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PSYCHOLOGICAL FACTORS ASSOCIATED WITH BURNOUT AMONG NURSES

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(... رَبِّ أَوْزِعْنِي أَنْ أَشْكُرَ
نِعْمَتَكَ الَّتِي أَنْعَمْتَ عَلَيَّ وَعَلَى
وَالِدَيَّ وَأَنْ أَعْمَلَ صَالِحًا تَرْضَاهُ
وَأَدْخِلْنِي بِرَحْمَتِكَ فِي عِبَادِكَ
الصَّالِحِينَ) النمل الاية ١٩

صدق الله العظيم

الإهـــداء

الى أمي الغالية أمد الله في عمرها التي ساندتني في كل مرحلة....

الى أبي العزيز أمد الله في عمره وبارك له في صحته الذي كان يدفعني دوماً ولا يبخل ...

الى زوجتي رفيقة دربي....

الى ابنتي و فلذتي رغد ...

الى عمي و اخوتي و أخواتي الأعزاء حفظهم الله جميعاً ....

الى اساتذتي ....

الى طلبة العلم جميعاً .....

أهدي هذا الجهد المتواضع ،الذي من الله علي بتوفيقه كي أتمه ...

الباحث

أدهم عزات حسن العمصي

شكـــر و تـــقدير

(... رَبِّ أَوْزِعْنِي أَنْ أَشْكُرَ نِعْمَتَكَ الَّتِي أَنْعَمْتَ عَلَيَّ وَعَلَى وَالِدَيَّ وَأَنْ أَعْمَلَ صَالِحًا تَرْضَاهُ وَأَدْخِلْنِي بِرَحْمَتِكَ فِي عِبَادِكَ الصَّالِحِينَ.) النمل الاية ١٩

يارب لك الحمد لك كما ينبغي لجلال وجهك و عظيم سلطانك ، أحمدك و أشكرك على التوفيق الذي كان يصاحبني في مراحل البحث ، فإن وُفِقت فمن الله ، و إن زللت فمن نفسي الضعيفة ، و أصلي و اسلم على النبي محمد صلى الله عليه وسلم الذي حض على طلب العلم و على صحابته و تابعيهم باحسان الى يوم الدين .

أتوجه بالشكر و العرفان الى والداي و زوجتي و اخوتي جميعاً ما قدموه لي من دعم و توجيه على طريق اتمام هذا البحث و اسال الله العظيم بان يجزيهم عني خير الجزاء .

و أتوجه بالشكر الى اصدقائي الذين دعموني و نصحوني خلال رحلة البحث وفقهم الله ما يحبه و يرضاه.

و اتوجه بالشكر و العرفان الى جامعتي الجامعة الاسلامية صرح العلم و منارة العلماء ،و محضن الدعاة، أدامها الله نوراً على ثرى هذا الوطن العظيم و رئيسها و الى عمادة الدراسات العليا و عمادة كلية التربية و اعضاء الهيئة التدريسية ما قدموه من مساعدة لاتمام هذا البحث .

و اتوجه بجزيل الشكر الى استاذي المربي بشير الحجار الذي ارشدني في مراحل البحث.

و أتوجه بالشكر و العرفان الى مشرفي الدكتور سمير قوته و الى الدكتور عاطف الأغا لما بذلوه في سبيل المساعدة في انجاح هذا البحث فجزاهم الله عنا خير الجزاء .

و أتوجه بالشكر الى السادة الذين سوف يتفضلون بمناقشة هذا البحث ، افادنا الله من علمهم و جزاهم الله عنا خير الجزاء .

كما أتقدم بالشكر للسادة الذين حكموا أدوات البحث لما قدموا لي من راي و مشورة .

كما أتقدم بالشكر الى الإخوة الزملاء الذين شاركوا في هذه الدراسة ، و الى الدكتور نافذ بركات الذي ساعدني في المعالجات الإحصائية لهذا البحث ، فجزاهم الله عني خير الجزاء .

و في الختام أتوجه بالشكر الجزيل لكل من ساعد و ساهم في اتمام هذا البحث و انجازه، و أدعوا الله أن يوفق كل من يسلك درب العلم و يعينه و جزى الله الجميع خير الجزاء .

أدهم عزات حسن العمصي

سبتمبر ٢٠٠٧

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§ Introduction

Nursing profession is the oldest job that human ever practice, starts in our Islamic history with the battles which our profit Mohammed fight in and the wounded care which was the job of ohm Salama the woman, she practice nursing and fighting in the battle field.

A history of the Western Sanitary Commission, written in 1854, begins with this credit to Florence Nightingale's pioneering work: the first organized attempt to mitigate the horrors of war, to prevent disease and save the lives of those engaged in military service by sanitary measures and a more careful nursing of the sick and wounded, was made by a commission appointed by the British Government during the Crimean war 1854, to inquire into the terrible mortality from disease that attended the British army at Sebastopol, and to apply the needed remedies. It was as a part of this great work that the heroic young Englishwoman, Florence Nightingale, with her army of nurses, went to the Crimea to care for the sick and wounded soldier, to minister in hospitals, and to alleviate suffering and pain, with a self-sacrifice and devotion that has made her name a household word, wherever the English language is spoken. In the armies of France the Sisters of Charity had rendered similar services, and even ministered to the wounded on the battle field; but their labors were a work of religious charity and not an organized sanitary movement. (Timby: 1996).

The nursing continue to develop to be clearly a profession with thousand colleges all over the world and nursing staff prove himself by his effect on the patient health with criteria of the profession which include:

- Draws on a well-defined body of intellectual knowledge.
- Uses the scientific methods to enlarge that body of knowledge, improving education and service.
- Educates its practitioners in institutions of higher learning.
- Functions autonomously in control of professional policy and activity and functions within a code of ethics.

- Is composed of individuals who consider this occupation as their lifework, contributing to the good of society through service to others.
- Requires continuous professional development.

It face now as a profession very much acceptance between the student to study due to the continuous need for it and the quality of services they provide to become now as registered nurses in Gaza strip only 4600 registered nurse . (Nursing syndicate: 2006).

These nurses work in very exhausted conditions According to the world health organization report in Palestine Nursing and midwifery personnel per 10000 populations 16.0, Hospital beds per 10000 populations 13.3, Primary health care units and centers 2.0.(WHO:2004).

This bad environmental, political and the work overload which contain very stressful work conditions produce many psychological discomfort state among nurses , the most obvious problem is the burnout ,The burnout among nurses is not only in Palestine but also all over the world;

A study by Seskevicius A. on The burnout syndrome among nurses working in Lithuanian cardiac surgery centers, the study was performed using a questionnaire. A total of 180 questionnaires completed by nurses in Lithuanian cardiac surgical centers revealed 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. (Seskevicius: 2006)

Another study of Piko BF. Burnout, role conflict, job satisfaction and psychosocial health among Hungarian health care staff which applied in two major hospitals in Szeged, Hungary, 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. (Piko: 2006)

While a study of Quattrin R. And others on Level of burnout among nurses working in oncology in an Italian region, the study done in Oncology wards in public hospitals in a northeastern Italian region, which applied on 100 nurses working on oncology wards, the results shows that The global response rate was 71% (100 of 140); 35% of the nurses had a high level of emotional exhaustion, 17% had a high level of depersonalization, and 11% had a high level of personal achievement. Significantly high levels of emotional exhaustion were found in nurses older than 40 with a working seniority of more than 15 years, those who had chosen to work on an oncology ward, and those who wanted another work assignment. The mean emotional exhaustion in subjects who identified lack of coordination (disorganization) as an important cause of stress was 24.5, whereas the mean score in the nurses who did not cite disorganization as a cause of stress was 18.3. (Quattrin and others: 2006)

And a study of Hisashige A. On Burnout phenomenon and its occupational risk factors among Japanese hospital nurses, the subjects consisted of 898 nurses and 255 municipal service workers as the control group. Working conditions and workload burdens were more severe among nurses than among the municipal workers. The burnout phenomenon among the nurses was characterized by emotional exhaustion as well as depersonalization. Moreover, the rate ratio and multivariate analyses indicated that a great variety of occupational factors, not only interpersonal relationships, but the general working conditions and specific physical or mental workloads influenced the burnout phenomenon as well. Therefore, in examining measures dealing with the burnout phenomenon among nurses, it is considered important to evaluate the occupational factors systematically and comprehensively. (Hisashige :1991)

So as we see it's a phenomena all over the world among the nurses, this exhibit firstly the need of this study to be applied here in Gaza due to the importance of this study to clarify the needs of our nurses and the effects on patient care, and secondly there is no study done on the nurses here in Gaza in this subject, and its obviously shows the need to provide the researchers in this field to empower their knowledge and the decision maker to put in their perspective these data during policy making ,and the nurses themselves to insight them with their problems to take care .

§ Questions of the Study:

According to the previous mentioned information on the burnout shows that it's a common phenomena for staff in the human service professions, particularly in teaching, medical services, counseling, and social work, so its express this main question:

- **What is the prevalence of burnout among the Palestinian nurses in Gaza city?**

The following specific questions emerge from the main question:

1. What's the relation between burnout and stress among the nurses?
2. What's the relation between burnout and social support of the nurses?
3. What's the relation between burnout and educational level of the nurses?
4. What's the relation between burnout and the nurses' experiences?
5. What's the relation between burnout and the sex of the nurses?
6. What's the relation between burnout and the age of the nurses?
7. What's the relation between burnout and the working place of the nurses?
8. What are the factors that cause burnout among nurses?

§ The study hypotheses:

The hypotheses underlying this study are the following:

01. The researcher predict higher rates in total score of burnout at significant level ($a = 0.05$) among the Nurses.

02. The researcher predict higher rates of stressed nurses with significant statistical level at ($a == 0.05$) that positively related to the total score of burnout.

03. The researcher predicts higher rates of social support that positively related with the total score of burnout level at significant level ($a == 0.05$).

04. The researcher predict no significant statistical differences at level ($a == 0.05$) in the burnout total score due to the sex of the nurse.

05. The researcher predict no significant statistical differences at significant level ($a == 0.05$) in the burnout total score due to the age of the nurse.

06. The researcher predict no significant statistical differences at significant level ($a = 0.05$) in the burnout total score due to the educational level of the nurse.

07. The researcher predict no significant statistical differences at significant level ($a == 0.05$) in the burnout total score due to the Nurses' experiences.

08. The researcher predict no significant statistical differences at significant level ($a == 0.05$) in the burnout total score due to the working place (hospitals) of the nurses.

§ Purpose of the study:

The purposes of the study were:

1) To investigate of the degree of burnout experienced by nurses working in Public Hospitals in the area of Gaza city.
2) To identify of factors like stress and its effects on burnout.
3) To identify of factors like social support and its effects on burnout.
4) To identify of the relation between burnout and nurses' experiences.
5) To identify of the relation between burnout and educational level of the nurse.
6) To identify of the relation between burnout and the sex of the nurse.

7) To identify of the relation between burnout and the age of the nurse.

8) To identify of the relation between burnout and working place of the nurse.

9) To identify through a case study the causes that lead to burnout.

§ Significance of the study:

1) The need of this study to be applied here in Gaza due to the importance of this study to clarify the needs of our nurses and the effects on patient care to document it to be used by the researchers in this field.

2) There is no study done on the nurses here in Gaza in this subject so it's important to be provided to the decision maker to put in their perspective these data during policy making.

3) To be provided to the nurses themselves to insight them with their problems to take care.

§ Definitions of terms:

- *Burnout*: Burnout has been defined in many ways since the early 1970's. The word itself is a grass roots rather than scientific term, coined to give name to a set of symptoms individuals were experiencing in certain settings (Maslach & Goldberg: 1998).

"The main characteristics [of burnout] are an overwhelming exhaustion: feelings of frustration, anger, and cynicism and a sense of ineffectiveness and failure" (Maslach & Goldberg: 1998, p. 63).

The operational definition is:

Burn out is a state of fatigue or frustration brought about by a devotion to a cause, a way of life, or a relationship that failed to produce the expected reward, and measured by a tool consists of many symptoms in a checklist.

-Stress: (Roughly the opposite of relaxation) is a medical term for a wide range of strong external stimuli, both physiological and psychological, which can cause a physiological response called the general adaptation syndrome, (Hans Selye: 1936)

The operational definition of the researcher is:
A physiological or psychological response to a stressor beyond what is needed to accomplish a task.

- Social support: social support as information that leads individuals to believe they are loved and cared for, valued and esteemed. Individuals with strong social support participate in a network of communication and mutual cooperation.

- Educational level: is the post secondary education that the nurse accomplished.

- Nurses' experiences: is the time that the nurse spends from he starts working in the employment until now including the number of practical and theoretical skills that he gain.

-working place: is the place that the person (the nurse) working in, which vary from department to clinic.

§ The Study limitations:

-Time limitation: the study will be applied on the nurses in 2006-2007.

- Place limitation: the study will be applied on the nurses whom working in the hospitals of Gaza city.

§ Study tools:

Several tools were used in this study:

1. Maslach Burnout Inventory survey. **(**christina maslach)
2. Work Stress checklist. (developed by the researcher)
3. Social Support Questionnaire. (kyoko fujiwara&others:2003)
4. Questionnaire to measure the other variables like age, sex, educational level, experience.

Chapter two

Theoretical Framework

1. NURSING PROFESSION.

2.BURNOUT.

3.STRESS.

4.SOCIAL SUPPORT.

1- NURSING PROFESSION.

§ THE HISTORY OF NURSING IN THE ISLAM:

- **THE SPREAD OF ISLAM:**

In order to understand how medicine developed in the Middle Ages, we have to look back at the history and find out the important things that happened during the Seventh Century.
In 570 A.D., a man was born in a small city in the Arabian Peninsula, called Mecca (Haykal 1976), his name was Mohammed. In 610 A.D. he declared a new religion, Islam. In 632 A.D., he died after uniting the Arab tribes who had been torn by revenge, rivalry, and internal fights. Out of these mostly illiterate nomadic people, he produced a strong nation that encountered and conquered, simultaneously, the two known empires at that time, namely, the Persian and Byzantine Empires. In a man's life-time, the Islamic Empire extended from the Atlantic Ocean on the West, to the borders of China on the East. In 711 A.D., only 80 years after the death of their prophet, the Arabs crossed to Europe to rule Spain for more than 700 years. In 732 A.D., they threatened Paris and their thrust was stopped at Tours (Eigeland 1976).

In 831 A.D., the Moslems of North Africa invaded Sicily and ruled it for 200 years. By 846 A.D., they controlled the southern part of Italy and encountered Rome (Hitti 1977).

The hold of the Moslems over Italy remained so firm that Pope John VIII (872-882 A.D.) deemed it prudent to pay tribute for two years (Hitti 1977) in 869 A.D.; the Arabs captured Malta (Ibn-Khaldun).

In the tenth century, from Italy and Spain, the Arabs extended their raids through the Alpine passages into mid-Europe. In the Alps, there are a number of castles and walls which tourists' guides attribute to the

Invasion of the Moslems of Sicily. In the southern part of Italy and in Sicily, a great civilization was established and through which the torch of knowledge spread to Europe, mainly through the University of Salerno in the southern part of Italy (Hitti 1977, Parente 1967).

The expansion of the Moslems in Europe was not limited to those from North Africa and Spain. The Moslems, under the Ottoman Empire, invaded Europe from the East. They occupied a good part of Middle Europe and besieged Vienna twice, once during the reign of Sulayman 1 (1520-1566 A.D.) and the other during the reign of Mohammed IV (1648-1687 A.D.) (Hitti 1977).

§ ISLAM AND THE PROMOTION OF CULTURE AND SCIENCE:

As the Moslems challenged the civilized world at that time, they preserved the cultures of the conquered countries. On the other hand, when the Islamic Empire became weak, most of the Islamic contributions in art and science were destroyed. This was done by the Mongols who, out of barbarism, burnt Baghdad (1258 A.D.), and by the Spaniards, who out of hatred, demolished most of the Arabic heritage in Spain. The difference between the Arabs and these was the teachings of Islam which:

1. ***stressed the importance and respect of learning***. For example, the first word revealed to the Moslems' prophet Mohammed was "Read". In Mohammed's era, a captured enemy was freed if he paid a ransom or taught ten Moslems writing and reading. In their holy book, the Qur'an, the importance of knowledge has been repeatedly stressed as it says "Those who know and those who do not are not equal." The prophet Mohammed stressed learning by saying. "One hour of teaching is better than a night of praying." One of the early princes, Khalid fbn Yazid (end of the 7th century), gave up his treasure for the study of medicine and chemistry. He studied medicine under John the Grammarian of Alexandria and chemistry under Merinos the Greek (Haddad 1942). He also encouraged several Greek and Coptic medical books to be translated into Arabic.

2. ***Forbade destruction***. On conquering Mecca, the prophet Mohammed

Strongly stated that no homes, animals, or trees should be destroyed. His followers abided with these principles when conquering other countries.

3. ***Encouraged cleanliness and personal hygiene*.** Islam instructed them to approach God in their prayers five times a day with bodies and clothes spotlessly clean.

4. *developed in them the respect of authority and discipline*. For example, realizing the scourges and terror of plague, their prophet Mohammed (p.b.u.h.) decreed that "no man may enter or leave a town in which plague broke out." And to make this law all the more binding and effective, he promised the blessing of heaven to those who die of plague by stating that if a man died of plague he would be considered a martyr (Haddad 1942). Thus Mohammed (p.b.u.h.) laid for the Moslems the laws governing cordon and quarantine for the first time in history and made it work.

5. ***Tolerated other religions*.** The Islamic religion recognizes Christianity and Judaism and considers their followers to be people with holy books like Moslems. Moreover, they candidly treated the Jews at an era when the latter were persecuted in Europe. Dr. Jacob Minkin, a reputable Rabbi and scholar says "It was Mohammedan Spain, the only land of freedom the Jews knew in nearly a thousand years of their dispersion ... While during the Crusades, the armored Knights of the Cross spread death and devastation in the Jewish communities of the countries through which they passed, Jews were safe under the sign of the Crescent. They were not only safe in life and possessions, but were given the opportunity to live their own lives and develop a culture so unique and striking that it went down in history as the 'Golden Ages'. The Moors, the Muslim conquerors of Spain in 711, were not religious fanatics. They were strong in their faith but generous with regard to the religious convictions of others.... "The Renaissance of Art in Italy says George A. Dorsey, has blinded us to the Renaissance of Science in Spain, which fostered science, promoted culture, encouraged learning, and set a premium on intellectual pursuits, no matter whether the intellect was Moslem, Christian or Jew. Not since the days of Greece had the world known such thirst for knowledge, such passion for learning, such spirit shared by the prince and the usual people alike" (Minkin 1968).

The Arabs were assimilated by the vast new countries they reached. From this marriage of genuine characters and righteousness with the ancient and well established civilizations, a great new nation was born. It is difficult to identify this new breed as Arabs, because although the language was Arabic, all the scientists were not necessarily from the Arabian Peninsula. It is also equally difficult to describe it as Islamic, because although the majority of the scientists were Moslems, sponsored by Moslem rulers, and governed by the Islamic law, yet some scientists were Christians or Jews, especially at the early phase of the Islamic civilization: the translation period to Arabic, and the decline part: the translation period to Latin and Hebrew. Therefore, in this article, the adjectives Arabic or Islamic will be used as synonyms.

- **MEDICINE AND NURSING BEFORE ISLAM:**

1. In order to comprehend the contributions of Arabs to medicine and nursing, we must have in our minds a picture of the condition of medicine before they arrived to the scene. Generally speaking, two elements are required for medical practice:

- **MANPOWER AND HOSPITALS**:

A. MANPOWER BEFORE ISLAM:

There were medical centers in different parts of the world which were later either under control of the Arabs or in touch with them. For example, in Syria, medicine and nursing was advanced and was greatly influenced by the Byzantine civilization which affected also the economic and administrative systems (Hammameh 1962).

From the fifth century on, the Greek was the language of learning in Syria. The knowledge of the Arabs of the Greek civilization was mainly through the Syrian scholars who translated it into Arabic. In Egypt, Alexandria was another center for culture. The Arabs got in touch with both the ancient Egyptian and Greek civilizations through the Egyptian

scholars. In Persia, there was a medical school in a city called Jundi-Shapur in which medicine was highly developed. The Abbasi Caliphs during the 8th century encouraged the Persian physicians to translate into Arabic the medical knowledge therein, to build medical centers in Baghdad, the capital of their empire, and to run newly built hospitals. With further expansion east, the Arabs through contacts with India and China, brought ideas and methods, not only in medicine, but also in mathematics, chemistry, philosophy, etc.

B. HOSPITALS BEFORE ISLAM:

Hospitals as we know them now probably were not present. True, there were places for the sick to stay, but these were mainly temples or annexes to temples that were run by priests. Gods were supposed to play a major role in the art of healing. For example, the God was the Egyptian symbol of fecundity and protectors of the pregnant and parturient. (Speert 1973).

