaustion	Between Groups	.381	3	.127	.112	.953
	Within Groups	123.117	109	1.130		
	Total	123.498	112			
Depersonalization	Between Groups	2.118	3	.706	.589	.623
	Within Groups	130.554	109	1.198		
	Total	132.672	112			
Low Personalization Accomplishment	Between Groups	2.893	3	.964	.689	.561
	Within Groups	152.553	109	1.400		
	Total	155.447	112			
Total Scores Burnout	Between Groups	1.056	3	.352	.315	.815
	Within Groups	121.866	109	1.118		
	Total	122.923	112			

*The value of F at df (3, 109) and significance level 0.05 = 2.69
**The value of F at df (3, 109) and significance level 0.01 = 3.97

From the above table, data shows that burnout scores are similar for the study sample regardless of their experience.

On the other hand the study of (Elamassi, A., 2007) was agreed with this study. It said that no significant statistical differences at level (a == 0.05) in the burnout total score due to the Nurses' experiences.

Also the results of the study contradict with the results of (Abu masood, 2010) who indicated that differences were significant between experience and the level of burnout at its three dimensions with experience.

Question 10: There is no significant difference at ($\alpha \leq 0.05$) in burnout scores due to Specialization.

In order to investigate the difference in burnout among mental health workers according to Specialization of the study population, the researcher used one way ANOVA. The following table shows that: There are no significant differences at ($\alpha \leq 0.05$) in all burnout factors among mental health workers due to Specialization.

Table (19): One Way ANOVA comparing burnout according to specialization

Variable	Source of variable	Sum of Squares	Df	Mean Square	F value	Sig. level
Emotional Exhaustion	Between Groups	1.640	3	.547	.489	.69
	Within Groups	121.858	109	1.118		
	Total	123.498	112			
Depersonalization	Between Groups	6.258	3	2.086	1.799	.152
	Within Groups	126.414	109	1.160		
	Total	132.672	112			
Low Personalization Accomplishment	Between Groups	5.777	3	1.926	1.402	.246
	Within Groups	149.670	109	1.373		
	Total	155.447	112			
Total Scores Burnout	Between Groups	4.070	3	1.357	1.244	.297
	Within Groups	118.852	109	1.090		
	Total	122.923	112			

*The value of F at df (3, 109) and significance level 0.05 = 2.69
**The value of F at df (3, 109) and significance level 0.01 = 3.97

From the above table, data shows that burnout scores are similar for the study sample regardless of their specialization.

The results of the study is similar to (Ean, 2007) study that showed was that the demographic variables of the medical social workers did not have significant associations with the HSJSQ scores.

Recommendations

The researcher recommended the following points:

Management system

1- Employers must recognize the demands placed on mental health workers and value their contribution to mental health services. So they should support these workers, materially and morally.

2- Management must change the direction of mental health workers about their work and make them more receptive to work. This leads to a doubling of effort and creativity in their work that reduces their burnout.

3- Decision-makers in the Ministry of Health must adopt strategies to break the rigor and routine observed in government business and choice of a suitable strategy to alleviate the burnout level, as adopting a policy of recycling so as not to stay the employee in the job more than 5 years, and must study the main reasons that led to the suffering of a large proportion of mental health workers from burnout.

4- Develop an implementation plan covering the strategy's objectives, likely outcome and scope; who is involved and what resources are required; and its timings.

Management relationship

1- Seek support and commitment of hospital board and management, senior mental health and medical staff, and the relevant unions and professional associations.

2- Hold meetings with mental health workers for their cooperation with them and look at their problems, that it therefore of great importance in their lives and this helps mental health workers and encourages them to focus and dedication to their work.

3- Hold educational sessions on an ongoing basis for mental health workers to stand on the latest developments in the work, this encourages them and helping them does their jobs in a more positive manner.

4- Encourage mental health workers to perform their work by providing them with different kinds of reinforcement which helps to reduce the feeling of burnout, and enhances competition among them.
5- Provide clear, timely and meaningful communication with all staff involved during the development of the control intervention.
6- Establish a systematic basis for monitoring and evaluation of control strategies. This increases the chances of overcoming the pressure situations and exhaustion among workers in the mental health.
7- Attention with material and moral support for workers in the mental health centers because individual satisfaction about his career is the first stages of professional accomplished and then avoid injury of burnout.
8- Give workers in mental health centers the opportunity to practice the skills of effective leadership and management, such as participation in the paperwork, scheduling meetings, and supervision, and making important decisions.
9- Provides information on evaluating mental health workers performance against the elements and standards in an employee's performance plan and assigning a summary rating of record.

Deal with clients

1- Taking into account that has a social worker and psychological in mental health centers experience and expertise of patients will be facing of psychological problems resulting from multiple causes.
2- Use patients' consultation techniques to identify treatment objectives.
3- Provide the patients with clear advice and recommendations.
4- Outline different forms of communication used to deal with patients.
5- Describe how to use consultation techniques to identify treatment objectives, as positive body language and positioning of the patients (no barriers between themselves and patients).

6- Assist in patients' complaints being resolved, for example: Allow the patients to fully explain their problem without interruption, listen carefully and clarify, show empathy and do not argue, try to resolve the situation and find a mutually agreeable solution, make any explanations confidently, but calmly, apologize for any inconvenience, record details of the complaint for future reference.

7- Describe patients' confidentiality in line with the Data Protection Act, to include:

- Relevant, not excessive gathering of information in the consultation process.
- Ensuring information is accurate, up to date and only used for job specific purposes.
- Security of information kept for no longer than is necessary.
- Fairly and lawfully processing information.
- Not transferred to other countries without adequate protection or need.
- Rights of the patients to know what information is held about them on computer and in written format.

Training

1- Training of specialized professional frameworks be able to offer consultancy needed to address pressures of work and burnout.

2- Awareness workers in the mental health centers about the psychological problems they will face in the work environment because the expectation of worker that which will be offset by problems may be reduce their psychological effects.

3- Awareness workers in the mental health centers about adopting face effective methods to avoid exposure to stressful situations and help them to deal with problems in effective ways.

Social support

1- Re-evaluate services identified in the organization’s plan as being non-essential and decide whether they can be discontinued.

2- Provide psychological and social support services for mental health workers and their families.
3- Address stigmatization issues that might be associated with participation in such services.
4- Work with communications experts to shape messages that reduce the psychological impact of the burnout.
5- Provide medical and public health with educational and training materials.

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Appendices

- ***Arabic Checklist.***
- ***English Checklist.***
- ***The judgmental professionals table.***
- ***Facilitation letter.***

Appendix 1

ARABIC BURNOUT CHECKLIST.

بسم الله الرحمن الرحيم

(استبيان)

الأخ الموظف/_____ المحترم،،،

السلام عليكم ورحمة الله وبركاته،،،

تقوم الباحثة فاطمة محمود أبو عكر بإعداد بحث لنيل درجة الماجستير في الصحة النفسية المجتمعية – علوم التمريض بعنوان: "الاحتراق الوظيفي لدى العاملين في مراكز الصحة النفسية الحكومية في قطاع غزة". **وذلك تحت إشراف الأستاذة الدكتورة سناء أبو دقة والدكتور عبد العزيز ثابت. استكمالاً لدرجة الماجستير من خلال الإجابة على كل فقرة من فقرات الاستبيان.**

يهدف هذا الاستبيان للتعرف على الاحتراق النفسي بين الأشخاص الذين يعملون في عيادات الصحة النفسية التابعة لوزارة الصحة الفلسطينية في قطاع غزة، **والباحثة تعّرف الاحتراق النفسي الوظيفي إجرائياً بأنه: "حالة من الإنهاك الجسدي والانفعالي والعقلي تظهر على شكل إعياء شديد وشعور بعدم الجدوى وفقدان الأمل وتطور مفهوم ذات سلبي واتجاهات سلبية نحو العمل والحياة والناس". ويتكون من ثلاثة محاور، هي: الإجهاد الانفعالي، تبلد المشاعر ، نقص الشعور بالانجاز الشخصي، والذي يقاس بالاستبانة المعدة لذلك والمكونة من (49) عبارة تضمها الأبعاد أو المحاور السابقة. مع العلم أن التدريج المستخدم في أداة القياس هو من (0 إلى 6)، على عبارات المقياس، ويتضمن البنود الأتية:**