In those days, sanctuary, prayers, incitation, and hypnosis were integral parts of the therapy.

§ CHARACTERISTIC FEATURES OF HOSPITALS IN THE ISLAMIC CIVILIZATION:

During the Islamic civilization, hospitals had much developed and attained specific characteristics:

1. ***equals*:** Hospitals served all peoples irrespective of color, religion, or background. In hospitals, physicians and nurses of all faiths worked together with one aim in common: the well-being of patients.

2. ***Separate wards*:** Patients of different sexes occupied separate wards. Also different diseases especially infectious ones were allocated different wards.

3. ***Separate nurses*:** Male nurses were to take care of male patients, and vice versa.

4. *Baths and water supplies*: Praying five times a day is an important pillar of Islam. Sick or healthy, it is an Islamic obligation; of course

Physical performance depends on one's health, even he can pray while lying in bed. Before praying, washing of face, head, hands, and feet must be done, if possible. For certain conditions, a bath is obligatory. Therefore, these hospitals had to provide the patients and employees with plentiful water supply and with bathing facilities.

5. ***Practicing physicians*****:** Only qualified physicians were allowed by law to practice medicine. In 931 A.D., the Caliph Al-Mugtadir from the Abbasid dynasty, ordered the Chief Court-Physician Sinan Ibn-Thabit to screen the 860 physicians-of Baghdad, and only those qualified were granted license to practice (Hamarneh 1962).

The counterpart of Ibn- Tbabit, Abu-Osman Sai'd Ibn-Yaqub was ordered to do the same in Damascus, Mecca, and Medina. The latter two cities were in need for such an act because of hundreds of thousands of pilgrims visiting them every year. This was to prevent taking advantage of these pilgrims and to curb the spread of diseases among them.

6. ***Rather medical schools***: The hospital was not only a place for treating patients, but also for educating medical students, interchanging medical knowledge, and developing medicine as a whole. To the main hospitals, there were attached expensive libraries containing the most up-to-date books, auditoria for meetings and lectures, and housing for students and house-staff.

7. ***Proper records of patients***: For the first time in history, these hospitals kept records of patients and their medical and nursing care.

8. ***Pharmacy:*** During the Islamic era, the science and the profession of pharmacy had developed to an outstanding degree. The Arabic material medical became so rich and new drugs and compounds were introduced because the Muslims had contact with almost all the known world at that time, either through control or trade. Their ships sailed to China and the Philippines, and their convoys made trades with black Africa, Europe and Asia. Chemistry became an advanced science, and there were means and need for a specialization called pharmacy.

Thus, the main Arabian hospitals were models for medieval hospitals

built later in Europe. They were rather medical schools to which those seeking advanced medical knowledge, from the East or West, attended.

§ MEDICAL AND NURSING ETHICS IN ISLAM:

The medical profession was a well respected specialty and its Leaders kept it this way by laying down proper ethics. Al-Tabari, the chief physician in 970 A.D., described the Islamic code of ethics as follows (Hamamch 1971, Levy 1967):

I. ***Personal characters of the physician and the nurse:***

The Physician and the nurse ought to be modest, virtuous, merciful, and UN addicted to liquor. He should wear clean clothes, be dignified, and have well-groomed hair and beard. He should not join the ungodly and scoffers, nor sit at their table. He should select his company to be persons of good reputation. He should be careful of what he says and should not hesitate to ask forgiveness if he has made an error. He should be forgiving and never seek revenge. He should be friendly and peacemaker. He should not make jokes or laugh at the improper time or place.

II. ***The obligation towards patients*:**

They should avoid predicting whether a patient will live or die; only God (Allah) knows. They ought not to loose his temper when his patient keeps asking questions, but should answer gently and compassionately. They should treat alike the rich and the poor, the master and the servant, the powerful and the powerless, the elite and the illiterate. God will reward him if he helps the needy. The physician and the nurse should not be late for his rounds or his house calls. They should be punctual and reliable. They should not wrangle about their fees. If the patient is very ill or in an emergency, the physician should be thankful, no matter how much he is paid. He should not give drugs to a pregnant woman for an abortion unless necessary for the mother's health. If the physician prescribes a drug orally, he should make sure that the patient understands the name correctly, in case he would ask for the wrong drug and get worse instead of better. He should be decent towards women and should not divulge the secrets of his patients.

III. ***His obligation towards the community:***

The physician and the nurse should speak no evil of reputable men of the community or be critical of any one's religious belief.

These ethics was before any European think of any ethics or medicine or nursing.

§ HISTORY OF NURSING IN EUROPE:

In ancient times, when medical lore was associated with good or evil spirits, the sick were usually cared for in temples and houses of worship. In the early Christian era nursing duties were undertaken by certain women in the church, their services being extended to patients in their homes. These women had no real training by today's standards, but experience taught them valuable skills, especially in the use of herbs and drugs, and some gained fame as the physicians of their era. In later centuries, however, nursing duties fell mostly to relatively ignorant women.

In the 17th cent., St. Vincent de Paul began to encourage women to undertake some form of training for their work, but there was no real hospital training school for nurses until one was established in Kaiserwerth, Germany, in 1846. There, Florence Nightingale received the training that later enabled her to establish, at St. Thomas's Hospital in London, the first school designed primarily to train nurses rather than to provide nursing service for the hospital. Similar schools were established in 1873 in New York City, New Haven (Conn.), and Boston. Nursing subsequently became one of the most important professions open to women until the social changes wrought by the revival of the feminist movement that began in the 1960s the late 20th cent.

§ FLORENCE NIGHTINGALE THE FIRST EUROPEAN NURSE:

Florence Nightingale is most remembered as a pioneer of nursing and a reformer of hospital sanitation methods. For most of her ninety years, Nightingale pushed for reform of the British military health-care system

And with that the profession of nursing started to gain the respect it deserved. Unknown too many, however, was her use of new techniques of statistical analysis, such as during the Crimean War when she plotted the incidence of preventable deaths in the military. She developed the "polar-area diagram" to dramatize the needless deaths caused by unsanitary conditions and the need for reform. With her analysis, Florence Nightingale revolutionized the idea that social phenomena could be objectively measured and subjected to mathematical analysis. She was an innovator in the collection, tabulation, interpretation, and graphical display of descriptive statistics. (Lipsey, Sally.: 1993)

Florence Nightingale's two greatest life achievements--pioneering of nursing and the reform of hospitals--were amazing considering that most Victorian women of her age group did not attend universities or pursue professional careers. It was her father, William Nightingale, who believed women, especially his children, should get an education. So Nightingale and her sister learned Italian, Latin, Greek, history, and mathematics. She in particular received excellent early preparation in mathematics from her father and aunt, and was also tutored in mathematics by James Sylvester. In 1854, after a year as an unpaid superintendent of a London "establishment for gentlewomen during illness," the Secretary of War, Sidney Herbert, recruited Nightingale and 38 nurses for service in Scutari during the Crimean War.

During Nightingale's time at Scutari, she collected data and systematized record-keeping practices. Nightingale was able to use the data as a tool for improving city and military hospitals. Nightingale's calculations of the mortality rate showed that with an improvement of sanitary methods, deaths would decrease. In February, 1855, the mortality rate at the hospital was 42.7 percent of the cases treated (Cohen 131). When Nightingale's sanitary reform was implemented, the mortality rate declined. Nightingale took her statistical data and represented them graphically. She invented polar-area charts, where the statistic being represented is proportional to the area of a wedge in a circular diagram (Cohen 133).

As Nightingale demonstrated, statistics provided an organized way of learning and lead to improvements in medical and surgical practices. She

Also developed a Model Hospital Statistical Form for hospitals to collect and generate consistent data and statistics. She became a Fellow of the Royal Statistical Society in 1858 and an honorary member of the American Statistical Association in 1874. Karl Pearson acknowledged Nightingale as a "prophetess" in the development of applied statistics. (Wadsworth Jr. &others: 1986)

§ ANTEBELLUM NURSING IN THE AMERICAN HISTORY:

On plantations in the antebellum south black female slaves acted as midwives, provided child care, and performed other nursing duties for both whites and blacks. Male nurses composed the majority of hospital workers in the handful of established marine and charity hospitals of the mid-nineteenth century. Hospital officials often hired former hospital patients who had no formal training in medicine or nursing. The forces that supplanted the untrained nurse did not come into play until the late nineteenth century and early twentieth century. New and centralized technologies fueled the rise of hospital-based care. A greater acceptance of surgical procedures, urbanization, and nurses' own efforts to grapple with social problems culminated in the ascent of the trained nurse.

The idea of nursing—middle-class women managing and supervising the preparation of food, supplies, and linens and administering medications and treatments—gained momentum during the Civil War (1861–1865). Approximately twenty thousand women volunteers worked in military hospitals, but almost none had any hospital or practical training in nursing. Union hospitals hired female nurses to complement the staff of male nurses, convalescent soldiers, and male ward masters responsible for day-to-day supervision. In Confederate hospitals significantly fewer Southern women worked as nurses. Black male slaves bathed and fed patients daily. Catholic nuns played a unique role, nursing wounded soldiers from both the Confederate and Union armies. When the war ended, medical departments dismantled their massive hospital complexes, and most of the female nurses returned to teaching, domestic service, writing, family, and marriage.

Occasionally reformers extolled the benefits of trained nurses and the specific suitability of women for that role, but the goal of a trained nurse

Attendant languished for more than a decade after the Civil War. The 1880 census revealed that, while over ten thousand nurses were available for hire, less than 1 percent were graduates of hospital nursing courses. By 1873 only four schools of nursing existed in the United States: the New England Hospital for Women and Children and Massachusetts General Hospital in Boston, New Haven Hospital in Connecticut, and Bellevue Hospital in New York City. Over the next quarter century Americans witnessed a dramatic increase in the number of nursing schools from slightly over 400 in 1900 to approximately 1,200 by 1910. Among African American women, the number of hospital-trained graduates did not keep pace. Racial quotas in northern nursing schools and outright exclusion from training schools in the South limited their access to training. In 1879 the first African American woman graduated from the New England Hospital for Women and Children in Boston. Hospital schools with the explicit mission of training black nurses to serve the African American community opened their doors in the late nineteenth century: Spelman Seminary in Atlanta (1886), Hampton Institute in Virginia (1891), Providence Hospital in Chicago (1891), and Tuskegee Institute in Alabama (1892) (Hines, Darlene:1989).

§ NURSING EDUCATION:

By the beginning of the twentieth century middle-class Americans accepted nursing as a worthy albeit demanding vocation for young women. The women who entered nursing schools encountered an unregulated and often exploitative field. Hospital administrators opened nursing programs to avail their hospitals of a cost-effective student labor force. Nursing students practiced their skills as apprentices under the supervision of second-and third-year nursing students. Most schools offered limited courses in basic anatomy, physiology, or biology, and student nurses did not systematically rotate through all medical specialties, and the education of this profession develops to master and PhD (Kalisch&others: 1986).

Nursing leaders and educators, aware of the poor formal instruction in most hospital-based programs, pushed for fundamental reforms in nursing education and national legislation governing the licensing and practice of nursing. College-based nursing programs received a welcome

Endorsement when Columbia University appointed Mary Adelaide Nutting the first full-time professor of nursing in 1907. Nutting and her nursing colleagues established the *American Journal of Nursing* in 1900. Nurses revealed a growing professional awareness when they reorganized several professional nurses' groups under one national organization, the American Nurses Association (ANA), in 1912. That year the National Organization for Public Health Nursing organized its charter. Black graduate nurses, excluded from full representation in the ANA until 1951, established the National Association of Graduate Colored Nurses (NAGCN) in 1908, and Mabel Keaton Staupers served as the organization's first executive director (1934–1946). Although African American nurses grappled with the same professional issues as their white counterparts, racial discrimination and dismal employment opportunities amplified the black nurses' struggles (Mottus, Jane E: 1981).

§ NURSING IN THE ARMED FORCES:

The exegesis of war created a receptive environment for nurses to press their grievances and further their professional goals while providing a crucial service to the nation. When military leaders reluctantly established the Volunteer Hospital Corps for female nurses during the Spanish-American War (1898), nursing leaders insisted on trained applicants from accredited nursing schools. In 1901 the Army Nurse Corps became a permanent service within the Medical Department, and the Navy Nurse Corps followed in 1908. Military medical officials in concert with nursing educators standardized and improved nursing education and established the Army School of Nursing in 1918 to meet the demands of World War I. During World War II the U.S. government agreed to award officer's rank to military nurses (Maher, Mary: 1999).

Congressional leaders agreed to subsidize nursing schools and nursing education to attract women to nursing, a boon for all nurses but of special importance to black women. Black nursing leaders vigorously lobbied military officials, who finally agreed to desegregate the Navy Nurse Corps in 1948. Throughout the history of military conflict in the United

States, nurses overwhelmingly established their ability to handle the intensity and stresses of wartime nursing, characteristics readily apparent in Korea and Vietnam, where nurses staffed Mobile Army Surgical Hospitals (MASH).

Male nurses did not share equally from the advances in military nursing or the softening of cultural boundaries defining sex-stereotyped roles that came out of the women's movement. Until the mid-twentieth century only a limited number of schools accepted male applicants. State boards of nursing restricted licensure for men, and as far back as the Spanish-American War military officials pointedly refused to accept male applicants in any branch of the Nursing Corps. Nursing remained one of the most thoroughly feminized occupations in the United States with women making up almost 90 percent of all nursing school graduates in 1990(Rosenberg, Charles E:1995).

Nursing in the twenty-first century became a multi-tiered career. Registered nurses worked in every facet of acute and long-term care; they staffed public, industrial, and community health departments and they achieved diverse skills and specialization of practice. Nurses who obtain postgraduate degrees enhance their role as providers of health care as nurse practitioners, clinical nurse specialists, nursing educators, and researchers. With degrees in finance and business, nurses have also broadened their job choices as hospital and health-care institution administrators (Schultz, Jane E: 1992).

§ NURSING AS A PROFESSION:

Nursing, like all professions, is based on the ideal of service to humanity. The practice of nursing involves altruistic behavior, is guided by nursing research and is governed by a code of ethics.

Nursing continues to develop a wide body of knowledge and associated skills. There are a number of educational paths to becoming a professional nurse but all involve extensive study of nursing theory and practice and training in clinical skills.

The authority for the practice of nursing is based upon a social contract that delineates professional rights and responsibilities as well as

mechanisms for public accountability. In almost all countries, nursing practice is defined and governed by law and entrance to the profession is regulated by national, state, or territorial boards of nursing.

§ ALTRUISM OF THE NURSES:

Ethical theory that regards the good of others as the end of moral action; by extension, the disposition to take the good of others as an end in itself. The term (French, *altruism*, derived from Latin *alter*: "other") was coined in the 19th century by Augusto Comte and adopted generally as a convenient antithesis to egoism. Most altruists have held that each person has an obligation to further the pleasures and alleviate the pains of other people. The same argument holds if happiness, rather than pleasure, is taken as the end of life (McWilliams, Nancy: 1984).

§ NURSING ETHICS:

Is the discipline of evaluating the merits, risks, and social concerns of activities in the field of nursing. There are many defined codes of ethics for nurses.

Nursing ethics shares many principles with other branches of health care ethics, such as beneficence and non-malfeasance, but also has a number of distinctions.

§ HUMAN RIGHTS AND NURSING PRACTICE:

Ethics has been an integral part of nursing practice from the earliest foundations of modern nursing in the late nineteenth century. This has always entailed a respect for human rights of the persons in their care. However, early attempts to define ethics in nursing were focused more on the virtues of the nurses themselves, rather than looking at how the rights of the patient or client might be promoted in particular. In the modern era, the ethics of nursing has shifted more toward the promotion of these rights and the duties of the nurse (McHale & Gallagher 2003).

The importance of human rights in nursing was made explicit in a statement adopted by the International Council of Nurses in 1983.

§ DISTINCTIVE NATURE:

Although historically much of nursing ethics has been derived from medical ethics, there are some factors that differentiate it from this. The key difference is that paternalism, which is often a key feature in theories of medical ethics, is generally not compatible with nursing ethics (Rumbold 1999).

This is because nursing theory seeks a collaborative relationship with the person in their care. It therefore emphasizes autonomy of the person being nursed over paternalistic practice where the health professional seeks to do what *they* believe to be in the person's or societies best interests. Codes of conduct for nurses tend to be written in the ethical framework of deontology and are therefore based on the rights of the patient and the duties of the nurse rather than on utilitarian concerns of the consequences justifying the action.

§ COMMON THEMES IN NURSING ETHICS:

Increasingly, the nurse's role is one of advocate for the interests of the people in their care. In terms of ethical theory, this means having a respect for the autonomy of the person to make decisions about their own treatment and be provided with information available in order to do this. So the principle of informed consent, where a person understands fully the implications of having or refusing a treatment, is one which is held in the nurse's mind when suggesting treatment options. (Rumbold 1999) This principle is not absolute as people are sometimes unable to make choices about their own treatment due to being incapacitated or having a mental illness that affects their judgment. This means that the nurse has to weigh their duty of care against the autonomy of the person in care.

Other common themes are that of truth telling in interactions with the person in care. This, however, also has to be weighed against any unnecessary harm that may be caused by divulging the information. Confidentiality is also an important principle in many nursing ethical codes. This is where information about the person is only shared with others after permission of the person, unless it is felt that the information must be shared to comply with a higher duty such as preserving life. (Rumbold 1999)

Nurses are interested in the quality of life of the people in their care. In medical ethics theories, this can be measured by QALYs. However, this is highly controversial as it is very difficult to measure the quality of someone else's life objectively and this can be particularly difficult if the person in care is unable to communicate their need, such as when they are unconscious or in a vegetative state

§ NURSING THEORY:

Nursing theory is the term given to the body of knowledge that is used to support nursing practice. In their professional education nurses will study a range of interconnected subjects which can be applied to the practice setting. This knowledge may be derived from experiential learning, from formal sources such as nursing research or from non-nursing sources. To speak of nursing theory is often difficult. Nursing is many things to many people. Most universally agreed upon is that Nursing is a science involving people, environment and process fueled by a vision of transcendence in the context of healthcare. It is interesting to note that 90% of all Nursing theories have been generated in the last 20 years. Many schools encourage students to formulate theories of Nursing as part of their curriculum. Some might argue that this multiplicity of theory is detrimental to the practice and undermines common vision. Others would say that the nature of the young science is sufficiently far reaching to require such tactics in order to elicit true consensus. It cannot be denied, however, that there is much vanity involved in the formulation of nursing theory. The pages of "Nursing Science Quarterly", a major mouthpiece for Nursing Theory, are rife with examples of semantically hair-splitting.

§ NURSING MODELS:

Are conceptual models, constructed of theories and concepts? They are used to help nurses assess, plan, and implement patient care by providing a framework within which to work. They also help nurses achieve uniformity and seamless care.

§ UNIVERSAL FEATURES OF NURSING MODELS:

All nursing models involve some method of assessing a patient's individual needs and implementing appropriate patient care. An essential

Portion of each nursing model is measurable goals in order that the process can be evaluated in order to provide better care for the patient in the future. Almost all nursing models are used to produce a document known as a care plan that is used to determine a patient's treatment by nurses, doctors and other healthcare professionals and auxiliary workers. These documents are considered to be living documents — they are changed and evaluated on a daily basis as the patient's condition and abilities change.

Theories of Nursing fall into roughly 5 categories. There are met theories, grand theories, mid-range theories, min-theories and micro-theories.

§ HISTORY OF NURSING MODELS:

The original role of the nurse was primarily to care for the patient as prescribed by a physician. This evolved into the biomedical model of nursing care which still strongly influences nursing practice today. The biomedical model focuses heavily upon path physiology and altered homeostasis but fails to identify individual differences and whilst it works well for traditional medical and physical care, it focuses solely on the treatment of disease, making little account of psychological, socio-cultural, or politico-economic differences between individuals. The Biomedical Model essentially views all patients with the same disease as the same problem regardless of their religion, culture, or ethnicity. This is in contrast to the social model of healthcare that places emphasis on changes that can be made in society and in people's own lifestyles to make the population healthier.

The first theorist to clearly articulate a role of nurses distinct from the medical profession was Florence Nightingale. Her theories were developed during the Crimean War and published in *Notes on Nursing: What it is, and what it is not* in 1859. Nightingale's model is based on the idea that the nurse manipulates the environment to promote the patient's well being.

Nurses quickly realized that treating patients based upon their disease rather than making a holistic assessment was not a satisfactory way of attending patient care.

Major nursing theorists

- Imogene King
- Madeleine Leininger
- Betty Neuman
- Dorthea Orem
- Hildegard Peplau
- Rosemarie Rizzo-Parse
- Isabel Hampton Robb
- Martha Rogers
- Calista Roy
- Helen Erickson

Purposely left off this list is that most famous of all nurses, Florence Nightingale. Ms. Nightingale never actually formulated a theory of nursing science but was posthumously accredited with same by others who categorized her personal journaling and communications into a theoretical framework.