صفر	1	2	3	4	5	6
لا أعاني مطلقاً	مرات قليلة بالسنة	مرة في كل شهر	مرات قليلة بالشهر	مرة في كل أسبوع	مرات قليلة بالأسبوع	كل يوم

نرجو التكرم بقراءة العبارات بدقة ثم التعبير عن رأيك فيها بوضع علامة (×) في المكان الذي يتفق مع رأيك علماً بأن الإجابات ستعامل بسرية وستستخدم لأغراض البحث العلمي فقط.

شاكرين لكم حسن تعاونكم في خدمة البحث العلمي

مع عاطر التحية وموفور الاحترام

الباحثة
فاطمة أبو عكر
المشرفان/
د. سناء أبو دقة
د. عبد العزيز ثابت

تعليمات

فيما يلي قائمة بالأعراض التي قد يعاني منها العاملون في الصحة النفسية، اقرأ كل عبارة بدقة، وبعد التأكد من انطباق العبارة عليك أرجو أن تضع علامة داخل أحد المربعات الموجودة إلى يسار السؤال والتي تصف العرض أحسن وصف، أي إلى أي مدى تنطبق عليك هذه المشكلة خلال الشهر الماضي حتى اليوم، ضع العلامة داخل دائرة واحدة فقط بعد كل مشكلة مع عدم إغفال الإجابة عن أي عبارة، إذا غيرت رأيك في الاستجابة، امسح العلامة الأولى تماماً وضعها في المربع المناسب.

اقرأ المثال الآتي قبل أن تبدأ:

مثال

ما مقدار انطباق الأعراض الآتية عليك:

م	العبارة	الشدة بدرجة قوية .... بدرجة ضعيفة جداً						
		6	5	4	3	2	1	0
1.	**أشعر أن الضغوط التي تواجهني في عملي هي سبب ما أعانيه من متاعب جسدية**		×					

أولاً: بيانات شخصية

الجنس: ☐ ذكر ☐ أنثى

العمر: ☐18 – 25 سنة ☐ من 26–35 ☐ من 36– 45 ☐ من 46 فأكثر

منطقة السكن (العنوان) : ☐رفح ☐ خانيونس ☐ الوسطى ☐ غزة ☐ شمال غزة

الحالة الاجتماعية: ☐متزوج ☐ أعزب ☐ مطلق ☐أرمل

عدد الأطفال –في حال متزوج–: ☐ طفل واحد ☐ من 2–5 أطفال ☐ أكثر من 5 أطفال

المستوى العلمي: ☐ دبلوم ☐ بكالوريوس ☐ دراسات عليا

الدخل الشهري: ☐ 1001 –2000 ☐ 2001– 3000 ☐ 3001 فما أكثر

ساعات العمل: ☐ أقل من 8 ساعات ☐ من 8– 10 ساعات ☐ أكثر من 10 ساعات

الخبرة: ☐ أقل من 4 سنوات ☐ من 4– 10 سنوات ☐ من 10– 15 سنة ☐ سنة فما فوق

التخصص: ☐ممرض ☐ دكتور ☐ أخصائي اجتماعي ☐أخصائي نفسي

ثانياً: محاور وفقرات الاستبانة

ما مقدار انطباق الأعراض الآتية عليك:

م	العبارة	الشدة بدرجة قوية .... بدرجة ضعيفة جداً						
		6	5	4	3	2	1	0
	أولاً: الاجهاد الانفعالي Emotional Exhaustion							
.1	أشعر أن الضغوط التي تواجهني في عملي هي سبب ما أعانيه من متاعب جسدية							
.2	أتعامل بفاعلية عالية مع مشكلات المرضى الذين أعالجهم							
.3	أشعر بالإرهاق المستمر عندما أستيقظ من نومي							
.4	لقد أنجزت أشياء كثيرة مهمة لمهنتي							
.5	أشعر بالضغط النفسي بسبب ممارستي لمهنتي							
.6	أتعامل بهدوء مع المشكلات الانفعالية للمرضى							
.7	يضايقني تضحيتي بوقت راحتي							
.8	أشعر بأنني منهك بسبب ممارستي لعملي							
.9	أشعر بالحيوية والنشاط عند ممارستي لمهنتي							
.10	أشعر بأني أعمل في هذه المهنة بإجهاد كبير							
.11	إن التعامل مع المرضى طوال اليوم يسبب لي الإجهاد والتعب							
.12	أشعر بأنه من الصعب أن أهدأ وأحس بالاسترخاء بعد يوم أقوم فيه بمعالجة المرضى							

م	العبارة	الشدة بدرجة قوية .... بدرجة ضعيفة جداً						
		6	5	4	3	2	1	0
13.	ساعات عملي تمتد لفترات طويلة							
14.	في أحيان كثيرة أضطر لأن أبقى في مكان عملي حتى بعد انتهاء ساعات العمل							
15.	تنتابني نوبات من الصداع من حين لآخر خلال تأديتي للعمل							
	ثانياً: تبلد المشاعر Depersonalization							
16.	أصبحت أجد صعوبة في ضبط إنفعالاتي نتيجة ممارستي لمهنتي							
17.	إن التعامل المباشر مع المرضى يسبب لي ضغوطاً نفسية شديدة							
18.	أفقد صبري عندما لا يستجيب المرضى لما أطلبه منهم							
19.	أشعر بالسعادة عند مساعدة المرضى							
20.	لا أكترث عندما لا أؤدي الأعمال على وجهها الصحيح							
21.	أشعر بأني أتعامل مع بعض المرضى وكأنهم جماد لا بشر							
22.	لا أكترث لما يحدث مع المرضى من مشكلات							
23.	أحس بالقلق لأن هذه المهنة تزيد من تبلد وقسوة عواطفي							
24.	أشعر أنني أصبحت أكثر قسوة مع الناس بعد التحاقي بمهنتي							
25.	إنني قلق لان هذه الوظيفة تحجر عواطفي							
26.	أشعر بأن المرضى يلقون علي مسؤولية بعض المشكلات التي تواجههم							
27.	أصبح أمر الحب والكره سيان							
	ثالثاً: نقص الشعور بالانجاز الشخصى Low personal accomplishment							
28.	أشعر بالضيق عندما يناقشني المرضى بموضوع ما							

م	العبارة	الشدة بدرجة قوية .... بدرجة ضعيفة جداً						
		6	5	4	3	2	1	0
29.	أشعر بأن علاقتي غير طبيعية مع المرضى أثناء قيامي بأعمال مهنتي							
30.	أشعر بتدني دافعيتي تجاه عملي							
31.	من السهل لدي خلق جو مريح مع المرضى							
32.	أشعر بالإحباط بسبب ممارستي لمهنتي							
33.	أشعر بأن تصرفات المرضى تزيد في ضغوط العمل علي							
34.	أشعر بأن لدي تأثير ايجابي في حياة كثير من الناس من خلال ممارستي لهذه المهنة							
35.	أشعر بأنني مثبط العزيمة بسبب وظيفتي							
36.	أشعر بغياب الحوافز المادية والمعنوية من الآخرين							
37.	أشعر بعدم توفر جو بيئي آمن ومناسب لحل المشاكل التي تواجه العاملين							
38.	أشعر بعدم وجود مسمى وظيفي							
39.	أشعر بالخوف أثناء عملي وعدم وجود إجراءات أمنية مناسبة							
40.	أواجه عبء عمل كبير طوال اليوم							
41.	أشعر بالقلق من غياب الأدوية							
42.	أواجه نقص في توفر المصادر والتحضيرات المناسبة للتعامل مع المريض							
43.	أشعر بغياب الفرص المناسبة للترقيات							
44.	أشعر بالقلق من التقلبات السياسية							
45.	أعاني من الإيذاء الجسدي من المريض أو أهله							
46.	أعاني من السلوكيات الخطأ من المريض أو أهله							
47.	أعاني من الإيذاء النفسي من المريض أو أهله							

م	العبارة	الشدة بدرجة قوية .... بدرجة ضعيفة جداً						
		6	5	4	3	2	1	0
48.	أشعر بأنني مهما أنجز في مكان عملي فإن النتيجة واحدة							
49.	مسئولي المباشر لا يقيم عملي من حين لآخر							

Appendix 2

ENGLISH BURNOUT CHECKLIST.