Also left off are many who simply improvised on others work and acclaimed their thoughts as new theoretical vision.

§ EXAMPLES OF NURSING MODELS:

The models used vary greatly between institutions and countries. However, different branches of nursing have different "preferred" nursing models. These are summarized below:

Psychiatric nursing

- Roy's model of nursing
- Tidal Model

Children's nursing

- Casey's model of nursing

Adult nursing

- Nightingale's model of nursing

- Roper, Logan and Tierney
- Orem's Model of Nursing

Community and rehabilitation nursing

- Orem's Model of Nursing

Critical care nursing

- Synergy model of nursing (Anderson, Norma E.: 1981)

§ NURSING PROCESS :

The **nursing process** is a process by which nurses deliver care to patients. It is often supported by nursing models or philosophies. The nursing process was originally an adapted form of problem-solving and is classified as a deductive theory.

§ CHARACTERISTICS OF THE NURSING PROCESS:

The nursing process is a cyclical and ongoing process that can end at any stage if the problem is solved. The nursing process exists for every problem that the patient has, and for every element of patient care, rather than once for each patient. The nurse's evaluation of care will lead to changes in the implementation of the care and the patient's needs are likely to change during their stay in hospital as their health either improves or deteriorates. The nursing process not only focuses on ways to improve the patient's physical needs, but on social and emotional needs as well.

§ STAGES OF THE NURSING PROCESS:

The Nursing process is often remembered by the acronym **ADPIE** ("A Delicious PIE" mnemonic is sometimes used to remember this):

- **A**ssessment (of patient's needs)
- **D**iagnosis (of human response needs that nursing can assist with)
- **P**lanning (of patient's care)
- **I**mplementation (of care)
- **E**valuation (of the success of the implemented care)

In many countries, such as the United Kingdom, the diagnosis stage of the process is omitted. Although nurses in the UK determine a patient's needs or problems, they are not widely regarded as "diagnoses".

Stage one: assessment

The nurse should carry out a complete and holistic nursing assessment of every patient's needs, regardless of the reason for the encounter. Usually, an assessment framework, based on a nursing model or Water low scoring, is used. The purpose of this stage is to identify the patient's nursing problems. These problems are expressed as either actual or potential.

Stage two: diagnosis

In the U.S., nurses make a nursing diagnosis which is a standardized statement about the health of a client (individual, family, or community) for the purpose of providing nursing care. Nursing diagnoses express the result of the assessment of the patient's problems.

Nursing diagnoses are part of a movement in nursing to standardize terminology which includes standard descriptions of diagnoses, interventions, and outcomes.

Stage three: planning

In agreement with the patient, the nurse addresses each of the problems identified in the planning phase. For each problem a measurable goal is set.

Stage four: implementation

The methods by which the goal will be achieved are also recorded at this stage. The methods of implementation must be recorded in an explicit and tangible format in a way that the patient can understand should he wish to read it. Clarity is essential as it will aid communication between those tasked with carrying out patient care.

Stage five: evaluation

The purpose of this stage is to evaluate progress toward the goals identified in the previous stages. If progress towards the goal is slow, or if regression has occurred, the nurse must change the plan of care accordingly. Conversely, if the goal has been achieved then the care can cease. New problems may be identified at this stage, and thus the process will start all over again. It is due to this stage that measurable goals *must* be set - failure to set measurable goals will result in poor evaluations. (Hamric, &others: 2000).

§ NURSING PRACTICE :

It has been suggested that the section *Nursing practice* from the article *Nursing* be merged into this article or section.

Nursing practice is the actual provision of nursing care. In providing care nurses are implementing the nursing care plan which is based on the client's initial assessment. This is based around a specific nursing theory which will be selected as appropriate for the care setting. In providing nursing care the nurse uses both nursing theory and best practice derived from nursing research.

§ NURSING CARE :

PATIENT CARE: is part of a nurse's role in implementing a care plan. Usually, nurses will perform patient assessment and evaluation of care while doing their patient care.

INFECTION CONTROL: Nurses must observe the principles of cleanliness at all times to prevent the spread of sickness.

RECORDS: Nurses keep accurate records of all care and observations for many purposes.

TEMPERATURE: Nurses may take a person's temperature several times a day. The normal body temperature is traditionally thought of as 37 degrees Celsius (98.6 degrees Fahrenheit).

MEDICATION: In some countries, advanced practice nurses can prescribe medication, however most nurses administer medication that is prescribed by a physician.

DIET: Diet is important to help sick people get well and well people to stay healthy. A dietitian, or other health care professional may place the patient on a regular, light, soft, or liquid diet. (RCN: 2003).

- **NURSING CARE PLAN:**

A **nursing care plan** outlines the nursing care to be provided to a patient. It is a set of actions the nurse will implement to resolve nursing problems identified by assessment. The creation of the plan is an intermediate stage of the nursing process. It guides in the ongoing provision of nursing care and assists in the evaluation of that care.

- **CHARACTERISTICS OF THE NURSING CARE PLAN:**

1. It focuses on actions which are designed to solve or minimize the existing problem.
2. It is a product of a deliberate systematic process.
3. It relates to the future.
4. It is based upon identifiable health and nursing problems.
5. Its focus is holistic.

- **ELEMENTS OF THE PLAN:**

In the USA, the nursing care plan consists of a NANDA nursing diagnosis with related factors and subjective and objective data that support the diagnosis, nursing outcome classifications with specified outcomes (or goals) to be achieved including deadlines, and nursing intervention classifications with specified interventions.

- **THE NURSING PROCESS:**

Care plans are formed using the nursing process. First the nurse collects subjective data and objective data, and then organizes the data into a systematic pattern, such as Marjory Gordon's functional health patterns. This step helps identify the areas in which the client needs nursing care. Based on this, the nurse makes a nursing diagnosis. As mentioned above,

The full nursing diagnosis also includes the relating factors and the evidence that supports the diagnosis. For example, a nurse may give the following diagnosis to a patient with pneumonia that has difficulty breathing: Ineffective Airway Clearance related to trachea-bronchial infection (pneumonia) and excess thick secretions as evidenced by abnormal breath sounds; crackles, wheezes; change in rate and depth of respiration; and effective cough with sputum.

After determining the nursing diagnosis, the nurse must state the expected outcomes, or goals. A common method of formulating the expected outcomes is to reverse the nursing diagnosis, stating what evidence should be present in the absence of the problem. The expected outcomes must also contain a goal date. Following the example above, the expected out come would be: Effective airway clearance as evidenced by normal breath sounds; no crackles or wheezes; respiration rate 14-18/min; and no cough by 01/01/01.

After the goal is set, the nursing interventions must be established. This is the plan of nursing care to be followed to assist the client in recovery. The interventions must be specific, noting how often it is to be performed, so that any nurse or appropriate faculty can read and understand the care plan easily and follow the directions exactly. An example for the patient above would be: Instruct and assist client to TCDB (turn, cough, and deep breathe) to assist in loosening and expectoration of mucous every 2 hours.

The evaluation is made on the goal date set. It is stated whether or not the client has met the goal, the evidence of whether or not the goal was met, and if the care plan is to be continued, discontinued or modified. If the care plan is problem-based and the client has recovered, the plan would be discontinued. If the client has not recovered, or if the care plan was written for a chronic illness or ongoing problem, it may be continued. If certain interventions are not helping or other interventions are to be added, the care plan is modified and continued.

There are also care plans written for "at risk" problems, as well as "wellness" care plans. These follow a similar format, only designed to

Prevent problems from happening and continue or promote healthy behavior (Chaska, Norma L., ed. 2001).

§ NURSING INJURY, STRESS, AND NURSING CARE:

The health care industry is one of the largest employers in the United States, with more than 7 million employees in 1990 and with that number expected to increase to more than 10 million by the year 2000 (BLS, 1991).

These health care environments are high-risk workplaces with a wide range of exposures and hazards (Hudson, 1990; Rogers and Travers, 1991; Wilkinson et al., 1992). The U.S. Bureau of Labor Statistics (BLS) reports the incidence rate per 100 full-time workers for nonfatal occupational injuries and illnesses for 1993 was 11.8 for hospital establishments and 17.3 for nursing and personal care facilities. This compares to a private industry rate of 8.5 (BLS, 1994b). In addition, the Bureau reports that for 1992 the incidence of injuries and illnesses involving days away from work is greater for certain occupations than their proportion of total employment. These relatively hazardous occupations include male-dominated work, such as construction and transportation; female-dominated activities, such as nursing care and housekeeping services; and gender-shared activities, such as assembling products. Nurses' aides (NA) were second only to truck drivers in the total number of cases of disabling injury and illness, with an estimated 145,900 cases for truck drivers compared to 111,100 for NAs. For persons in all occupations working less than 1 year, NAs were reported as having the most injuries or illnesses (approximately 67,000), primarily sprains

The cost implications to health care providers of relatively high injury rates for their employees are especially troublesome down the road because, according to BLS estimates, the industry's work force is expected to grow at twice the rate for all confirm wage and salary workers between 1992 and 2005. In 1992, private sector health services employed 8.5 million workers, for whom nearly 700,000 work-related injuries and illnesses were reported that year.

Nursing personnel deliver care to individuals in a variety of settings including hospital-based and community-based environments. Only within recent years has any real attention been paid to the occupational risks and injuries of nurses. Also, there is evidence that stress related to work overload and staffing patterns, including shift work, can and does contribute to illness and injury in the nurse population (Jung, 1986; Phillips and Brown, 1992). Many factors such as the physical work environment, organizational and institutional characteristics, and personal work practice habits contribute to health care workers' occupational risk for hazard exposure and the resultant injury and stress that occurs (Rogers and Travers, 1991). The impact of these events is of concern not only in terms of the health risk to the worker, but also because of the effects on quality care and nursing.

Much of the research that is discussed describes the nature and severity of specific injuries of major concern in nursing and stress in nursing. The paper also provides some linkage, although less frequently, for the relationships of injury and stress to the quality of nursing care delivered and the impact of these factors on the nursing profession. Several investigations have reported

Various types of injuries, but back injuries and needle stick injuries are of most concern and therefore will be most examined. While the reporting of assaults on health care workers may be improved, violence toward this group seems to be rising and will be discussed as a serious emerging threat (Lanza, 1992; Lechky, 1994). In addition, stress continues to plague nurses resulting in burnout and high turnover. It is clear that factors influencing injury and stress, and interactions between and among them, are of significant importance.

§ *STRESS AND NURSING:*

Packard and Motowidlo (1987) have stated that:

(When patients require bodily care, understanding, empathy and full, unconditional acceptance, or when many complex tasks are required unexpectedly, hospital nurses find practical, tangible evidence of the worth of their talents, skills, and commitment to people. But when nurses recognize that their work is undervalued, underappreciated, disparaged,

Taken for granted and when in addition they are treated discourteously or even pitted against one another for the meager rewards of their jobs, then nurses properly regard such stressors as undesirable).

The authors purport that when this happens job performance is poorer.

It is well documented in the literature that nursing work results in significant amounts of stress leading to a variety of work-related problems such as absenteeism, staff conflict, staff turnover, decreased morale, and decreased practice effectiveness (MacNeil and Weisz, 1987; Doering, 1990; Hiscott and Connop, 1990; Rees and Cooper, 1992; Fielding and Weaver, 1994).

The review of the literature that follows examines the relationship between nursing work and stress and related outcomes, emphasizing the impact on work and performance.

In an early study, Gentry and colleagues (1972) examined the psychological responses of 34 RNs working in various intensive care units (ICU) and non-ICU settings within a Medical Center–Veterans Administration hospital (VAH) complex. A battery of standardized psychological test measures was used. Medical Center ICU (MC-ICU) nurses reported more depression, hostility, and anxiety then did non-ICU nurses and nurses in the VAH critical care units (CCU).

The MC-ICU settings produced more complaints and ones concerned with an overwhelming workload, limited facilities and space, inadequate help for proper patient care, too much responsibility, too little continuing education, poor organization, excessive paperwork, inadequate communication with physicians, transition of personnel, and intra staff tension. The authors contend that:

the finding that MC- and VAH-CCU nurses differed rather markedly both in their levels of affect and their likes / dislikes about their work was indeed interesting, since both groups perform essentially the same duties with the same type of patients in virtually identical physical surroundings. What it suggests is that the CCU setting as such is not intrinsically stressful, but rather becomes so when adequate help is not available to care for the patients properly, when nurses are not provided with

Necessary continuing education, and when a deliberate effort is not made to instill a feeling of pride and "team spirit" within the staff as a whole.

Packard and Motowidlo (1987) conducted a survey study for 5 hospitals to assess the relationship between subjective stress, job satisfaction, and job performance in 366 hospital RNs and LPNs. A second survey instrument was sent to the supervisor and a coworker of the primary nurse subject (n = 165 and 139, respectively) asking about the nurse's work performance. Increased stress encounters diminished both job satisfaction and job performance and increased episodes of depression. Job satisfaction was not depressed and hostile nurses had lower job performances than did nurses with little or no depression or personal hostility.

Early studies have purported that critical care and intensive care nurses experience more stress than nurses in other areas. Research has not consistently validated this concept, however. MacNeil and Weisz (1987) measured the level of psychological distress experienced by critical care nurses (n = 80) and non-critical-care nurses (n = 106) employed in a large acute care hospital, and its relationship to absenteeism. Non-critical-care nurses reported significantly higher psychological distress scores than did the critical nursing group and nearly twice the rate of absenteeism. These results may indicate better staffing or orientation in critical care nursing. Alterations in the work environment and conditions and stress management programs are needed to reduce nurses' distress.

Foxall and colleagues (1990) surveyed 138 nurses including 35 ICU nurses, 30 hospice nurses, and 73 medical-surgical nurses to determine differences in stress levels among the groups. While there were no overall significant differences among the groups with respect to stress levels, significant differences did occur for subscales: ICU and hospice nurses perceived significantly more stress related to death and dying than did medical-surgical nurses; ICU and medical-surgical nurses perceived significantly more stress related to floating than did hospice nurses; and medical-surgical nurses perceived significantly more stress related to work-overload and staffing than did ICU and hospice nurses. While the effects of job stress on the quality of patient and family care were not specifically addressed, stress management programs were encouraged,

Particularly in the area of death and dying, to alleviate burnout and facilitate more effective care. In addition, work environment issues such as increased staffing levels and decreased floating were encouraged to minimize work overload and the potential for reduced quality of care. Similar findings were reported by Boumans and Landeweerd (1994) who studied 561 ICU and non-ICU nurses from 36 units in 16 hospitals. Non-ICU nurses had more work pressure, absenteeism, and health complaints than did the ICU nurses.

Yu and colleagues (1989) surveyed a random sample of 952 RNs obtained through a statewide nurse's association membership list to identify specific job stressors across 10 clinical specialties. Results indicated that stress seems to arise from the overall complexity of nurses' work rather than specific tasks. Stressors were uniform across specialty areas, with the greatest levels reported in administration, cardiology, medical-surgical, and emergency room nursing.

Several studies have examined stress in other types of nursing fields. Jennings (1990) found that among 300 U.S. Army head nurses in 37 different army hospitals, stress resulted in psychological symptoms as measured by the Brief Symptom Inventory. Of particular importance is the notion that managers bear the responsibility for attenuating the stress experienced by staff. The question raised is: Can managers who are experiencing psychological distress them-Related to job performance, but selves adequately intercede to reduce staff stress, as well as manage their units efficiently and effectively?

Using several instruments, Power and Sharp (1988) compared stress and job satisfaction among 181 nurses at a mentally handicapped hospital and 24 hospice nurses. Hospice nurses characteristically reported stress as primarily associated with death and dying and with inadequate preparation to meet the emotional needs of patients and families, but did not report significantly high workload stress as had been observed in other studies. This may be due partly to the relatively high staff-to-patient ratio in a hospice setting. Conversely, nurses working with mental handicapped patients reported significantly more stress associated with workload, conflict with other nurses, and the nursing environment.

In a study of neurosurgical nurses, the authors interviewed several nurses about aspects of neurosurgical nursing that were perceived as stressful by staff. Findings suggest that being exposed to life-and-death situations among young children, being short of essential resources, being on duty with too few staff, and dealing with aggressive relatives constituted major stressful events. Comments made by staff suggested that performance at work is adversely influenced by stress (Snape and Cavanagh, 1993). These findings were echoed in a study of dialysis nurses who also indicated that work load is a major contributing factor not only to overall stress and work performance, but to burnout as well (Lewis et al., 1992). In addition, a sample of 155 members of the Association of Pediatric Oncology Nurses reported that the relapse or sudden death of a favorite patient was their greatest source of stress. The second most common stressor was a workload perceived as too great to give quality patient care (Emery, 1993).

- BURNOUT IN NURSES:

Berland (1990) discusses the issue of burnout in nurses at Vancouver General Hospital and factors that influence burnout, including increasing patient activity, greater family needs, higher professional standards, and static hospital budgets that often result in staff shortages and reduced quality of care. To address the problem, the hospital administration empowered head nurses to restrict patient admission to their unit to protect staff nurses from burnout. After 18 months, evaluation of the new policy indicated that staff nurses felt more in control of their workload and could better shape and improve quality of care for patients.

- *TURNOVER:*

Eriksen and colleagues (1992) describe two potentially negative consequences of consistently high workloads in an understaffed situation: decreased quality of care and lower job satisfaction, which may lead to increased nurse turnover. An RN-LPN nurse partnership model of care was implemented in the critical care setting to prevent these potential consequences. The purpose of the model program was to develop "qualified extenders" for the critical care staff nurse so as to reduce workload and thereby affect the quality of care given. In this model,

Vocational nurses were given an 8-week education and orientation program termed the "licensed vocational nurse critical care specialty program." Certain aspects of direct and indirect nursing care were taught that were then to be considered tasks delegated to the licensed vocational nurse extenders. Evaluation of the program revealed statistically significant increases in nurse job satisfaction; perceptions of reduced workload and stress; a perception by RNs and physicians of increased nursing care quality; decreased RN turnover and sick time; and a positive perception of the role of the LPN in the critical care unit.

Mann and Jefferson (1988) describe many reasons for high turnover rates on medical intensive care units (MICU) including heavy workloads, lack of recognition, and lack of administrative support and leadership that can lead to stress. The authors surveyed 47 nurses in the MICU and found that understaffing and workload were the most stressful problems that influenced the quality of care. Proactive measures were implemented to reduce problems.

§ NURSING IN PALESTINE:

The Arab-Israeli war of 1948, known in Israel as the War of Independence, is called al-Nakba or the Catastrophe by Palestinians.

Yet this fundamental Palestinian wound, and the power of its memory today, cannot simply be wished away.

The obscure anniversary in question, July 11-15, is little known outside of Palestinian memory. Yet it helped forge the fury, militancy and Palestinian longing for land in exile that helps drive the conflict today. In fact, it's not possible to understand today's firefights without first understanding the Nakba in 1948.

The nursing history started after that at 1950 when an agreement contracted between world health organization and UNRWA to monitor the health of Palestinian refugee, the UNRWA start to prepare health programs and prepare health care giver.

Now there are many hospitals and clinics with many nursing college produce many qualified nurses every year on highly standers.

- **BURNOUT AMONG NURSES IN GAZA:**

Based on the experience of the researcher I fell that this phenomenon is widely spread in our nursing community but no study done on this subject, so this subject will try to focus on this phenomenon and explain it. (the researcher)

There are a lot of factors associated to cause burnout in nurses like:

- The shortage of nursing and resources.
- The presence of anxiety about treatment and care plane.
- Absence of resources and preparation to deal with patients and their families.
- The absence of protective securing measures to the nurse after he has been infected.
- Poor control on the danger and infections transmission to the nurses.
- The high levels of danger and infections
- The presence of work overload.
- The inappropriate wages according to the nature of the work.
- The work is distorted and far from good management.
- Vague responsibilities , Absence of job description
- Absence of the opportunities to the nursing for decision making participation
- Absence of creative environment in the profession,
- The absence of the environment to solve the problems that face the nurses.
- The absence of communication between the top and the base of the nursing.
- The misunderstanding to the nature of nursing profession
- Client's family behaves high-handedly.
- Lack of preparation and resources to deal with gasping or dying people
- The conflict between work requirement and home requirement.
- Inability to control the over the work time.
- Long working time prevents the social interaction.
- Inability to predict the work time
- The continuous shifting without stability
- The presence of time pressure to achieve the work.
- Lack of control on the work content.
- Misuse of nursing skills.