Questionnaire

Brother employee / _____ Esquire,,,

Peace be upon you and God's mercy and blessings

The researcher Fatma Mahmoud Abu Akar prepares a search for a master's degree in community mental health - Nursing Science entitled**: "Burnout among Mental Health Workers in Gaza Strip",** under the supervision of Prof. Dr. Sana Abu Daqqa and Dr. Abdul Aziz Thapet. In order to complement a master's degree, through answering to every paragraph of the questionnaire.

The aim of this questionnaire is to identify burnout among people who work in mental health clinics of the Palestinian Ministry of Health in the Gaza Strip. The researcher know burnout procedurally as: **"a state of exhaustion of physical, emotional and mental appear in the form of exhaustion severe and feeling of futility and hopelessness and the evolution of the concept of negative and negative attitudes towards work and life and people".** It consists of three axes, namely: Emotional Exhaustion, Depersonalization, Low personal accomplishment, which is measured by the questionnaire prepared for that and consisting of (49) paragraph contained previous dimensions or axes. Knowing that staging used in the measurement tool is (0 to 6), and includes the following items:

0	1	2	3	4	5	6
Never	a few times a year	once a month or less	A few times a month	once a week	a few times a week	Every day

Please read out the words carefully and then express your opinion mark (x) in place that is consistent with your opinion note that the answers will be treated confidentially and will be used for the purposes of scientific research only.

Thank you for your cooperation in the service of scientific research.
With greetings and good respect.

Researcher
Fatma Abu Akar
Supervising:
Prof. Sana Abu Daqqa
D. Abdul Aziz Thapet

Instructions

The following are a list of symptoms that might suffer from working in mental health, read each statement carefully, and after making sure of the applicability of the phrase you hope to put a sign inside one of the boxes to the left of the question and that describes your situation, that is, to what extent apply to you this problem over the past month even today, place the tag inside only one circle after every problem without forgetting the answer for any phrase, if you change your mind in response, completely clear the first sign, and place it in the appropriate box.

Read the following example before you begin:

Example

How much the following symptoms apply to you:

No	Item	Degree A strong degree.... Very weak degree						
		0	1	2	3	4	5	6
1-	I feel the pressure that I'm having in my work is the reason I suffer from physical troubles						X	

First: personal data

Sex: ☐ male ☐ Female

Age: ☐ 18-25 year ☐ 26- 35 year

☐ 36- 45 year ☐ more than 46 year

Address: ☐ Rafah ☐ Khanyounis ☐ central governorate

☐ Gaza ☐ North Gaza

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Number of children - if married -: ☐ one ☐ 2-5 ☐ more than 5

The level of education: ☐ Diploma ☐ BA ☐ Postgraduate

Monthly Income: ☐ 1001- 2000 ☐ 2001- 3000 ☐ more than 3000

Working hours: ☐ less than 8 ☐ 8- 10 ☐ more than 10 hours

Experience: ☐ less than 4 years ☐ 4- 10 year

☐ 10- 15 year ☐ more than 15 year

Specialization: ☐ doctors ☐ nurses ☐ Psychologist ☐ Social worker

Second: Paragraphs of the questionnaire
How much the following symptoms apply to you:

No	Item	Degree A strong degree.... Very weak degree						
		0	1	2	3	4	5	6
	First: Emotional Exhaustion							
1-	I feel the pressure that I'm having in my work is the reason I suffer from physical troubles							
2-	I deal with high efficiency with the problems of patients who treat							
3-	I feel constant fatigue when I wake up from my sleep							
4-	I have accomplished many things important to my career							
5-	I feel stress because of my practice for my career							
6-	I deal calmly with emotional problems for patients							
7-	I'm embarrassed to sacrifice time palms							
8-	I feel exhausted because of my practice for my work							
9-	I feel energetic when practicing my profession							
10-	I feel that I am working in this profession a great stress							
11-	Dealing with patients throughout the day causes me stress and fatigue							
12-	I feel that it is hard to calmer and felt relaxed after							

No	Item	Degree A strong degree.... Very weak degree						
		0	1	2	3	4	5	6
	the day when I treat patients							
13-	Hours practical stretch for long periods							
14-	Often he had to stay in the work place until after the end of working hours							
15-	I suffer bouts of headaches from time to time during my work							
	Second: Depersonalization							
16-	I find it difficult to control my emotions as a result of practicing my profession							
17-	Dealing directly with patients causes me severe psychological pressure							
18-	I Lose patience when patients do not respond to ask them							
19-	I feel happy when helping patients							
20-	I do not care when do not perform work on her face right							
21-	I feel I am dealing with some patients as if they were inanimate not humans							
22-	I do not care what happens with patients of problems							

No	Item	Degree A strong degree.... Very weak degree						
		0	1	2	3	4	5	6
23-	I feel concerned that this profession increases the insensitivity and cruelty of my emotions							
24-	I feel I have become more severe with people after I joined the professions							
25-	I am concerned because this function petrified my emotions							
26-	I feel that patients throwing the responsibility for some of the problems they face							
27-	Love and hate became one							
	Third: Low personal accomplishment							
28-	I feel annoyed when discussing patients in a particular subject area							
29-	I feel unnatural relationship with patients during my work career							
30-	I feel low motivation towards practical							
31-	Easy I have to create a relaxed atmosphere with patients							
32-	I feel frustrated by the practice of the profession							
33-	I feel that the actions of patients exceeding the pressures of work							

No	Item	Degree A strong degree.... Very weak degree						
		0	1	2	3	4	5	6
34-	I feel that I have a positive influence in the lives of many people through my practice of the profession							
35-	I feel inhibitor determination because of my job							
36-	I feel the absence of material and moral incentives from others							
37-	I feel the lack of a safe and suitable environment to solve the problems faced by workers							
38-	I feel that there is no job title							
39-	I feel afraid in my work and the lack of appropriate security measures							
40-	I'm having a large workload throughout the day							
41-	I am concerned the absence of drugs							
42-	I'm having a shortage in the availability of resources and the appropriate preparations to deal with the patient							
43-	I feel the absence of appropriate opportunities for promotions							
44-	I am concerned political instability							
45-	suffer from physical abuse from the patient or his family							

No	Item	Degree A strong degree.... Very weak degree						
		0	1	2	3	4	5	6
46-	I suffer from the wrong behaviors of the patient or his family							
47-	I suffer from psychological abuse from the patient or his family							
48-	I feel no matter how accomplished in the work place, the result is the same							
49-	Direct officials not assess practical from time to time							