- The work is meaningless
- Vague future of the profession.
- It is difficult to take your holiday or ead.
- Vague of the role of nursing profession,
- Absence of opportunities for development and progression of the nurse.
- The rigidity of work shifts programs,
- A lot of night shifts duty.
- Absence of personal relation which lead to social isolation.
- The presence of conflict with other nurses.
- The presence of conflict with other employers inside the hospital.
- The presence of verbal hostility from the client's family towards the nurses.
- The presence of physical hostility from the client's family towards the nurses.
- Client's family behaves high-handedly.
- Absence of trust in the care plane that physicians decide and nurses applied.
- Bad relation with the supervisors and the managers.
- Bad attitude and behavior of physician towards nurses
- Supervisors behave selfishly and inconsistently
- supervisors don't understand my job
- Supervisors discriminate from another coworker
- Supervisors force the way of thinking and doing.
- Anxiety related to lateness or absence of salaries
- Anxiety related to Israeli violence and siege
- Anxiety related to martyr or injury of a member of the nurse family
- Anxiety related to death of a member of nurse family
- Anxiety related to bad health status of a member of nurse family
- The nature of profession delays the achievement of religious duties sometimes.
- Anxiety related to the presence of social or psychological problems
- Anxiety related to the bad health status of the nurse himself.
- Anxiety related to the unstable political problem.
- Fear of loosing your salary due to the political issue.

So the researcher will try to explore these phenomena by this research. (The researcher)

2- BURNOUT

§ HISTORICAL DEVELOPMENT OF THE BURNOUT CONCEPT:

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.

§ THE PIONEER PHASE:

The first few articles about burnout appeared in the mid-1970s in the United States (Freudenberger, 1974, 1975; Maslach, 1976). The significance of these first articles was that they provided an initial description of the burnout phenomenon, gave it its name, and showed that it was not an aberrant response by a few deviant people but was actually more common.

The way in which the burnout phenomenon was identified and labeled illustrates its social origin. As a psychiatrist, Freudenberger was employed in an alternative health care agency. He observed that many of the volunteers with whom he was working experienced a gradual emotional depletion and a loss of motivation and commitment. Generally, this process took about a year and was accompanied by a variety of mental and physical symptoms. To denote this particular mental state of exhaustion, Freudenberger used a word that was being used colloquially to refer to the effects of chronic drug abuse: "burnout."

At about the same time, Maslach, a social psychology researcher, was studying the ways in which people cope with emotional arousal on the job she was particularly interested in such cognitive strategies as "detached concern" and "dehumanization in self-defense," but soon discovered that both the arousal and the strategies had important implications for people's professional identity and job behavior. When by chance she described these results to an attorney, she was told that poverty lawyers called this particular phenomenon "burnout." Once Maslach and her colleagues adopted this term, they discovered that it was immediately recognized by their interviewees; thus, a new colloquial expression was born.

Do these anecdotes about the "discovery" of burnout indicate that the phenomenon did not exist before? Obviously not. For instance, Burisch presents several examples of psychological states that have been described previously in the literature. These states match the current description of burnout but have been labeled differently (e.g., "exhaustion reaction").
In 19S3, Schwartz and Will published a case study of Miss Jones, a disillusioned psychiatric nurse, who is probably the most prominent (and often cited) exam' pie of burnout. Moreover, essayists have portrayed fictional burned-out characters long before the concept was introduced in the mid-1970s. For instance, Thomas Mann's description of the protagonist in *Buddenbrooks* (1922) includes the most essential features of burnout, such as extreme fatigue and the loss of idealism and passion for one's job. Most famous, however, is Graham Greene's *A Burnt out Case* (1960), in which a spiritually tormented and disillusioned architect quits his job and withdraws into the African jungle. The symptoms displayed by this character fit quite well with current descriptions of burnout.

Given these forerunners, why did the burnout syndrome not attract public attention until the mid-1970s? Several authors point to a specific constellation of economic, social, and historical factors. Farber suggests that "American workers have become increasingly disconnected and alienated from their communities, and increasingly insistent upon attaining personal fulfillment and gratification from their work. The combination of these two trends has produced workers with higher expectations of fulfillment and fewer recourses to cope with

Frustrations—a perfect recipe for burnout" (1983a, p. II). Farber also points to a problematic development in the human services. Originally these services were based in the community, but after World War II social services work became more professionalized, bureaucratized, and isolated. Governmental interference increased, and clients became needier and more entitled to services. Consequently, it became more difficult for people to find professional fulfillment in human services work, and disillusionment and burnout became increasingly common.

In addition, Cherniss (1980a) argued that the tendency toward individual-ization in modern society has led to increasing pressure on the human services. Because the traditional social fabric is disintegrating, more and more problems in living have to be solved by professionals instead of relatives, neighbors, or other members of the community. Furthermore, over the past decades, the government has cut back costs for many human service agencies, so that an increasing workload has to be managed by even fewer people. Cherniss (1980a) also points to the decline of the authority of professionals over the past decades and to the recent development of what he calls the "professional mystique." The latter involves the public's belief that professionals experience a high level of autonomy and job satisfaction, are highly trained and competent, work with responsive clients, and is generally compassionate and caring. This mystique is reinforced by the professionals' education and leads to high and unrealistic

§ BURNOUT: A MULTIDIMENSIONAL PERSPECTIVE:

It has been almost 20 years since the term *burnout* first appeared in the psychological literature. The phenomenon that was portrayed in those early articles had not been entirely unknown, but had been rarely acknowledged or even openly discussed. In some occupations it was almost a taboo topic because it was considered tantamount to admitting that at times professionals can (and do) act "unprofessionally." The reaction of many people was to deny that such a phenomenon existed, or, if it did exist, to attribute it to a very small (but clearly mentally disturbed) minority. This response made it difficult, at first, to take any work on burnout seriously. However, after the initial articles were published, there was a major shift in opinion. Professionals in (him human services gave substantial support to both the validity of the phenomenon

And its significance as an occupational hazard. Once burnout was acknowledged as a legitimate issue, it began to attract the attention of various researchers.

Understanding of burnout has grown dramatically since that shaky beginning. Burnout is now recognized as an important social and individual problem. There has been much discussion and debate about the phenomenon, its causes, and its consequences. As these ideas about burnout have proliferated, so have the number of empirical research studies to test these ideas. We can now begin to speak of a body of work about burnout, much of which is reviewed and cited in the current volume. This work is now viewed as a legitimate and worthy enterprise that has the potential to yield both scholarly gains and practical solutions. What I would like to do in this chapter is give a personal perspective on the concept of burnout.

Having been one of the "pioneers" in this field, the advantage of a long-term viewpoint that covers the 20 years from the birth of the concept of burnout to its present proliferation. (Maslach & Jackson: 1981)

§ A MULTIDIMENSIONAL MODEL OF BURNOUT:

The operational definition, and the corresponding measure, that is most widely used in burnout research is the three-component model developed by Susan Jackson and Maslach (Maslach & Jackson, 1981a, 1981b. 1984a, 1986).

They define burnout as a psychological syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who work with other people in some capacity. Emotional exhaustion refers to feelings of being emotionally overextended and depleted of one's emotional resources. Depersonalization refers to a negative, callous, or excessively detached response to other people, who are usually the recipients of one's service or care. Reduced personal accomplishment refers to a decline in one's feelings of competence and successful achievement in one's work.

This definition of burnout did not derive from an existing theory but was developed on the basis of several years of exploratory research. This

research involved interviews, surveys, and field observations of employees in a wide variety of "people-oriented" professions, including health care, social services, mental health, criminal justice, and education.

§ BURNOUT: AN EXISTENTIAL PERSPECTIVE:

The introduction of burnout to the scientific community in the mid-1970s has been followed by several controversies among its scholars. One of the first major controversies at that time centered on the question of definition. One of the major controversies today centers on the underlying dynamic of burnout.

The argue that the root cause of burnout lies in our need to believe that our lives are meaningful, that the things we do—and consequently we ourselves—are useful and important (Pines & Aronson, 1988). Frankl (1963) writes that "the striving to find meaning in one's life is the primary motivational force in man" (p. 154). When people try to find meaning in their life through work and feel that they have failed, the result is burnout.

What makes the search for meaning such a powerful force is the basic tragedy all human beings have to face, i.e., the finality and inevitability of death. According to Becker (1973), "The idea of death, the fear of it, haunts the human animal like nothing else" (p. ix). Our need to believe that the things we do are meaningful is our way of dealing with the angst caused by facing up to our mortality, lb avoid and deny death we need to feel heroic, to know that our lives are meaningful, that we matter in the larger, "cosmic" scheme of things.

How people choose to become heroes depends to a large extent on their culture's prescribed hero system. Whatever the hero system, according to Becker, people serve it "in order to earn a feeling of primary value, of cosmic specialness, of ultimate usefulness to creation, of unshakable meaning".
Since religion provides a better answer to the existential dilemma than work, people who attempt to find existential significance through their work are more likely to burnout than people who derive their existential significance from a religious belief. Following this line of reasoning, one possible interpretation of the flourishing of burnout these days is the secularization of society. A similar point of view has been forwarded by

Lasch (1979) who talks about the failings of "the culture of narcissism" that has replaced the religious authorities of the past. More recently, Mander (1991) described what happens in "the absence of the sacred."

Failure in the existential quest for meaning is the root cause of burnout, as This is why burnout tends to afflict people with high goals and expectations when entering such professions as pediatrics (Pines, 1981), nursing (Kanner, Kafry, & Pines, 1978; Pines & Kanner, 1982), organizational consultation (Pines, 1992) management (Etzion, Kafry, & Pines, 1982), kindergarten teaching (Maslach & Pines, 1977), social work (Pines & Kafry. 1978), and mental health work (Pines & Maslach, 1978). All this work suggests that when highly motivated professionals who identify with their work and hope to derive from it a sense of existential significance fail to accomplish their work goals and feel unable to make a significant contribution, they become susceptible to burnout.

When highly motivated nurses, who entered nursing "to help people . . . do good for humanity . . . make life and death more comfortable for fellow human beings" (Shubin, 1978), feel unable to relieve their patients' pain and suffering, they are unable to derive a sense of existential significance from their work and thus become susceptible to the danger of burnout. In a study of nurses *(N* - 32), the work characteristics that had the highest correlations with burnout were work pressure (the feeling that there is not enough time or sufficient force to do the work right) (r - .53; $p < .001$), a feeling of lack of success at work (r - .49; $p < .001$), and the sense of responsibility for patients' pain *(r* - .48; *p* <, 001) (Pines & Kanner, 1982).

When "passionate, idealistic, and dedicated teachers" (Bloch:1977) feel unable to educate and inspire their students because of apathy, discipline problems, overcrowded classrooms, shortage of available support staff, excessive paperwork, and excessive testing, they are likely to burn out (Farber, 1982).

§ THE EXISTENTIAL PERSPECTIVE AND DEFINITIONS OF BURNOUT:

As noted earlier, one of the early controversies among scholars studying burnout centered on the question of definition (e.g. Paine, 1982b; Maslach, 1982c). And indeed, the definitions were many and varied. Here are three of the most frequently quoted definitions. According to Freudenberger and Richelson (1980), burnout is "a state of fatigue or frustration brought about by devotion to a cause, way of life, or relationship that failed to produce the expected reward" (p. 13). According to Maslach (1982a), "burnout is a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who do 'people work' of some kind" (p. 3). According to Pines and Aronson (1988), burnout is "a state of physical, emotional and mental exhaustion caused by long term involvement in situations that are emotionally demanding".

While these definitions very in several aspects, all three of them (as well as virtually all the other definitions in the scientific literature) share? View of burnout as a state of fatigue and emotional exhaustion that is the end result of a gradual process of disillusionment. According to Freudenberger and Richelson, this process is caused by failure to produce an expected and desired goat. According to Maslach, the process is caused by doing "people work." According to Pines and Aronson, the process is caused by long term involvement in emotionally demanding situations.

Viewing burnout as the end result of a process implies an initial state of high motivation and high involvement. This is true for the three definitions of burnout presented above as well as for most other definitions found in the literature. For Freudenberger and Richelson, the initial state is characterized by devotion to a cause. For Maslach, the initial state is characterized by personalization and high personal accomplishment among individuals who do people work. For Pines and Aronson the initial state is characterized by high emotional involvement. In other words, in all three cases burnout is described as the result of a process of disillusionment that is typically found among highly motivated individuals. This process of disillusionment highlights once again the root cause of burnout—a sense of failure in the existential quest for meaning. If you don't feel a devotion to your cause, if you do people work but don't care about the people you work with, if you are not emotionally involved

In your work—you are not likely to burn out. But if you are devoted to your work and are emotionally involved, if you expect to derive from your work a sense of existential significance—and you feel that you have failed— you are a likely candidate for burnout.

The existential perspective can be applied to virtually all of the descriptions of the process of burnout that appeared in the scientific literature. Let us examine, for example, three descriptions of the process of burnout that were provided by leading scholars in burnout research.

According to Cherniss (1980), a major source of burnout is professionals' inability to develop a sense of competence (1980a) and self-efficacy the argue that feelings of efficacy and competence are so important because they give professionals a sense of existential significance.

§ BURNOUT: A PERSPECTIVE FROM SOCIAL COMPARISON THEORY:

Despite the fact that occupational burnout in the human service professions has been the focus of numerous research efforts, most research in this area has been a theoretical and has focused little attention on the social psychological processes that might be relevant. Moreover, although in-depth social psychological analyses of the burnout phenomenon have been presented (e.g., Harrison, 1983; Maslach & Jackson, 1982), these approaches have lacked firm empirical evidence. This chapter tries to bridge the gap between social psychological theory and burnout research. This will be done in part by uniting burnout to recent developments in social exchange theory). However, the main focus in this chapter will be upon applying recent theoretical work on social comparison processes under stress to occupational burnout.

Our central thesis is that burnout develops primarily in a social context, and that to understand the development and persistence of burnout attention has to be paid to the way individuals perceive, interpret, and construct the behaviors of others at work. Two major assumptions behind our perspective are the following. First, individuals in the human service professions are involved in relationships with clients and patients, and in these relationships social exchange processes and expectations of equity

And reciprocity plays an important role. As Maslach (1982b) noted, a characteristic of burnout is that the stress arises from the social interaction between helper and recipient. Second, individuals will be inclined to deal with problems at work by engaging in social comparison with their colleagues and superiors, and by relating their own experiences to those of others—particularly colleagues in similar positions. Such comparisons may have consequences for the development and persistence of burnout symptoms.

We will first discuss recent developments in social comparison theory that are important for understanding stress at work. Next we will describe a number of major stressors in the nursing profession and a number of personality variables that seem relevant to burnout. We will then present some findings from a study among nurses, and we will show that each of the burnout dimensions proposed by Maslach (1982b) has different relationships to various stressors and personality characteristics. Finally, we will discuss some of our findings on the role of social comparison processes as related to burnout.

§ SOCIAL COMPARISON THEORY, STRESS, AND AFFILIATION:

Research on stress and social comparison was originated by the classic experiments of Schachter (1959) on the relationship between fear and affiliation. Although Festinger (1954) confined himself to the evaluation of abilities and opinions, Schachter expanded the domain of social comparison to include emotions as well. His research showed that women who were experiencing fear because they were anticipating some electric shocks wanted to be with someone else, but only someone who was in the same situation. According to Schachter, individuals under stress seek out others for reasons of self-evaluation in order to assess the appropriateness of their own reactions. Later research substantiated this idea by showing that the need for social comparison is enhanced when individuals feel uncertain about how to feel and react. This was, for example, demonstrated when uncertainty was manipulated by false feedback (Gerard, 1963) and when the source of one's arousal was unknown (Mills & Mintz, 1972).

Over the past decade, there has been a resurgence of interest in social comparison tendencies under stress, particularly stimulated by Wills's (1981) influential paper. Wills suggested that when individuals are confronted with a threat to self-esteem, they engage in downward comparisons with less competent others in an attempt to restore the way they feel about themselves. This motive is called self-enhancement. Downward comparisons may, according to Wills, lead to derogation of others or to affiliation with less fortunate others. Indeed, a number of survey studies have shown that individuals faced with serious diseases and crises, such as arthritis patients (Blalock, McEvoy-DeVellis, & DeVellis, 1989), mothers of medically fragile infants and women with impaired fertility (Affleck & Tennen, 1991), and cancer patients (Wood, Taylor, & Lichtman, 1985), tend to compare themselves with others who are worse off, and to perceive themselves as better off than most others facing the same or a similar stressor. For instance, among mothers of high risk infants, most mothers mentioned some aspect in which they felt better off than other parents with such infants (Affleck, Tennen, and Pfeiffer. Fiflied & Rowe. 1987). Among arthritis patients, the perception that one had fewer problems with one's performance than other patients made patients more satisfied with their own performance (Blalock et al., 1989).

As noted by Taylor et al. (1990), the focus in research on social comparisons under threat has been quite different than was the case in the original work of Schachter (1959) and in subsequent experimental studies on fear and affiliation (Cottrell & Epley, 1977). Schachter emphasized the affinitive activity that occurred in response to threat, but most recent research has focused on cognitive social comparison activity. Such activity constitutes the bringing to mind of other people as a way of making downward comparisons, and is characterized by the self-serving perception and construction of others as being worse off. It is important to make a clear distinction between this last process and affiliation because there is increasing evidence that in stressful situations there is no preference whatsoever for downward affiliation. Thirty years ago, Rabbie (1963) showed that the high-feai person was avoided in all experimental conditions. In another study, cancer patients indicated a preference for affiliation with others who were similarly or better off, although more subjects preferred someone similar (Molleman, Pruyn, & Van

Knippenberg, 1986). Individuals with problematic marriages preferred on the average contacts with those who had better marriages, but those with happy marriages indicated a preference for contact with others who were as happy as they were (Buunk, VanYperen, Taylor, & Collins, 1991). Other evidence indicates that interaction with depressed individuals leads to the desire to avoid further interaction (Coyne, 1976a).

As Gibbons and Gerrard (1991) noted, the foregoing suggests that while a person may find solace in the realization that other people are struggling even more with the same problems, he or she does not necessarily want to be in the presence of those people. In a similar vein, Taylor and Lobel (1989) suggested that people under threat avoid contact with persons who are doing worse, or are worse off, and prefer actual contact with persons who are doing better. Taylor and Lobel argue that individuals under stress are faced with two major coping tasks: regulating their emotions and obtaining relevant problem-solving information (Lazarus & Folkman, 1984). The first need is best addressed through Wills; lead to derogation of others or to affiliation with less fortunate others. Indeed, a number of survey studies have shown that individuals faced with serious diseases and crises, such as arthritis patients (Blalock, McEvoy-DeVellis, & DeVellis, 1989), mothers of medically fragile infants and women with impaired fertility (Affleck & Tennen, 1991), and cancer patients (Wood, Taylor, & Lichtman, 1985), tend to compare themselves with others who are worse off, and to perceive themselves as better off than most others facing the same or a similar stressor. For instance, among mothers of high risk infants, most mothers mentioned some aspect in which they felt better off than other parents with such infants (Affleck, Tennen, and Pfeiffer. Fiflied, & Rowe. 1987). Among arthritis patients, the perception that one had fewer problems with one's performance than other patients made patients more satisfied with their own performance (Blalock et al., 1989).

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§ WHAT IS THE DIFFERENCE BETWEEN STRESS AND BURNOUT?

Burnout may be the result of unrelenting stress, but it isn't the same as too much stress. Stress, by and large, involves too much*:* too many pressures that demand too much of you physically and psychologically. Stressed people can still imagine, though, that if they can just get everything under control, they'll feel better. Burnout, on the other hand, is about not enough. Being burned out means feeling empty, devoid of motivation, and beyond caring. People experiencing burnout often don't

See any hope of positive change in their situations. If excessive stress is like drowning in responsibilities, burnout is being all dried up.

Stress vs. Burnout	
Stress	Burnout
Characterized by over engagement	Characterized by disengagement
Emotions are over reactive	Emotions are blunted
Produces urgency and hyperactivity	Produces helplessness and hopelessness
Exhausts physical energy	Exhausts motivation and drive, ideals and hope
Leads to anxiety disorders	Leads to paranoia, detachment, and depression
Causes disintegration	Causes demoralization
Primary damage is physical	Primary damage is emotional
Stress may kill you prematurely, and you won't have enough time to finish what you started.	Burnout may never kill you, but your life may not seem worth living.

One other difference between stress and burnout: While you're usually aware of being under a lot of stress, you don't always notice burnout when it happens. The symptoms of burnout — the hopelessness, the cynicism, the detachment from others — can take months to surface. If someone close to you points out changes in your attitude or behavior that are typical of burnout, listen to that person. (Buunk et al., 1991; Molleman et al.. 1986).

§ INDIVIDUAL APPROACHES:

Individual approaches have focused on the symptoms displayed by burned-out individuals. Such approaches were especially popular during the pioneer phase of burnout work. Burnout was considered a syndrome consisting of many related symptoms, of which exhaustion was the most prominent one, and long laundry lists of individual burnout symptoms were drafted. Frustrated expectations and goals were regarded as the major cause for burnout. It was observed that idealistic and strongly

Motivated individuals, who are extremely dedicated to their work and who are over involved in their jobs, were more likely to burn out. Although some authors emphasized the process of burning out, the prevailing view was a more static one that concentrated on the end state: the burnout syndrome.
The first two contributions criticize this state conception of burnout in similar ways. According to both Burisch and Hallsten, the state conception of burnout is over inclusive. Too many symptoms are associated with it, so that burnout cannot be discriminated from other mental states such as stress, depression, and alienation with a wide differences but it could be differentiated.

Burisch argues that the burnout literature has ignored many relevant research traditions (e.g., crisis theory, incentive theory, psychosomatics), all of which have dealt with something like burnout from various perspectives. Although Burst and Hallsten share most criticisms on the present burnout conception, they offer different alternatives. However, both authors emphasize that burnout should be studied as a process rather than as a state. Burisch maintains that burnout is best conceptualized as a fuzzy set, i.e., a highly nonspecific entity, the generic name for certain types of crises that manifest themselves in a multifaceted symptomatology. He identifies loss of autonomy as the salient causal factor: failing to get what one wants or having to endure what one wants to avoid. Rather than hoping for a circumscribed cause of burnout to emerge (something akin to a burnout virus), investigators should study what is actually happening during the course of burnout. Burisch outlines an action model that employs an action episode as its basic unit of analysis. The individual's latent motives lie at the core of the action episodes. Burisch identifies four types of disturbed action episodes, each of which may eventually lead to burnout. By offering his action model, Burisch provides a framework for more sophisticated theory and research. (Maslach & Jackson 1982).

§ BURNING OUT: A FRAMEWORK:

Recent methodological improvements within the area of burnout have permitted a more solid foundation for the burnout phenomenon (Garden, 1987).

Shirom (1989) delineates and discusses many conceptual consequences of these later studies. He concludes that burnout essentially "refers to a combination of physical fatigue, emotional exhaustion and cognitive weariness" and that "the depletion of energetic resources . . . does not overlap any other established behavioral science concepts". Burnout is a chronic, negative, affective response with fatigue and emotional exhaustion as its core aspects. This view of the burnout phenomenon is here referred to as the state conception of burnout, since it identifies burnout with affective states. Researchers within the field may have different opinions regarding antecedents and consequences of the phenomenon, but most of them appear to adhere to this state conception and to the view that burnout is adequately operational zed by the Burnout Measure (BM) (Pines & Aronson, 1988) or by the emotional exhaustion scale from the Maslach Burnout Inventory (MBI) (Maslach & Jackson, 1981a). Shirom seems to be an exception in stating that scales such as MBI and BM are contaminated by depression, frustration, and anxiety and that these scales should be purified.

Most of the conclusions from Shirom's review arc reasonable. However, the review does raise some questions and doubts. Nearly all studies referred to are based on MBI and BM or variants of them, and consequently the accuracy of the conclusions is dependent on the validity of these instruments. Significant data from depth interviews or clinical settings (e.g. Freudenberger & North, 1986) are lacking, and the quite different portraits given from these and other contexts (active and passive burnout; chronic and temporary states; acute and progressive onsets, etc.) are not commented on. Finally, the inference that the gradual depletion of resources does not overlap with other established concepts seems questionable.

The concept of burnout was earlier criticized for being mainly descriptive, anecdotal, and vaguely defined (Farber, 1983a; Freudenberger, 1983a; Maslach, 1982c; Meier, 1983). This criticism is still valid, but perhaps not of primary significance. Presumably, the basic problem is that burnout does not have a sufficiently distinctive character

In comparison with such related concepts as depression, stress, and alienation. Its etiology and its distinguishing aspects in relation to these phenomena are not specified. In parallel to what Abramson, Metalsky, and Alloy (1989) noted about depression, it is argued here that definitions of burnout based on symptoms alone are less useful than those based on an etiology, not just for conceptual clarity but also for prevention and cure.
Since burnout, as measured by MBI or BM, has been shown to correlate with nearly every organizational and psychological aspect of the work environment. (Shamir: 1986).

§ PERCEIVED ENVIRONMENTAL CONGRUENCY THAT HELP TO REDUCE BURNOUT:

The key aspect for this process is an environment that is perceived as incongruous. For professionals, the availability of two organizational factors is crucial: (1) personal and organizational competencies and resources for attaining organizational goals and professional standards, and (2) various forms of social support, including shared values and goals. Both these factors seem necessary to the vulnerable professional to create a positive self-image.

The more incongruous the organizational environment, the lower the expectations of achievement and high self-esteem. Without organizational problems, the process of burning out is unlikely to occur for professionals.
The degree of perceived environmental congruency corresponds to

(t) Perceived personal and organizational competencies/resources for attaining organizational goals and professional standards, and

(2) Perceived social support and shared goals. Goal expectations are primarily related to this congruency. Vulnerability and low self-complexity may contribute to more modest and unstable, reactive perceptions of congruency (Linville: 1985).

§ BURNING OUT AND RELATED PROCESSES:

This burning-out process is consistent with some control, cognitive, and behavioral models of reactive depression (e.g., 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, 1985, 1988) 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 (see also Chapter 14). There has only been equivocal support for phase transitions as responses to undesirable events (Silver & Wort man, 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 (cf. Shirom, 1989).

§ COMPARISONS WITH RELATED CONCEPTS:

The concept of burning out as presented here deviates from related concepts such as stress, alienation, crisis, and depression in that it specifies a certain etiology with motives and a behavior pattern. The outcome of a burning-out process may be similar to states and criteria of stress-strain, depression, and crisis, although it is always a result of an enduring process. As such, burning out can be considered a special instance of these phenomena.

An important aspect is the possible no homeostatic solutions from the process, thereby deviating from homeostatic concepts such as stress (e.g., Apply & Trumball, 1986; Cooper & Payne, 1988; Schuler, 1980; but also Hobfolt, 1988). Thus, it resembles the crisis concept (Caplan, 1964; Reiter & Strotzka, 1977; Viney, 1976) in presuming different developmental consequences. By specifying a certain etiology and behavior pattern, the framework shows similarities to the commitment-disengagement cycle (Klinger, 1977) and to the type a behavior pattern (Burke, 1984; Ganster, 1987; Pittner & Houstone. 1980). In comparison to the latter concept, however, burning out has less the character of a trait or a typology, although it bears some resemblance to the interpretation of type A behavior as presented by Matthews (1982). She emphasizes the importance of uncontrollability, self-involvement, and ambiguous standards for the occurrence of type a behavior. From this perspective, burning out might be seen as a model for the development of type A behavior into helplessness and hopelessness.

The MB! Dimensions of burnout (emotional exhaustion, reduced personal accomplishment, and depersonalization) are all easily derived from the scripts assumed to be involved in burning out. Burning out, however, is a narrower phenomenon than burnout as operational zed by MBI and BM.? It is assumed that the state conception of burnout as measured by MBI and BM might include all persons belonging to the phases of frustrated strivings, success depression, strenuous no commitment, general depression, circumscribed frustration, and work alienation, irrespective of their etiological pattern.

The only empirical data at hand that illustrate the relationship between the state conception of burnout and burning out are from a minor study

(Hallsten, 1988). There it was assumed that a BM score above 4.0 was indicative of belonging to any of the phases mentioned above. Sixteen percent of the sample had a score above this criterion (but none of these seemed to belong to success depression, circumscribed frustration, or work alienation as judged by the information presented during the interviews and the criteria outlined above). Five percent of these subjects showed a history of absorbing commitment and frustrated strivings while 11 % had a career starting with strenuous no commitment. The depression process was more common than the burning-out process. The distinguishing aspects between these two careers were primarily the goal orientation, commitment, and effort exhibited. An advantage from a perspective of discriminative validity was that the distinction between burning out and being depressed was clearly correlated with degree of professionalism. The depression process was more common among nonprofessionals while the burning-out process was more typical for professionals.

§ CAN BURNOUT BE PREVENTED OR TREATED?

Because burnout is related to stress, many of the methods effective in countering stress can help prevent burnout as well. For one thing, it's important to build or maintain a foundation of good physical health, so be sure to eat right, get enough sleep, and make exercise part of your daily routine.

§ PREVENTING JOB BURNOUT:

The most effective way to head off job burnout is to quit doing what you're doing and do something else, whether that means changing jobs or changing careers. But if that isn't an option for you, there are still things you can do to improve your situation, or at least your state of mind.
(Pittner & Houstone: 1980)

Ways to Prevent Job Burnout	
Clarify your job description	Ask your supervisor for an updated description of your job duties and responsibilities. You may then be able to point out that some of the things you're expected to do are not part of your job description and gain a little leverage by showing that you've been putting in work over and above the parameters of your job.

Request a transfer	If your workplace is large enough, you might be able to escape a toxic environment by transferring to another department. Talk to your supervisor or court a request from another supervisor.
Ask for new duties	If you've been doing the exact same work for a long time, ask to try something new: a different grade level, a different sales territory, a different machine.
Look for a new job	Update your résumé and apply for jobs that are related to but different from what you do now.
Make a career move	Get whatever training you need to make a big move in the same field, such as practicing a new area of law or teaching high school rather than elementary.
Make a career change	If you know you want to work in a different career, start taking steps toward it now, even if it's one community-college course at a time. Find out what the requirements are for the job you really want and start meeting them little by little.
Get career advice	Consult a career counselor or use the services of an agency that offers vocational services.

§ BEST DEFENSE AGAINST ALL BURNOUT: BEING WITH OTHER PEOPLE:

Although taking time to yourself to relax is important in reducing stress, if you are approaching burnout, it's also crucial that you cultivate relationships with other people and spend time socializing with them. Poor relationships and isolation can contribute to burnout, but positive relationships can help prevent or reduce its onset.

Here are some steps you can take to improve your relationships with others:

- **Nurture your closest relationships, such as those with your partner, children or friends.** These relationships can help restore energy and alleviate some of the psychological effects of burnout, such as feelings of being underappreciated. Try to put aside what's burning you out and make the time you spend with loved ones positive and enjoyable.

- **Develop casual social relationships, on and off site, with people at your workplace.** "We do all kinds of things, whether it is getting together to play cards or going out to eat. It gives everyone an opportunity to relax and blow off steam," a teacher wrote to a contributors' site. Just remember to avoid hanging out with negative-minded people who do nothing but complain.

- **Connect with a cause or a community group that is personally meaningful to you.** Joining a religious, social, or support group can give you a place to talk to like-minded people about how to deal with daily stress — and to make new friends. If your line of work has a professional association, you can attend meetings and interact with others coping with the same workplace demands.
- **Practice healthy communication.** Express your feelings to others who will listen, understand, and not judge. Burnout involves feelings that fester and grow, so be sure to let your emotions out in healthy, productive ways.

In summary, to prevent or recover from burnout, learn to cultivate methods of personal renewal, self-awareness, and connection with others, and don't be afraid to acknowledge your own needs and find ways to get your needs met. (Pittner & Houstone: 1980)

§ BURNOUT AND NURSING*:*

In burnout the cumulative effects of a stressful work environment gradually overwhelm the defenses of staff members, forcing them to withdraw psychologically. Understanding the experience of professional and paraprofessional nurses who suffer from burnout requires a close examination of the environments in which they function. We examined differences in nursing burnout by occupational levels (professional versus paraprofessional nurses), type of facility (acute care hospitals versus long-term care facilities), and professional exposure to patients with poor prognosis for survival (high, moderate, low). (Pittner & Houstone: 1980)

3-THE STRESS

§ INTRODUCTION:

At one time or another, most people experience stress. The term stress has been used to describe a variety of negative feelings and reactions that accompany threatening or challenging situations. However, not all stress reactions are negative.

A certain amount of stress is actually necessary for survival. For example, birth is one of the most stressful experiences of life. The high level of hormones released during birth, which are also involved in the stress response, are believed to prepare the newborn infant for adaptation to the challenges of life outside the womb.

These biological responses to stress make the newborn more alert promoting the bonding process and, by extension, the child's physical survival. The stress reaction maximizes the expenditure of energy which helps prepare the body to meet a threatening or challenging situation and the individual tends to mobilize a great deal of effort in order to deal with the event. Both the sympathetic/adrenal and pituitary/adrenal systems become activated in response to stress. The sympathetic system is a fast-acting system that allows us to respond to the immediate demands of the situation by activating and increasing arousal. The pituitary/adrenal system is slower-acting and prolongs the aroused state. However, while a certain amount of stress is necessary for survival; prolonged stress can affect health adversely (Bernard & Krupat, 1994).

Stress has generally been viewed as a set of neurological and physiological reactions that serves an adaptive function (Franken, 1994). Traditionally, stress research has been oriented toward studies involving the body's reaction to stress and the cognitive processes that influence the perception of stress. However, social perspectives of the stress response have noted that different people experiencing similar life conditions are not necessarily affected in the same manner (Pearlin, 1982).

Research into the societal and cultural influences of stress may make it necessary to re-examine how stress is defined and studied.

There are a numbers of definitions of stress as well as number of events that can lead to the experience of stress. People say they are stressed when they take an examination, when having to deal with a frustrating work situation, or when experiencing relationship difficulties. Stressful situations can be viewed as harmful, as threatening, or as challenging. With so many factors that can contribute to stress it can be difficult to define the concept of "stress".

Hans Selye (1982) points out that few people define the concept of stress in the same way or even bother to attempt a clear-cut definition. According to Selye, an important aspect of stress is that a wide variety of dissimilar situations are capable of producing the stress response such as fatigue, effort, pain, fear, and even success. This has led to several definitions of stress, each of which highlights different aspects of stress. One of the most comprehensive models of stress is the Bio-psychosocial Model of Stress (Bernard & Krupat, 1994).

According to the Bio-psychosocial Model of Stress, stress involves three components: an external component, an internal component, and the interaction between the external and internal components.

§ THE BIOPSYCHOSOCIAL MODEL OF STRESS:

The external component of the Bio-psychosocial Model of stress involves environmental events that precede the recognition of stress and can elicit a stress response. A previously mentioned, the stress reaction is elicited by a wide variety of psychosocial stimuli that are either physiologically or emotionally threatening and disrupt the body's homeostasis (Cannon, 1932).

We are usually aware of stressors when we feel conflicted, frustrated, or pressured. Most of the common stressors fall within four broad categories: personal, social/familial, work, and the environment. These stressful events have been linked to a variety of psychological physical complaints. For example bereavement is a particularly difficult stressor and has provided some of the first systematic evidence of a link between

Stress and immune functioning. Bereavement research generally supports a relationship between a sense of loss and lowered immune system functioning. Health problems and increased accidents are also associated with stressful work demands, job insecurity and changes in job responsibilities (Bernard & Krupat, 1994).

Stressors also differ in their duration. Acute stressors are stressors of relatively short duration and are generally not considered to be a health risk because they are limited by time. Chronic stressors are of relatively longer duration and can pose a serious health risk due to their prolonged activation of the body's stress response.

The internal component of stress involves a set of neurological and physiological reactions to stress. Hans Selye (1985) defined stress as "nonspecific" in that the stress response can result from a variety of different kinds of stressors and he thus focused on the internal aspects of stress. Selye noted that a person who is subjected to prolonged stress goes through three phases: Alarm Reaction, Stage of Resistance and Exhaustion. He termed this set of responses as the General Adaptation Syndrome (GAS).

This general reaction to stress is viewed as a set of reactions that mobilize the organism's resources to deal with an impending threat. The Alarm Reaction is equivalent to the fight-or-flight response and includes the various neurological and physiological responses when confronted with a stressor. When a threat is perceived the hypothalamus signals both the sympathetic nervous system and the pituitary.

The sympathetic nervous system stimulates the adrenal glands. The adrenal glands release corticosteroids to increase metabolism which provides immediate energy. The pituitary gland releases adreno-corticotrophic hormone (ACTH) which also affects the adrenal glands. The adrenal glands then release epinephrine and nor epinephrine which prolongs the fight-or-flight response.

The Stage of Resistance is a continued state of arousal. If the stressful situation is prolonged, the high level of hormones during the resistance phase may upset homeostasis and harm internal organs leaving the organism vulnerable to disease. There is evidence from animal research

That the adrenal glands actually increase in size during the resistance stage which may reflect the prolonged activity. The Exhaustion stage occurs after prolonged resistance. During this stage, the body's energy reserves are finally exhausted and breakdown occurs. Selye has noted that, in humans, many of the diseases precipitated or caused by stress occur in the resistance stage and he refers to these as "diseases of adaptation." These diseases of adaptation include headaches, insomnia, high blood pressure, and cardiovascular and kidney diseases. In general, the central nervous system and hormonal responses aid adaptation. However, it can sometimes lead to disease especially when the state of stress if prolonged or intense.

Richard Dienstbier (1989) questions the emphasis the GAS places on the role of chronic stress and proposes another model of stress, Physiological Toughening, which focuses on the duration of stressful events. He points out that stressors vary in their durations. Acute stressors are the briefest and often involve a tangible threat that is readily identified as a stressor. Chronic stressors are those of a longer duration and are not readily identified as stressors because they are often ambiguous and intangible. Because chronic stressors have become such a part of modern life, they may be taken for granted and can therefore pose a serious health risk if they are not recognized and properly managed. Physiological Toughening is concerned with the third category of stressors, intermittent stressors. Intermittent stressors are the most variable in duration, alternating between periods of stress and calm. If an intermittent stressor is viewed as a challenge, it may improve one's physiological resistance to stress by causing repeated, periodic increases in sympathetic arousal which conditions the body to better withstand subsequent stressors. This can be seen from research indicating that experienced subjects show few or none of the deleterious effects of environmental stressors. For example, Astronauts are trained to have available response sequences, plans, and problem-solving strategies for all imaginable emergencies. Emergencies are therefore transformed into routine situations decreasing the intensity of the stressful situation (Mandler, 1982).

Mandler's (1982) Interruption Theory of stress provides a transition between the internal component of stress and the interaction component. Mandler defines stress as an emergency signaling interruption. The basic

Premise is that autonomic activity results whenever some organized action or thought process is interrupted. The term interruption is used in the sense that any event, whether external or internal to the individual, prevents completion of some action, thought sequences, or plan and is considered to be interrupted. Interruption can occur in the perceptual, cognitive, behavioral, or problem-solving domains. The consequences of the interruption will always be autonomic activity and will be interpreted emotionally in any number of ways, ranging from the most joyful to the most noxious.

The third component of the bio-psychosocial model of stress is the interaction between the external and internal components, involving the individual's cognitive processes. Lazarus and colleagues (1984b; 1978) have proposed a cognitive theory of stress which addresses this interaction. They refer to this interaction as a transaction, taking into account the ongoing relationship between the individual and the environment. Their theory places the emphasis on the meaning that an event has for the individual and not on the physiological responses. Lazarus et al. believe that one's view of a situation determines whether an event is experienced as stressful or not, making stress the consequence of appraisal and not the antecedent of stress. According to this theory, the way an individual appraises an event plays a fundamental role in determining, not only the magnitude of the stress response, but also the kind of coping strategies that the individual may employ in efforts to deal with the stress.

According to the Transaction Theory of stress, the cognitive appraisal of stress is a two-part process which involves a primary appraisal and a secondary appraisal. Primary appraisal involves the determination of an event as stressful. During primary appraisal, the event or situation can be categorized as irrelevant, beneficial, or stressful. If the event is appraised as stressful, the event is then evaluated as a harm/loss, a threat, or a challenge. A harm/loss refers to an injury or damage that has already taken place. A threat refers to something that could produce harm or loss. A challenge event refers to the potential for growth, mastery, or some form of gain. Lazarus argues that we cannot assess the origins of stress by looking solely at the nature of the environmental event; rather stress is a

Process that involves the interaction of the individual with the environment.

These categories are based mostly on one's own prior experiences and learning. Also, each of these categories generates different emotional responses. Harm/loss stressors can elicit anger, disgust, sadness, or disappointment. Threatening stressors can produce anxiety and challenging stressors can produce excitement.

This theory helps to integrate both the motivational aspects of stress and the varying emotions that are associated with the experience of stress. Secondary appraisal occurs after assessment of the event as a threat or a challenge. During secondary appraisal the individual now evaluates his or her coping resources and options. According to the theory of transactions, stress arises only when a particular transaction is appraised by the person as relevant to his or her well-being. In order for an event to be appraised as a stressor, it must be personally relevant and there must be a perceived mismatch between a situation's demands and one's resources to cope with it.

Dienstbier (1989) offers a reformulation of the Transaction theory, which focuses on the emotional consequences of appraising an event as a stressor or as a challenge. He asserts that when an event is appraised as a challenge, it lead to different physiological consequences than when it is appraised as a harm/loss or threat. Dienstbier uses the term stress to refer to transactions that lead only to negative emotions and he uses the term challenge to describe a transaction that could lead both to positive and negative emotions.

A series of studies by Marianne Frankenhaeuser (1986) and colleagues provide some support for Dienstbier's assertion that a stressor evaluated as a challenge should be viewed more positively than a harm/loss or threat event.