Appendix 3

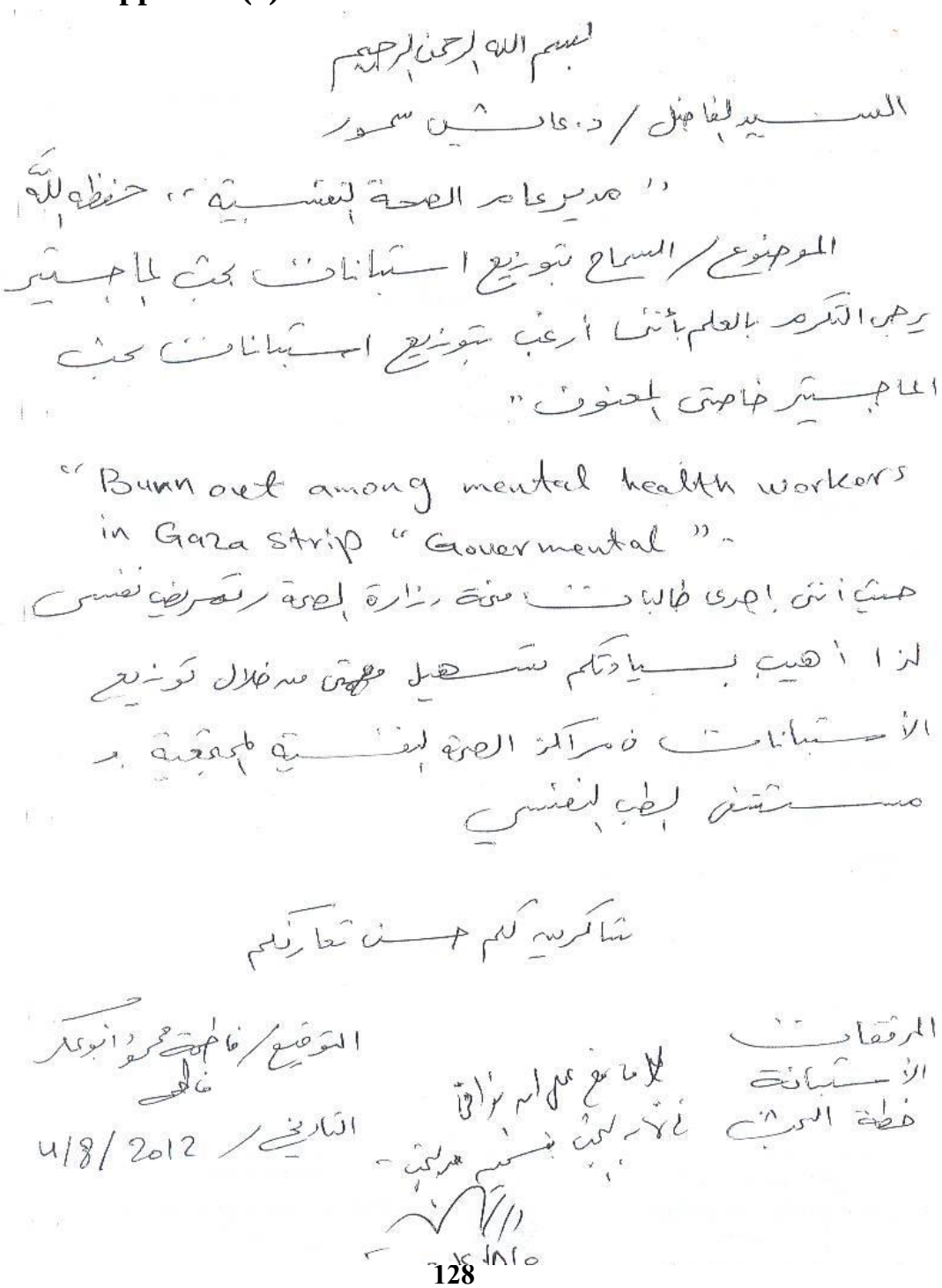
▪*The judgmental professionals Table*

No	The professional	Specialty	The place of Work
1	Dr. Ashraf Al Gedi	Mental Health Professional	Islamic University/Gaza
2	Dr. Yosef El Jesh	Mental Health Professional	Islamic University/Gaza
3	Dr. Jameel Tahrawi	Mental Health Professional	Islamic University/Gaza
4	Dr. Atef El Aga	Psychologist	Islamic University/Gaza
5	Dr. Yousef Awadallah	Public health Professional	Rafah Clinic for mental health

Appendix 4

▪ *Facilitation letter*

Appendix (3): Facilitate the task of the researcher



بسم الله الرحمن الرحيم

السيد الفاضل / د. عادل سمور

" مدير عام الصحة النفسية " حفظه الله

الموضوع / السماح بتوزيع استبانات بحث الماجستير

يرجى التكرم بالعلم بأننا أرغب بتوزيع استبانات بحث الماجستير خاصتي الصغوف "

" Burnout among mental health workers in Gaza strip " Governmental ".

حيث أنني إحدى طالبات منحة وزارة الصحة / تمريض نفسي

لذا أهيب بسيادتكم تسهيل مهمتي من خلال توزيع الاستبانات في مراكز الصحة النفسية المجتمعية و مستشفى الطب النفسي

شاكرين لكم حسن تعاونكم

المرفقات : الاستبانة

التوقيع / فاطمة محمود أبو بكر غالي

التاريخي / 4/8/2012