According to Frankenhaeuser, physiological reactions to stressors depend on two factors: effort and distress. She found that there are three categories of physiological responses to stress. Effort with distress leads to increases of both catecholamine and cortisone secretion and result from daily hassles.

These stressors are experienced as negative emotions. This category corresponds to Dienstbier's characterization of the negative emotions present in an event appraised as a harm/loss or as a threat. Effort without distress leads to an increase of catecholamine and suppression of cortical secretion. These stressors are experienced as positive emotions.

This category corresponds to Dienstbier's characterization of the positive emotions present in events appraised as challenging. Distress without effort leads to increased cortical secretion but not necessarily to catecholamine secretion. This is the pattern often found in depressed individuals.

Traditionally, stress research has been oriented toward studies involving the body's reaction to stressors (a physiological perspective) and the cognitive processes that appraise the event or situation as a stressor (a cognitive perspective). However, current social perspectives of the stress response have noted that different people experiencing similar life conditions are not necessarily affected in the same manner.

There is a growing interest in the epidemiology of diseases thought to result from stress. It has been noted that the incidence of hypertension, cardiovascular ailments, and depression varies with such factors as race, sex, marital status, and income. This kind of socioeconomic variation of disease indicates that the stressors that presumably dispose people toward these illnesses are somehow linked to the conditions that people confront as they occupy their various positions and status's in the society.

Pearlin (1982) observes that individuals' coping strategies are primarily social in nature. The manner in which people attempt to avoid or resolve stressful situations, the cognitive strategies that they use to reduce threat, and the techniques for managing tensions are largely learned from the groups to which they belong. Although the coping strategies used by individuals are often distinct, coping dispositions are to a large extent acquired from the social environment.

The orientation toward stress research is changing as awareness of the social and cultural contexts involved in stress and coping are examined. The bio-psychosocial model of stress incorporates a variety of social factors into its model that influence stress reaction and perception.

However, research into the cultural differences that may exist in stress reactions are also needed to examine how various social and cultural structures influence the individual's experience of stress.

Culture and society may shape what events are perceived as stressful, what coping strategies are acceptable to use in a particular society, and what institutional mechanisms we may turn to for assistance (Fumiko Naughton, personal communication).

Pearlin (1982) suggests that society, its value systems, the stratified ordering of its populations, the organization of its institutions, and the rapidity and extent of changes in these elements can be sources of stress.

§ A DEFINITION OF STRESS:

There are many different definitions of unhealthy stress, according to which authority you consult. Medical organizations, stress management consultants and your boss at work would probably all define stress in a slightly different way, depending on their perspective and experience. The UK Healthy and Safety Executive define stress in the following way: ***"the adverse reaction people have to excessive pressure or other types of demand placed on them".*** (Pearlin: 1982)

§ COPING WITH STRESS:

We hope at this point that you accept the fact that everyone experiences stress at some point. Most of the time, we also all manage to cope with stress, apart from in cases where people have nervous breakdowns or other total health collapses. When this happens, it is often because people have exhausted their internal coping strategies.
We examine healthy and unhealthy coping strategies. For example, an unhealthy coping strategy would be getting so drunk that you fall over and can't remember what happened the next morning. In contrast, a healthy way of coping would be to deal with the stress so that the pressure is released and the cause of the stress is resolved, perhaps by talking a problem through. (Pearlin: 1982)

§ STAFFING AND WORK-RELATED INJURIES AND STRESS IN NURSING PROFESSION:

Nursing personnel work in a wide range of health services settings including hospitals, nursing homes, and ambulatory and community-based environments. In performing their duties, they encounter a remarkable range of work-related hazards. Some evidence suggests that fatigue related to overwork and staffing patterns, including shift work, can contribute to injuries and stress among staff providing nursing services (Gold et al., 1992; Phillips and Brown, 1992). Factors such as the physical work environment, organizational and institutional characteristics and policies, and personal work habits contribute to exposure to the risk of injury and stress. Exposure to occupational hazards—physical, psychological, biological, chemical, and environmental—could have both short-term and long-

Term effects on the health and safety of the health care giver and, ultimately, on the safety and quality of patient care (Tan, 1991). A sizable proportion of the victims of nonfatal violence are care givers in hospitals and nursing homes. Evidence also exists of abusive and violent behavior of staff toward patients, at times resulting from stress and overwork and at other times from a breakdown of quality controls and appropriate supervision.

§ *INCIDENCE OF WORK-RELATED INJURIES AND ILLNESS:*

The health services industry is one of the largest employers in the United States, employing almost 9 million persons in 1993 (BLS, 1995c). More than half of this workforce is employed in hospitals and nursing homes. Recent statistics and other information suggest that these institutions are becoming increasingly hazardous places of work, exposing workers to a wide range of risks.

In 1993, private industry workplaces reported 6.7 million injuries and illnesses, a rate of 8.5 cases for every 100 full-time workers (BLS, 1994c). Of the 6.7 million cases, nearly 6.3 million were injuries that resulted in time lost from work.

While the injury and illness rate for private industry as a whole has remained about the same or declined slightly since 1980, the rates for hospitals and for nursing and personal care homes during the same period have increased by about 52 and 62 per 100 full time workers, respectively. During the same period, hospitals reported about 338,000 cases, an incidence rate of nearly 12 per 100 full-time workers, and nursing and personal care facilities reported about 216,000 cases, a rate of 17 percent.

Nine industries, each with at least 100,000 injuries annually, accounted for nearly 2 million, or 30 percent, of the 6.7 million injuries in 1993 (BLS, 1994a). Hospitals ranked second, and nursing and personal care facilities ranked fourth, among these industries.

Overexertion, being struck by an object, and falls at the same level[1] are the leading ways in which workers are hurt on the job. These events account for

More than one-half of the 2.3 million nonfatal injuries and illnesses that resulted in days away from work (BLS, 1995a). Workers in nursing and personal care facilities had the highest rate of injuries among all private industries due to overexertion or falling to the same level (BLS, 1995b).

Not surprisingly, most of the injuries and illnesses involving days away from work that are reported by registered nurses (RN), licensed practical nurses (LPN), nurse assistants (NA), orderlies, and attendants occur among women. Most of the workers in these occupations are women. NAs, who are employed predominantly in hospitals and nursing homes, ranked second only to truck drivers and laborers in the incidence of injuries and illness that involved loss of work days (BLS, 1995a). For persons in all occupations who had worked less than a year, NAs were reported as having the most injuries and illness, primarily strains and sprains mostly involving the back. They cited overexertion related to patient care as the primary cause. The major source of injury reported is the patient or the resident whom the aide was trying to lift or help in other ways.

The association between job category and injury may be confounded by the nature of the work activities; NAs' work involves a great deal of heavy lifting.

§ *WORK-RELATED STRESS*

Extensive information documents that nursing work is stressful and that it can lead to a variety of work-related problems such as absenteeism, staff conflict, staff turnover, morale problems, and decreased worker effectiveness (Doering, 1990; Hiscott and Connop, 1990; Rees and Cooper, 1992; Fielding and Weaver, 1994). Exacerbated stress can lead to burnout and turnover of nursing personnel. Both the causes and correlates of work-related stress, and the outcomes and sequel for nurses as well as patients or residents, are of concern to this committee.

§ *SOURCES AND CONSEQUENCES OF STRESS*

Several research studies focusing on nursing staff in acute care settings have attempted to identify a wide range of factors associated with stress. They include overwhelming workload, limited facilities and space, inadequate help, too much responsibility, too little continuing education, poor organization, excessive paperwork, inadequate communication with physicians, intra staff tensions, and many other variables. Lack of recognition and lack of administrative support and leadership also can lead to stress. Although RNs frequently reported in testimony and during the committee's site visits that low staffing levels cause stress, empirical evidence does not corroborate their perception, although it clearly can exacerbate other stressful circumstances, as discussed below.

Some early studies of stress found that critical care nurses and intensive care nurses experience more stress than do staff in other units, but research has not consistently validated this finding (MacNeil and Weisz, 1987; Yu et al., 1989; Foxall et al., 1990). A survey of emergency room RNs identified inadequate staffing and other resources, too many non nursing tasks, changing trends in emergency department use, and patient transfer problems as causes of stress. They also described shortages of nursing staff during busy periods and at night, and the use of untrained relief staff, as other important factors in stress (Hawley, 1992).

One specific source of stress among health care workers is shift work. According to a 1991 review of 16 studies conducted by the Office of Technology Assessment (OTA, 1991), rotating nurses reported higher levels of stress, had more sleep disturbances, had significantly higher personal health problems, and suffered more injuries and accidents related to lack of sleep than fixed-shift nurses. Other research studies on shift work also reported adverse effects on performance, workers' health, performance, and mental and physical fitness (Gold et al., 1992).

Nursing personnel who work with the elderly confront many complex and potentially stressful situations in nursing homes where the work is highly demanding and labor intensive. Nursing personnel who work with patients with Alzheimer's disease are especially vulnerable to the effects of stress and burnout. These patients present many difficult care and management problems because of their progressive cognitive, functional, and psychosocial deterioration, which can result in bizarre and combative behaviors, emotional outbursts, and wandering. Moreover, nursing home staffs are often poorly trained to cope with the disruptive behaviors of residents and are, therefore, repeatedly frustrated by their inability to manage recurrent problems (Stolley et al., 1991). Many nursing homes are also not equipped with environmental structures or the support and service systems required caring appropriately for the person with Alzheimer's disease (Peppard, 1984).

One recent study, using a quasi-experimental design with repeated measures, examined whether staff who cared for patients with Alzheimer's disease on a

Special care unit (SCU) experienced less stress and burnout than staff that cared for such patients on traditional (integrated) units (Mobily et al., 1992).

The principal area of stress reduction for nursing personnel working on the SCU involved staff knowledge, abilities, and resources. Similarly, subscale analysis indicated significantly less stress for staff who worked in the SCU with respect to residents' verbal and physical behavior. The SCU was designed specifically to provide the special environmental structures and support and service systems that are required to enhance

Functioning and decrease associated behavioral problems of patients. These may be important factors in reducing stress and burnout for staff caring for residents suffering from Alzheimer's disease (Mobily et al., 1992). The investigators also recommended that, whenever possible, staffs who work with such residents be screened carefully and selected for their ability to be sensitive to their needs, their flexibility, their imagination, and their ability to respond to persons with impaired communication and ever-changing moods (Coons, 1991). Specialized training in the care of residents with Alzheimer's disease is also a critical factor.

High stress at work can create morale problems that ultimately detract from the staff member's job performance (Sheridan et al., 1990).

The causal model developed from research on work-related stress and morale among nursing home employees highlights both antecedents and outcomes of work-related stress (Weiler et al., 1990). The outcomes of work-related stress are linked to adverse physical and psychological consequences (LaRocco et al., 1980). According to Weiler and colleagues (1990), these outcomes can include:

(1) Burnout, defined as a syndrome of emotional exhaustion, depersonalization, and lack of personal accomplishment;

(2) Depression, which is the degree of negative affect experienced by nursing personnel;

(3) Poor or low job satisfaction, which involves effective orientation of nursing personnel toward the work situation; and

(4) Work involvement, defined as the degree to which nursing personnel identify with their job.

Although ***burnout*** has been the focus of many studies (see, e.g., Pines and Maslach, 1978; Dolan, 1987; Husted et al., 1989; Berland, 1990; Oehler et al., 1991; Johnson, 1992; Kandolin, 1993; Duquette et al., 1994), a uniform definition of burnout has not been established. Proposed definitions range from a simple equation of burnout with staff turnover to effectively including all four of the outcomes identified above by Weiler

And colleagues. Nevertheless, most definitions found by the committee tend to describe burnout as having psychological, physical, and behavioral components. Pines and Maslach (1978, p. 236) define burnout as "a syndrome of physical and emotional exhaustion involving the development of a negative self-concept, negative job attitude and loss of concern and feeling for clients." In the long-term care setting, Heine (1986) characterizes burnout as a loss of concern for residents and physical, emotional and spiritual exhaustion that may lead to indifference or negative feelings toward elderly residents, overuse of chemical or physical restraints, and heightened potential for abuse. Because of the variety of definitions of burnout, the committee chooses simply to use the term for a state in which stress has resulted in persistent lower job satisfaction and potentially reduced work performance and effectiveness. At extreme levels of burnout, measurable problems such as increased staff turnover may occur. Goldin (1985), for instance, found that burnout results in such administrative difficulties as high rates of tardiness, absenteeism, and attrition.

Dolan and colleagues (1992) discuss issues surrounding the propensity of nursing staff to quit, which has been acknowledged as the best predictor of turnover. Behaviors related to stress, burnout, and depression are notable and can have a subsequent impact on quality of care and turnover. The investigators surveyed 1,237 staff who worked in 30 Quebec hospital emergency rooms and intensive care units about 14 job demands (the response rate was 84 percent). Results indicated that lack of professional latitude (which included restricted autonomy, skill underutilization, and lack of participation in clinical decision making), clinical demands, role difficulties, and workload problems all contributed to the propensity to quit. The authors suggested that interventions aimed at improving the quality of work and the general work-related quality of life should be implemented to enhance employee mental health, reduce rates of turnover, and curb costs.

The work conditions of RNs are repeatedly cited as being a source of stress. Some authors indicate that the quality of nursing care is seriously jeopardized and that RNs often leave nursing as a result of stress or burnout (Anonymous, 1986; Masterson-Allen et al., 1987; Lucas et al., 1993).

Many organizational factors have been cited that influence nursing stress, burnout, and productivity in nursing care, and that may result in short-term or long-term absenteeism. Research by Hare and Pratt (1988) has shown that higher levels of nursing burnout in both acute and LTC settings may be related to the nature of the physically and emotionally strenuous work tasks, low status in comparison to other positions in the health care system, limited training, low wages and benefits, and, of interest to this report, poor staff-to-patient ratios. Duquette and colleagues (1994) indicate that organizational stressors influence the development of burnout, particularly role ambiguity, staffing, and workload; age, with younger RNs being more susceptible to seeing their role as more ambiguous and their workload heavier; and buffering factors including hardiness, social support, and coping. Weiler and colleagues' (1990) causal model, developed from research on work-related stress and morale among nursing home employees, highlights both the antecedents and consequences of stress. The investigators suggest a variety of interventions to address organizational responses to stress. They include improved in-service training, increased variety in job tasks, improved supervision, clear and realistic objectives for resident care, higher wages and better benefits for staff, and adequate staffing levels. They note that higher compensation and richer staffing levels may be considered nonnegotiable by

Some administrators because of the cost implications associated with their implementation; but that the costs related to staff burnout, absenteeism, and turnover, can far outweigh the costs associated with adequate staffing and compensation. Health care administrators must address the issues of the impact of organizational stressors on nurses if there is to be any hope of resolving the problem (Whitley and Putzier, 1994).

New approaches to staff selection and recruitment, flexibility in staffing, increased resources, and increased decision making by nurses is essential.

Changes in the physical environment and structural factors may also be critical elements in preventing or alleviating stress and work-related tension and pressures. Lyman (1987) suggests that physical and architectural features, such as adequate space, separate activity rooms,

Staff offices and toilet facilities, resident care facilities, barrier-free hallways, visible exits with amenities such as wide entry doors and ramps, and emergency exits, may decrease care giver burden and stress.

Enhancing social support networks is another important strategy that can serve as a buffer against the stresses inherent in working with the elderly. Problems with support in the work environment, especially from peers and supervisors, have repeatedly been shown to be a primary source of stress among nurses (Cronin-Stubbs and Rooks, 1985). Further, compelling evidence exists that social support serves to mitigate the adverse effects of stress and to reduce burnout among nursing staff (Constable and Russell, 1986).

Violence and abuse, and stress and burnout in these health care workplaces.

4- SOCIAL SUPPORT

§ Introduction

Social support is one of the most studied processes of the last several decades.

Entering the term into medical or social science databases yields thousands of citations across dozens of fields or study.

This wide spread interest is likely due to the variety of important effects that have been associated with social support. Research has linked social support with a longer life, with reduced incidence of various diseases, with better recovery from illness, with improved coping with chronic. Illness, and with better mental health.

Enacted support is but one facet of the broader social support construct and enacted social support can occur in contexts other than troubles talk in close relationships. Similarly, troubles talk is not limited to close relationships. However, the processes of enacted support are distinctive and the troubles talk conversations of close relational partners are a frequent and significant site for these processes. (House: 1981)

§ THE IMPORTANCE OF Social SUPPORT:

Social support is an umbrella construct used to refer to several related yet conceptually distinct social phenomena and processes.
Social support is central to the broader social support construct. Prominent researchers in a wide variety of academic disciplines have defined social support in ways that state or imply it is conveyed through the actions of one person in interaction with another.
Researchers and laypersons alike conceive of social support as an "interpersonal transaction" that yields emotional concern, instrumental aid, information, or information relevant to self-evaluation. In a review of research on social support among the elderly. (House: 1981)

Antonucci (1985, p. 96) concluded, "Most definitions assume that social support is based on supportive social interactions" In a discussion of the significance of social support in personal relationships"

Gottlieb {1985b, p. 361) stated that "in the coping process, it is the behavioral manifestations of support expressed by my close associates - its materialization in interpersonal transactions that has greatest significance for the course and outcomes of my ordeal.

Enacted social support is also central to research on interventions. Many support interventions are designed to provide or improve the interactions stressed individuals have with their relational partners, peers who have experienced a similar stressful condition, or healthcare professionals {Gottlieb, 1906; Heller & Rook, 1997; Wortman & Conway, 1985).

In a review of research on social support interventions, Heller and Rook (1997, p. 650) suggested the social transactions through which support is expressed are "important building blocks" of relationships and of support interventions.

Given the conceptual centrality of social interaction to the social support construct, it is perhaps surprising that most researchers who study social support focus on other, related phenomena.
The most common measures tap an individual's perception that support is available, and there is evidence these perceptions reflect a relatively stable and global sense of acceptance rather than a summary report of what goes on in actual interactions (Sarason, Pierce, & Sarason, 1990). Similarly, even studies of supportive interactions more often enumerate their frequency rather than model their processes.
Interactions in which individuals discuss their problems and communicate various kinds of support are a central feature of the multifaceted social support construct and yet these interactive processes are among the least studied components of social support.

Troubles talk is one important type of conversation in which social support is enacted. The term was coined by Jefferson (1980, p. 153), who described it as "a conversation in which troubles are reported."

In research Goldsmith conducted with his colleagues (Goldsmith & Baxter, 1996; Goldsmith & McDermott, 1998), they have found that troubles talk episodes are recognized by many U.S. Americans not only by their topical focus on a trouble but also by the presumed purpose of the conversation, which is to assist in coping with the problem.

Troubles talk is distinct from conversations in which participants discuss problems in their relationship. For example, it is different from complaining or arguing about the other's behavior (e.g., "I'm stressed out because you and I don't communicate very well" or "If s a problem for me that you smoke in the house") or from having a relationship talk with the hearer (e.g., "I'm worried about where our relationship is headed"). However, troubles talk may include stresses or problems external to the relationship that affect both partners (e.g., when one's spouse is ill, it is likely to be a concern for both; financial difficulties, moving, or changing jobs may be stressors faced together).

Everyday conversations that are not focused on troubles are no doubt important to global perceptions of the supportiveness of a partner or relationship (Barnes & Duck, 1994; Gottlieb, 1985b; Leatham & Duck, 1990; Rook, 1990). However, Goldsmith focus is on one particularly important and prototypical type of conversation in which social support is enacted: conversations in which individuals talk about problems, from the hassles of daily life to the major life events that pose stressful challenges, threats, or losses.

Understanding how support is enacted in the context of troubles talk is important theoretically.

One of the ways social relationships facilitate well-being is by providing access to this kind of interaction, in which individuals can receive assistance with coping (Thoits, 1986).

Many measures of social support include items that measure the availability of someone with whom you can talk about problems, someone who will listen to you talk about your feelings, or someone to console you when you are upset. Evidence of the importance of troubles talk as a context for social support is also found in studies of the positive effects of access to a confidant.

Having at least one person with whom you can talk about personal problems or troubles is consistently associated with individual well-being (for a review, see Cohen & Wills, 1985; see also Uchino, Cacioppo, Malarkey, Glaser, & Kiecolt-Glaser, 1995).

There are also practical reasons for seeking to better understand troubles talk. Conversations in which one participant discloses a problem and seeks assistance can be challenging, both for the person who makes him- or herself vulnerable by disclosing and for the partner searching for words that can bring insight, comfort, and solidarity. Jefferson's (1980, 1984a, 1984b).

Conversation analytic studies showed how talk about a trouble poses special problems for the organization and coordination of conversation. Metts, Backhaus, and Kazoleas (1995) explained how troubles talk conversations depart in significant ways from the usual topics and structures of everyday talk: One person may take more than his or her share of the floor time to tell an extended narrative, the topic of the narrative may focus on negative emotions rather than the positive emotions that are preferred, and the hearer of the narrative will eventually feel a need to generate some contribution to the conversation that is topically relevant and yet sensitive to the potential for the other person to be embarrassed and vulnerable. In short, talking about a trouble initiates a type of conversation that differs from "business as usual." Hearing about another person's difficulties can create discomfort and anxiety and this, in turn, can lead hearers to say things that are insensitive and potentially hurtful (Lehman, Ellard, & Wortman, 1986).

Enacting support in troubles talk conversations is often experienced as highly salient and meaningful and yet potentially difficult to do well. Showing individuals how to participate more effectively in troubles talk empowers them to take better advantage of the assistance close relationships can offer.

§ CLOSE RELATIONSHIPS AS A PRIMARY CONTEXT FOR SUPPORT:

The literature on social support emphasizes benefits to individual health and well-being, but troubles talk also contributes to relational functioning and satisfaction (Acitelli, 1996).

For example, Cutrona (1996a) suggests that social support contributes to marital satisfaction by preventing emotional withdrawal or depression during times of stress, by preventing conflicts from escalating in intensity, and by strengthening the intimate bond between partners. Burleson, Albrecht, Sarason, and Goldsmith (1994) note that supportive interactions are a defining feature of healthy family interaction and crucial to friendships and amicable work relationships.

Among North Americans, close relationships are a primary context for social support in general and for talking about problems in particular (Wade, Howell, & Wells, 1994).

Wellman and Wortley (1990) interviewed adults in a residential area just outside Toronto who provided various kinds of support. Talking about problems was significantly more likely to occur in relationships that were intimate and voluntary and spanned more than one context (e.g., two friends who interact in one another's homes, talk over the phone, and work in the same organization).

Seventy-two percent of these "strong ties" provided emotional aid and the authors concluded that "respondents appear to get most of their social support - of all kinds -through their small number of strong ties" (Wellman & Wortley, 1990, p. 566).

Young, Giles, and Plantz (1982) reached similar conclusions in their study of social networks in rural communities in the eastern United States.
Further evidence of the importance of close relationships as a context for troubles talk comes from the Americans View Their Mental Health studies. These large nationwide representative surveys of adults in the United States were conducted in i957and 1976 (see Veroff, Douvan, & Kulka, 1981).

In response to a question about what you do "if something is on your mind that is bothering you or worrying you and you do not know what to do about it," 86% of the respondents reported talking about their worries and most of these conversations occurred in close relationships. About half of those who reported talking about worries said they talked only to their spouse. In addition, family, friends, and neighbors were mentioned

More often than formal sources of support such as clergy, doctors, and mental health specialists. In a follow-up study, Swindle, Heller, Pescosolido, and Kikuzawa (2000) examined data from the Americans View Their Mental Health surveys as well as similar data from the 1996 nationwide General Social Survey.

They focused on responses to the more serious circumstance in which individuals reported having felt an impending nervous breakdown. Across the forty-year period represented in their data, there was a strong increase in reliance on family and friends as partners in troubles talk. This trend remained even after controlling for demographic characteristics and perceived reason for the breakdown.

Troubles talk is a strong expectation of close relational partners. Coughlin (2003) asked college students to describe the communication patterns of people in families with "good communication."

The ability to share problems with one another and count on family members for support were among the most frequently mentioned and strongly endorsed standards students used for evaluating good family communication. Similarly, a study that asked students to tell stories about their families found talking about problems and responding with instrumental or emotional support were prominent themes (Vangelisti, Crumley, & Baker, 1999).

The ability to talk about problems and respond supportively not only is an abstract relational ideal but also serves as a strong predictor of relational satisfaction. Young adults' satisfaction with their family relationships are strongly correlated with their perceptions that family members share Problems with one another and respond supportively (Coughlin, 2003).

In a sample of women juggling work, home, and childcare demands, Erickson (1993) found emotional support from one's husband was a key predictor of marital well-being and protected against the risk of marital burnout.
Dehle, Larsen, and Landers (2001) asked married students to report daily for one week on the support they received and desired from their spouses. When expectations for support were met in day-to-day interactions, spouses had higher levels of marital satisfaction. In another survey of

Young married couples in a university community, Sprecher, Metts, Burleson, Hatfield, and Thompson (1995) compared the relative importance of companionship, supportive communication, and sexual expression. They found that supportive communication (which included items about "listening when I need someone to talk to," "helps me clarify my thoughts," and comfort with "having a serious discussion") was the best predictor of marital satisfaction.

Conversely, in a sample of individuals drawn from divorce court records, not having "someone to talk things over with" headed a list of marital complaints (Kitson & Holmes, 1992).

Even when partners were acknowledged to fulfill instrumental roles in the marriage (e.g., providing for a family or keeping house), the failure of spouses to achieve satisfactory communication, support, and concern was seen by many as sufficient reason to end a relationship.
Observational studies confirm that patterns of giving and receiving social support are associated with concurrent and prospective marital satisfaction (e.g., Collins & Feeney, 2000; Cutrona & Suhr, 1994; Pasch & Bradbury, 1998).

The links between giving and receiving social support and marital satisfaction are particularly poignant in studies of couples coping together with health problems (e.g., Abbey, Andrews, & Halman, 1995; Dunkel-Schetter, Blasband, Feinstein, & Herbert, 1992; Lydon & Zanna, 1992; Peyrot, McMurry, & Hedges, 1988; Rankin, 1992; Revenson & Majerovitz, 1990; Swanson-Hyland, 1996).

§ THE BUFFERING EFFECTS OF ENACTED SUPPORT:

The buffering effect of social support refers to models that associate social support with reductions in the negative effects of stress on wellbeing (for discussion of various buffering models, see Barrera, 1988; Lin, Woefel, & Light, 1985; Wheaton, 1985).

When stress has negative effects on physical and mental health, social support can reduce or buffer these negative effects.

The strongest effects of social support should be observed when individuals experience high levels of stress. Under low levels of stress, the health of individuals with low social support may not differ dramatically or at all from the health of individuals with high social support.

Tests of the buffering effect have produced mixed results. Some studies have reported evidence for buffering effects, whereas some have reported no effects or mixed support (e.g., see Grant, 1990, for a review).

These mixed findings may be due, in part, to limitations in measurement, sample, or statistical analysis (Kessler & McLeod, 1985; Veiel, 1992). Also, the failure to differentiate social network involvement, perceived available support, and enacted support contributes to mixed findings. Cohen and Wills (1985) identified studies whose method and statistical analyses provided a reasonable chance of detecting effects of support. They then distinguished among measures of integration in a social network, perceived available support, and enacted support. Within these categories, they further differentiated between global or aggregated measures (i.e., those that combine types of support) and measures of specific functions of support (e.g., informational support, emotional support, and tangible support). They found stress-buffering effects when studies measured the perception that others were available to provide the specific type of support needed to cope with a stressor (e.g., emotional support for a loss or informational support for a solvable problem). They suggested the belief that stress-specific resources are available and may lead an individual to appraise a stressful situation as less threatening, even if he or she doesn't actually solicit or receive the support that is available.

It is especially difficult to draw conclusions about the buffering effect of enacted support because relatively few studies of the buffering effect have measured enacted support or differentiated it from other facets of support. Several reviews report inconsistent evidence for a buffering effect of enacted support (Cohen & Wills, 1985; Cooper, 1986; Dunkel-Schetter & Bennett, 1990). Some studies even report the counterintuitive finding that individuals who receive more enacted support report higher levels of stress and/or *greater* negative effects of stress (Aneshensel & Frerichs, 1982; Barrera, 1981; Cohen & Hoberman, 1983; Coyne,

Aldwin, & Lazarus, 1981; Fiore, Becker, & Coppel, 1983; Husaini, Neff, Newbrough, & Moore, 1982; Sandler & Barrera, 1984).

Rather than accepting at face value the null or negative effects of enacted support, many researchers have searched for ways to fashion from unexpected empirical findings an explanation that retains a beneficial role for enacted support. Because so many conceptualizations of social support include a central role for individuals helping one another through social interaction, many researchers regard the failure to find a simple buffering effect of enacted support as an anomaly.

As Dunkel-Schetter and Bennett (1990, pp. 285-286) explained, "We have struggled with how to reconcile the available empirical evidence with our belief, and the arguments of other researchers, that received support should have buffering effects" This search for the buffering effects of enacted support has led in two complementary directions: research on factors that moderate the buffering effects of enacted support and a recognition that not all attempts at support are, in fact, experienced as helpful.

Variables That Moderate the Buffering Effects of Enacted Support

One type of refinement is to examine how the stress-buffering effects of enacted support are contingent on other factors, including the type and affective tenor of the relationship in which support is offered, the type and quality of support that is offered, the degree and character of stress experienced by the support recipient, and the support recipient's own ways of mobilizing, interpreting, and utilizing support. Analyses that fail to examine factors such as the timing of support, type of stressor, source of support, severity of stress, and recipient and provider characteristics may not reveal these localized buffering effects of social support.

The timing of measurement in the course of an individual's coping with a stressor might affect a researcher's ability to detect stress-buffering effects. Initially, when individuals recognize their need for support and act to mobilize it, or when network members observe distress and respond to it, those with the highest levels of stress or distress might be those who seek or receive the most enacted support. Once support has been mobilized, we would expect more support to be associated with less distress (Barrera, 1986; Schwarzer & Leppin, 1991).

The buffering effects of enacted support may also be obscured in studies that aggregate across different types of stress or different sources of support. Wethington and Kessler (1986) compared the buffering effects of perceived available support and total enacted support in a study of distress associated with a recent negative life event.

Many scholars cite their classic study as demonstrating that the perception that support is available is a more powerful source of buffering effects than actually receiving support.

Wethington and Kessler did find convincing buffering effects of perceived available support that were independent of the receipt of enacted support; however, they also found some evidence for a buffering effect of enacted support when they examined specific types and sources of support for particular kinds of life stresses (e.g., instrumental support from a spouse was associated with emotional adjustment among respondents who had serious physical illness).

They recommended that future research on enacted support examine the types of support given by different sources for specific life events. Studies that have engaged in these types of focused analyses have found buffering effects of enacted support for particular combinations of support type, support source, problem, and outcome.

Lin and colleagues (1985) examined support from various sources provided in response to a particular important and undesirable life event. They found buffering effects for support provided by close relational partners who were also similar to the recipient. However, even support from close, similar others did not buffer recipients from the negative effects of marital disruption. Okun, Sandler, and Baumann (1988) found that support from teachers and family (but not from friends) buffered students from the negative effects of negative school events and boosted the positive effects of positive school events.

Lim (1996) studied job insecurity faced by graduates of an MBA program. The greater an employee's sense of job insecurity, the more likely he or she was to express dissatisfaction with the job, to search for another job, and to engage in noncompliant job behaviors. However,

Support from supervisors and co-workers (but not from family and friends) lessened these negative effects of job insecurity. In contrast, supportive family and friends (but not support from supervisors or co-workers) reduced the degree to which job insecurity affected overall dissatisfaction with life. Dean, Kolody, Wood, and Ensel (1989) differentiated between the effects of several forms of expressive and instrumental support on depression and disability among the elderly.

Expressions of caring and concern, love and affection, social integration, help with daily living, and help with health and medical needs implied different kinds of interactions and occurred in different kinds of relational contexts (e.g., some types of support required proximity of adult children and opportunities for face-to-face interaction). In turn, different types of support had different patterns of association with degree of disability and depression. Studies such as these demonstrate how the positive effects of enacted support may be specific to particular combinations of problem type, support type, support source, and outcome measure.

The buffering effects of enacted support may also depend on the severity of stress experienced and the needs for support that result. Pennix and colleagues (1997) studied elderly persons with severe arthritis, with mild arthritis, and with no arthritis.

The effects of enacted support depended on the type of relationship and facet of support measured. Regardless of whether one had arthritis, having a partner and regular interaction in close relationships had positive effects. Many researchers now agree that the effectiveness of supportive behaviors depends on how adequately they are matched to the particular needs created by a stressor (e.g., Barrera & Ainlay, 1983; Eckenrode & Wething-ton, 1990; Heller et al., 1986; Hobfoll & Stokes, 1988; Pearlin, 1985; Schae-fer, Coyne, & Lazarus, 1981; Shinn, Lehmann, & Wong, 1984; Shumaker & Brownell, 1984; Thoits, 1986; Vachon & Stylianos, 1988; Wilcox & Vemberg, 1985).

A similar logic is evident in research on how different forms of support are helpful from different providers (e.g., Cutrona et al., 1994; Dakof &

Taylor, 1990; Dunkel-Schetter, 1984; Dunkel-Scherter & Wortman, 1982; Gore& Aseltine, 1995; Gottlieb, 1978; Lanza etal., 1995; LaRocco, House, & French, 1980; Martin et al., 1994; Okun et al., 1988; Wan, Jaccard, & Ramey, 1996; Yates, 1995) or in different phases of coping with a crisis (e.g., Folkman & Lazarus, 1985; Helgeson, 1993; Jacobson, 1986; Pearlin, 1985; Ugolini, 1998). This reasoning has been explicitly articulated in several matching models of support, most notably Cohen and McKay's (1984) stressor-specificity model of support and Cutrona and Russell's (1990) optimal matching model (see also Cutrona & Suhr, 1992,1994).

The matching models and the evidence for their utility. Although they represent a conceptual improvement over approaches to the study of support that fail to consider the match between support and stressor, these models have not succeeded in producing clear evidence for a buffering effect of enacted support. In this chapter I suggest this could be due in part to the limited model of communication processes implied by the matching metaphor.

§ MATCHING MODELS OF SUPPORT:

Cohen and McKay's {1984) stressor-support specificity model differentiated three kinds of support and conceived of these as different mechanisms through which personal relationships could buffer the harmful effects of stress.

Relationships may be a source of tangible support (provision of material resources), appraisal support (assistance in defining a situation as less threatening or in deciding how to cope), or emotional support (bolstering self-esteem and a sense of belonging).

They suggest "stressors and stress experiences can be categorized in terms of those that elicit coping requirements for tangible support, appraisal support, self-esteem support, and belonging support (or some combination of these), and only those interpersonal relationships that provide the appropriate forms of support will operate as effective buffers" (p. 261).

Cutrona's optimal matching model (Cutrona, 1990; Cutrona & Russell, 1990) utilizes previous theory and research to distinguish five types of

Support and four dimensions of life stresses to which support must be matched to be optimally effective.

The five types of support are as follows:

Emotional support ("the ability to turn to others for comfort and security during times of stress, leading the person to feel that he or she is cared for by others"),

Network support ("a person's feeling part of a group whose members have common interests and concerns"),
Esteem support ("the bolstering of a person's sense of competence or self-esteem by other people"),

Tangible aid ("concrete instrumental assistance"), and Informational support ("advice or guidance concerning possible solutions to a problem") (Cutrona & Russell, 1990, p. 322).

In subsequent work (Cutrona & Suhr, 1992, 1994), these types have been grouped into the broader categories of action-facilitating or problem-solving support (including informational support and tangible aid), nurturing support (including emotional support and network support), and esteem support.

Following Thoits (1986), Cutrona and colleagues view social support as assisted individual coping and their model is based on the assumption "that interpersonal interactions that maximize appropriate coping behaviors are most beneficial" (Cutrona & Russell, 1990, p. 328).

For example, if a particular kind of life stress creates a need to regulate emotions, then the optimal support by others is that which facilitates emotion-focused coping behavior.

The relationship between types of coping and types of support is assumed to be straightforward: Emotion-focused coping is facilitated by emotional and network support, whereas problem-focused coping is facilitated by tangible aid and informational support. Esteem support enhances both types of coping.

Life stresses differ in desirability (" the nature and intensity of the negative emotions they engender," Cutrona & Russell, 1990, p. 329),

Controllability (the degree to which an individual can prevent the occurrence or consequences of an event, Cutrona, 1990. p. 8),

Duration of consequences of an event, and life domain in which a stress occurs (loss or threat to assets, relationships, achievements, or social roles). These dimensions influence the types of coping demands individuals experience. For example, desirability of stress influences whether support is directed toward reducing uncertainty (for positive events) or toward preventing depression (for negative events), and negative events may require more support overall.

The controllability dimension has received the most attention in Cutrona's subsequent work. For uncontrollable life stresses, there is little the person can do about the stress except regulate his or her emotions, so emotional support and network support are predicted to be optimal In contrast, a person with a controllable stress can cope by doing something to prevent or alleviate his or her problems and this will be facilitated by information and tangible support.

Cutrona and Suhr (1992, 1994) have suggested that in interdependent relationships the controllability dimension should take into account not only the extent to which the individual with a problem can take action to alleviate or remove the stress but should also consider whether the support provider can control the problem. Thus, action-facilitating support will be more helpful if the provider has expertise or influence over the stressor.
A number of studies have tested matching models of buffering effects of enacted social support. Some find mixed evidence of buffering effects (Cutrona & Russell, 1900; Cutrona & Suhr, 1992, 1994; Grant, 1090: Kaniasty & Norris, 1992; Krause, 1986; Peirce et al., 1996; Swanson-Hyland, 1996; Wenz-Gross, Siperstein, Untch, & Widaman, 1997). Others find little or no evidence of buffering effects (Baker, 1997; Krause, 1987; Rosenberg, 1985; Tijhuis, Flap, Foets, Groenewegen, 1995; Ugolini, 1998; Wade & Kendler, 2000).

In summarizing their own attempts at testing the optimal matching model, Cutrona and Suhr (1994. pp. 131-132) conclude the original model needs

"a significant overhaul" and that "considerable work remains before we will uncover consistent patterns of optimal matches between stress and support type."

Although not entirely unsuccessful, matching models have not yielded a clear solution to the problem of finding buffering effects of enacted support. In any given study, we might point to limitations that could detract from a clear pattern of support for the matching model (e.g., problems with sample size or analytic strategy). However, I wish to propose several conceptual problems with matching models that limit their utility for explaining and predicting the effective enactment of social support.

§ SOCIAL SUPPORT IN THE PALESTINIAN CONTEXT:

Lots of researcher wondered about the ability to stand still with all the stressors and the Israeli aggression, and it's clearly obvious to us that the social support is the key factor that empowers our life.
The nature of Palestinian personality is supportive to other, the Islamic religion enhance the support between the society, and the nature of stressors it self provoke the arousal of supportive behavior and social support.
The health care team that work in the Palestinian hospital suffer a lot of stressors, and its clear that the social support stand to modify the bad effect of the stress which will be cleared after the end of the study.(the researcher).

Chapter three

Literature review:

THE LITERATURE REVIEW

The burnout is a common phenomena 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 four fold since the late 1880's (Cherniss, 1995)
, thereby increasing the potential for more burnout in the human service workforce. One reason such workers burn out easily is their humanitarian attitude (Pines, 1983).
Those personality characteristics contributing to these workers' desire to care for people seem to place them at a higher risk of burnout.
So in order to view the literature review I will show many studies on each variable I have mentioned it in my study just as examples and not due to lack of study and I will explore all the related literature:

- Literature review on burnout among nurses generally.
- Burnout and its relationship to the stress among nurses.
- Burnout and its relationship to the social support of the nurses.
- Burnout and its relationship to the educational level of the nurses:
- Burnout and its relationship to the nurses' experiences.
- Burnout and its relationship to the sex of the nurses.
- Burnout and its relationship to the working place of the nurses.

a- burnout among nurses generally:

1. **The study of Hisashige A**. (1991)

The title of the study: **Burnout phenomenon and its occupational risk factors among Japanese hospital nurses**.

The purpose of the study: To identify and evaluate recent working conditions and job content of hospital nurses in Japan, as well as the prevalence of the burnout phenomenon and the occupational risk factors responsible for it, a questionnaire survey was carried out. The subjects consisted of 898 nurses and 255 municipal service workers as the control group. Working conditions and workload burdens were more severe among nurses than among the municipal workers. The burnout phenomenon among the nurses was characterized by emotional exhaustion as well as depersonalization. Moreover, the rate ratio and multivariate analyses indicated that a great variety of occupational

Factors, not only interpersonal relationships, but the general working conditions and specific physical or mental workloads influenced the burnout phenomenon as well. Therefore, in examining measures dealing with the burnout phenomenon among nurses, it is considered important to evaluate the occupational factors systematically and comprehensively.

2. **The study of Stordeur S, Vandenberghe C, D'hoore W. (1999)**

The title of the study**: Predictors of nurses' professional burnout: a study in a university hospital.**

The aim: This study was designed to examine the level of burnout and to identify stressor among nurses in a teaching hospital.

Based on a sample of 625 nurses, results show that burnout levels are moderate (M. = 24.3, SD = 9.3) and comparable to those observed in physicians (M. = 26.6, SD = 9.8) and in the administrative staff of the same hospital (M. = 25.1, SD = 11.9). Multiple regression analyses selected 11 predictors significantly associated with burnout. Some contributed positively to burnout (job strain, lack of social support, conflicts with other nurses, conflicts with physicians, presence of stressors related to private life, feeling that the job is threatened, full-time vs. part-time status), whereas others contributed negatively (perceived job control, hierarchical level, death and dying of patients, feeling protected against occupational hazards). It is worthy of noting that leadership dimensions were not significantly related to burnout, once stressors were included in the regression model.

The results from this study confirm that perceived control reduces the effect of job strain on burnout. This suggests that if job strain is high, managers can reduce its effect by providing nurses with opportunities to control their work environment and relations with patients. Results also demonstrate that burnout is negatively correlated with job satisfaction and perceived unit effectiveness. Managers should invest in prevention programs, since burnout is as deleterious to individuals as to the organization.

3. **The study of Bakker AB, Killmer CH, Siegrist J, Schaufeli WB.(2000):**

The title of the study: **Effort-reward imbalance and burnout among nurses.**

This study among a sample of 204 German nurses tested the hypothesis that an imbalance of high extrinsic efforts spent (i.e. job demands) and low extrinsic rewards obtained (e.g. poor promotion prospects) are associated with the burnout syndrome: the depletion of nurses' emotional resources.

The results of a series of analyses of variances confirmed this hypothesis, by showing that those nurses who experienced an effort-reward imbalance (ERI) reported higher levels on two of the three core dimensions of burnout (i.e. emotional exhaustion and depersonalization) than those who did not experience such an imbalance. Moreover - as additionally hypothesized - significant interaction effects indicated that burnout (i.e. emotional exhaustion and reduced personal accomplishment) was particularly prevalent among those nurses who experienced ERI and put relatively high intrinsic effort into their jobs, as reflected by their strong tendency to be personally in control over job conditions.

4. **The study of Demerouti E, Bakker AB, Nachreiner F, Schaufeli WB.(2000):**

The title of the study**: A model of burnout and life satisfaction amongst nurses.**

This study, among 109 German nurses, tested a theoretically derived model of burnout and overall life satisfaction. The model discriminates between two conceptually different categories of working conditions, namely job demands and job resources.

It was hypothesized that: (1) job demands, such as demanding contacts with patients and time pressure, are most predictive of exhaustion; (2) job resources, such as (poor) rewards and (lack of) participation in decision making, are most predictive of disengagement from work; and (3) job demands and job resources have an indirect impact on nurses' life satisfaction, through the experience of burnout (i.e., exhaustion and disengagement). A model including each of these relationships was tested simultaneously with structural equations modeling.

Results confirm the strong effects of job demands and job resources on exhaustion and disengagement respectively, and the mediating role of burnout between the working conditions and life satisfaction. These findings contribute to existing knowledge about antecedents and consequences of occupational burnout, and provide guidelines for interventions aimed at preventing or reducing burnout among nurses.

5. **The study of Kalliath T, Morris R. (2002).**

The title of the study: **Job satisfaction among nurses: a predictor of burnout levels.**

Aim: This study assessed the impact of differential levels of job satisfaction on burnout among nurses, hypothesizing that higher levels of job satisfaction predict lower levels of burnout.

METHODS: This study used the Maslach Burnout Inventory (MBI) to measure emotional exhaustion, depersonalization, and personal accomplishment. The job satisfaction scale of Katzell et al was used to measure overall job satisfaction. Statistical tests for significance used were Confirmatory Factor Analysis, Structural Equation Modeling, and the chi statistic, Root Mean Square Error of Approximation, Goodness of Fit Index, and Comparative Fit Index.

RESULTS: The findings show that job satisfaction has a significant direct negative effect on emotional exhaustion, whereas emotional exhaustion has a direct positive effect on depersonalization. A significant indirect effect was seen of job satisfaction on depersonalization via exhaustion. The path coefficient shows that job satisfaction has both direct and indirect effects on burnout, confirming job satisfaction as a significant predictor of burnout.

6. **The study of Lee H**, **Song R**, **Cho YS**, **Lee GZ**,**Daly B.(2003)**

The title of the study: **A comprehensive model for predicting burnout in Korean nurses**

AIM: The purpose of this study was to understand the phenomenon of burnout among Korean nurses. 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.

METHODS: 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.

RESULTS: 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.

7. **The study of Vahey DC,Aiken LH, Sloane DM, Clarke SP, &Vargas D**.(2004):

The study title: **Nurse burnout and patient satisfaction**.

OBJECTIVES: This 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.

RESEARCH DESIGN/SUBJECTS: We conducted cross-sectional surveys of nurses (N=820) and patients (N=621) from 40 units in 20 urban hospitals across the United States. MEASURES: 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).

CONCLUSIONS: 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.

8. **The study of Taylor B, &Barling J. (2004):**

The study title: **Identifying sources and effects of career fatigue and burnout for mental health nurses: a qualitative approach.**

The study aimed to: identify work-related problems to assist mental health nurses to locate the sources and effects of career fatigue and burnout, set up a dialogue between the participants and the identified sources of stress in the workplace to address the identified problems, and make recommendations to a local Area Health Service to prevent and manage stressors in the practice of mental health nursing. In total, 20 experienced registered nurses working as mental health nurses were enlisted through a snowballing method of recruitment, and convenience sampling was used to intentionally target those research participants who were interested in identifying sources of career fatigue and burnout in their work. Data collection was via semi structured interviews which used questions reflecting the first stage method of narrative therapy, in which relative influence questioning is used to externalize the problem. The research questions related to the effect of burnout in mental health nursing across various interfaces, through the dominant story of emotional stress and fatigue. The sources of work-related problems for mental health nurses that contribute towards their experiences of career fatigue and burnout were: employment insecurity and actualization of the work-force; issues with management and the system; difficulties with the nature of the work, inadequate resources and services, problems with doctors, aggressive and criminal consumers, undervaluing consumers and nurses, physical and emotional constraints of the work setting, and nurse-nurse relationships and horizontal violence. The effects of stress were shown in dealing with and reacting to work place stressors.

9. **The study of Vimantaite R, & Seskevicius A. (2006):**

The study title: **The burnout syndrome among nurses working in Lithuanian cardiac surgery centers**.

The aim of this study: was to 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).

METHODS: The 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.

CONCLUSIONS: 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.

10. **The study of Piko BF. (2006):**

The study title: **Burnout, role conflict, job satisfaction and psychosocial health among Hungarian health care staff: a questionnaire survey.**

OBJECTIVES: The present 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. DESIGN: A questionnaire survey (anonymous questionnaires) has been carried out to detect these interrelationships.

SETTINGS: Two major hospitals in Szeged, Hungary.

METHODS: 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.

CONCLUSIONS: 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.

11. **The study of Li Calzi S, Farinelli M, Ercolani M, Alianti M, Manigrasso V, &Taroni AM.(2006):**

The study title: **Physical rehabilitation and burnout quantification of its: different aspects of the syndrome and comparison between healthcare professionals involved**

AIM: The aim of this study is to investigate burnout syndrome among physical rehabilitation professionals focusing on the differences between 4 categories of healthcare professionals involved.

METHODS: The experimental group consisted of 124 physiotherapy workers chosen among physicians, nurses, therapists, and technicians. The variables we chose to measure were: the presence of burnout (emotional exhaustion, depersonalization and lack of personal accomplishment), feelings of depression and anger, symptoms of psychological uneasiness and the level of perceived stress.

RESULTS: Overall the level of burnout experienced was medium-low. Emotional exhaustion was more prevalent among physiotherapists, while depersonalization was higher among physicians. Moreover mild feelings of depression emerged among technicians. No differences were found among the 4 categories when feelings of anger were considered, although anger was present at different levels (and more or less expressed) throughout the working environment.

12. **The study of Zhu W, Wang ZM, Wang MZ, LAN YJ, &Wu SY.(2006):**

The title of the study: **Job burnout and contributing factors for nurses**
OBJECTIVE: To investigate the degree of job burnout and contributing factors for nurses.
METHODS: 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.
CONCLUSION: 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. **The study of Hall L.2006**

The title of the study: **Burnout: results of an empirical study of New Zealand nurses**.
Burnout is conceptualized as a syndrome consisting of three components-emotional exhaustion, reduced personal accomplishment and

depersonalization of clients or patients that occurs in individuals who work in the human service professions, particularly nursing. It has been observed that nurses are at a high risk of burnout and burnout has been described as the 'professional cancer' of nursing. This is the first New Zealand study to use the Maslach Burnout Inventory (MBI) and the Phase Model of Burnout to determine the extent and severity of burnout in a population of 1134 nurses. Results revealed an overall 'low to average' level of burnout, suggesting that New Zealand nurses, apart from those in the 41-45 age group, are doing better than expected insofar as they are managing to avoid or not progress to the advanced phases of burnout. Possible explanations and directions for future research are presented.

B- Burnout and its relationship to the stress among nurses:

1. **The study of Oehler JM, & Davidson MG. (1992):**

The study title: **Job stress and burnout in acute and Nona cute pediatric nurses**

OBJECTIVE: To identify predictors of burnout in pediatric nurses and to compare the incidence of burnout, job stress, anxiety and perceived social support in acute and Nona cute care pediatric nurses. DESIGN: Prospective correlation-descriptive methodology was used to predict high, moderate or low burnout from length of work experience, perceived work stress and social support and anxiety.

SUBJECTS AND SETTING: Registered nurses (n = 121) employed full-time in neonatal and pediatric intensive care units and pediatric intermediate care units.

MEASUREMENTS AND RESULTS: Measures of job stress, anxiety, experience, social support and burnout were compared in acute and Nona cute care pediatric nurses. The overall mean incidence of burnout was in a moderate range for both acute and Nona cute care pediatric nurses for the emotional exhaustion and depersonalization subscales and in the high range of personal accomplishment subscales of the Maslach Burnout Inventory. Analysis of variance revealed no differences between groups. However, when nurses were grouped by high, moderate and low burnout scores, chi-square analysis revealed significant differences. More acute care nurses reported high burnout and more Nona cute care nurses reported low burnout. Discriminate function analysis revealed that job

Stress was the strongest significant predictor of burnout, followed by state anxiety, coworker support, trait anxiety and experience on the unit.

The study of Lewis SL, Bonner PN, Campbell MA, Cooper CL, &Willard A.(1994):

The title of the study: **Personality, stress, coping, and sense of coherence among nephrology nurses in dialysis settings**

The goal of this study: was to examine the relationships among personality types, personal and work-related stress, coping resources, and sense of coherence (SOC) among nephrology nurses in dialysis settings. Nurses (n = 49) from 13 dialysis units in New Mexico completed a demographic data form, Perceived and Nursing Stress Scales, SOC Scale, Coping Resources Inventory, and the Myers-Briggs Type Indicator (MBTI). The results indicated that there was a positive correlation between perceived personal stress and work-related stress, especially work load. Conversely, there were negative correlations between (a) both personal and work-related stress with SOC, and (b) both coping resources and SOC with burnout. High levels of personal and work-related stress were related to inadequate coping resources. Regression analysis indicated that the main contributing factors to emotional exhaustion (a major component of burnout) were low SOC, lack of staff support, personal stress, and heavy work load. Increased utilization of coping resources may facilitate the nurses' management of personal and work-related stressors.

2. **The study of Ramirez AJ, Graham J, Richards MA, Cull A, &Gregory WM.(1996):**

The title of the study: **Mental health of hospital consultants: the effects of stress and satisfaction at work.**

The aim: is to examine the relationship between consultants' mental health and their job stress and satisfaction, as well as their job and demographic characteristics, were also.

METHODS: Psychiatric morbidity was estimated using the 12-item General Health Questionnaire. The three components of burnout-emotional exhaustion, depersonalization, and low personal

Accomplishment-were assessed using the Maslach Burnout Inventory. Job stress and satisfaction were measured using study-specific questions.

FINDINGS: Of 1133 consultants, 882 (78%) returned questionnaires. The estimated prevalence of psychiatric morbidity was 27%, with no significant differences between the four specialist groups. Radiologists reported the highest level of burnout in terms of low personal accomplishment. Job satisfaction significantly protected consultants' mental health against job stress. Three sources of stress were associated with both burnout and psychiatric morbidity; feeling overloaded, and its effect on home life; feeling poorly managed and resourced; and dealing with patients' suffering. Burnout was also associated with low satisfaction in three domains: relationships with patients, relatives and staff; professional status/esteem; intellectual stimulation. In addition, being aged 55 years or less and being single were independent risk factors for burnout. Burnout was also more prevalent among consultants who felt insufficiently trained in communication and management skills.

3. **The study of Payne N. (2001):**

The study title: **Occupational stressors and coping as determinants of burnout in female hospice nurses.**

AIMS: Stressors, coping and demographic variables were examined as predictors of burnout in a sample of hospice nurses. The study aimed to investigate the level of burnout among hospice nurses; to ascertain which aspects of nursing work were positively or negatively related to burnout; to examine the relative contributions made by these different variables and to suggest individual and organizational interventions to reduce levels of burnout.

METHODS: Eighty-nine female nurses from nine hospices completed a battery of questionnaires comprising the Maslach Burnout Inventory, Nursing Stress Scale, Ways of Coping Scale and a demographic information form.

CONCLUSIONS: The importance of not labeling individuals as good and bad 'coppers' was discussed, as the effectiveness of a strategy may depend on the situation. It was concluded that the investigation of problem-focused and emotion-focused coping in relation to burnout, was oversimplifying the coping-burnout relationship.

4. **The study of Stordeur S, D'hoore W, And Vandenberghe C.(2001):**

The title of the study: **Leadership, organizational stress, and emotional exhaustion among hospital nursing staff**

STUDY'S RATIONALE AND OBJECTIVES: We examined the effect of work stressors and head nurses' transactional and transformational leadership on the levels of emotional exhaustion experienced among their staff.

METHODOLOGICAL DESIGN AND RESEARCH METHODS: A questionnaire was sent to all nurses of a university hospital. Usable returns were received from 625 nurses, giving a response rate of 39.2%. Data were treated using correlation analyses and multiple regressions. The latter modeled stressors and leadership as predictors of nurses' reported emotional exhaustion. MEASURES: Work stressors were assessed using the Nursing Stress Scale (NSS) which comprises 34 items divided into three subscales (referring to stress from the physical, psychological, and social environment), and the role ambiguity (three items) and conflict (three items) scales. Leadership was measured with the Multifactor Leadership Questionnaire.
CONCLUSIONS: This study provided, for the first time, a test of the influence of leadership on burnout among nurses, taking into account the role of work stressors. Future research is needed to examine if the effects reported herein can be replicated using the two other dimensions of burnout (depersonalization and reduced personal accomplishment).

5. **The study of :Taris TW, Peeters MC, Le Blanc PM,Schreurs PJ, Schaufeli WB.(2001).**

The title of the study: **From inequity to burnout: the role of job stress**

Aim; This research examined burnout (i.e., emotional exhaustion, depersonalization, and lack of personal accomplishment) among 2 samples of Dutch teachers as a function of inequity and experienced job stress in 3 different exchange relationships (with students, colleagues, and the school). It was hypothesized that inequity would be linked to burnout through the stress resulting from this inequity. Analysis of a cross-sectional sample (N = 271) revealed that this was indeed the case. Findings were replicated longitudinally using an independent sample of

940 teachers. It is concluded that the often-reported effect of inequity on burnout can partly be interpreted in terms of elevated levels of job stress. Implications of the findings are discussed.

6. **The study of :Greenglass ER, Burke RJ.(2001)**

The title of the study: **Stress and the effects of hospital restructuring in nurses.**

Aim: This study examines the extent of stress and burnout experienced by nurses during hospital restructuring. It includes both job-related outcomes such as job satisfaction and burnout, and psychosomatic outcomes such as depression. The study compares effects attributable to number of hospital restructuring initiatives with those attributable to specific work stressors such as workload, bumping (where one nurse replaces another due to greater seniority), and use of unlicensed personnel to do the work of nurses. It also examines the role of personal resources including self-efficacy and coping. Results show that, in hospitals undergoing restructuring, workload is the most significant and consistent predictor of distress in nurses, as manifested in lower job satisfaction, professional efficacy, and job security. Greater workload also contributed to depression, cynicism, and anxiety. The practice of bumping contributed to job insecurity, depression, and anxiety. The results point to specific deleterious effects of hospital restructuring. Implications of the findings are discussed. The extent to which workload issues are managed through appropriate practices can be expected to match the extent of nurses' experience of either job satisfaction or depression and anxiety. Such practices need to be part of an ongoing process of interaction between the hospital administration and nurses

7. **The study of :Garrosa E, Moreno-Jimenez B, Liang Y, Gonzalez JL.(2004)**

The title of the study: **The relationship between socio-demographic variables, job stressors, burnout, and hardy personality in nurses: An exploratory study**.

OBJECTIVES: A model of prediction of burnout in nursing that includes socio-demographic variables, job stressors, and personal vulnerability, or resistance, is proposed. DESIGN: A cross-sectional correlation design

Was used. A sample of 473 nurses and student nurses in practice from three General Hospitals in Madrid (Spain) completed the "Nursing Burnout Scale". The data were analyzed using descriptive statistics, Pearson correlations, and hierarchical multiple regression.

RESULTS: The proposed model is a good predictor of the diverse burnout sub-dimensions: emotional exhaustion, depersonalization, and lack of personal accomplishment. Significant predictors of burnout included age, job status, job stressors (workload, experience with pain and death, conflictive interaction, and role ambiguity), and hardy personality (commitment, control, and challenge).

CONCLUSIONS: Identifying an integrative process of burnout among nurses is an essential step to develop effective managerial strategies so as to reduce the burnout problem. Specifically, the present study suggests that intervention aimed at reducing the risk for burnout may achieve better results if it includes enhancement of workers' hardy personality rather than just decreasing environmental stressors.

8. **The study of Jenkins R, &Elliott P. (2004):**

The study title: **Stressors, burnout and social support: nurses in acute mental health settings.**

AIMS: (1) to investigate and compare levels of stressors and burnout of qualified and unqualified nursing staff in acute mental health settings; (2) to examine the relationships between stressors and burnout and (3) to assess the impact of social support on burnout and stressor-burnout relationships. METHODS: A convenience sample of 93 nursing staff from 11 acute adult mental health wards completed the Mental Health Professionals Stress Scale, Maslach Burnout Inventory and House and Wells Social Support Scale.

CONCLUSIONS: Qualified and unqualified nursing staff differed in terms of the prominence given to individual stressors in their work environment. The findings were consistent with the notion of burnout developing in response to job-related stressors. While staff support groups may be useful in alleviating feelings of burnout, the reverse buffering effect suggests that they should be structured in a way that minimizes negative communication and encourages staff to discuss their concerns in a constructive way.

9. **The study of Rowe MM, & Sherlock H. (2005):**

The study title: **Stress and verbal abuse in nursing: Does burn out nurses eat their young?**

AIM: The purpose of this study was to explore the types and frequency of verbal abuse of nurses by other nurses. Further, this study explored the components, characteristics, consequences and effects of abuse in an effort to better understand the dynamics of verbal abuse of nurses in the workplace. Nurses who experience occupational burnout are more likely to abuse other nurses. METHOD: Participants completed an adapted survey, incorporating the Verbal Abuse Scale and the Verbal Abuse Survey and demographic questions developed by the researchers. Specifically, types of verbal aggression, the frequency and stressfulness of each type, emotional reaction to verbal aggression, cognitive appraisal of verbally aggressive encounters, and similarity and effectiveness of coping behaviors were explored. The long-term negative effects of verbal aggression, including absenteeism and errors in patient treatment, were also evaluated to determine if verbal aggression is a contributing factor.

CONCLUSIONS: Verbal abuse in nursing is quite costly to the individual nurses, the hospitals and the patients. Nurses who regularly experience verbal abuse may be more stressed, may feel less satisfied with their jobs, may miss more work and may provide a substandard quality of care to patients.

10. **The study of Weyers S, Peter R, Boggild H, Jeppesen HJ, Siegrist J. (2006).**

The title of the study: **Psychosocial work stress is associated with poor self-rated health in Danish nurses: a test of the effort-reward imbalance model.**

The aim of this cross-sectional study (n = 367 nurses and nurses aides) was first to test the psychometric properties of the Danish questionnaire measuring ERI, and secondly to analyze whether psychosocial work stress is associated with six indicators of poor self-rated health. Results derived from confirmatory factor analysis indicate satisfying psychometric properties. Elevated risks of poor self-rated health (odds ratios varying from 1.92 to 4.76) are observed in nursing staff characterized by high effort in combination with low reward. Effects are

Enhanced in those respondents who additionally exhibit a high level of work-related over commitment.

In conclusion, despite methodological limitations, this study contributes to the validation of the ERI questionnaire in Danish language. Furthermore, by documenting associations with poor self-rated health, it supports efforts of theory-guided prevention of work stress in health care professions.

11. **The study of Stordeur S**, **D'hoore W**, **Vandenberghe C**.(2006)

The title of the study: **Leadership, organizational stress, and emotional exhaustion among hospital nursing staff**.

STUDY OBJECTIVES: We examined the effect of work stressors and head nurses' transactional and transformational leadership on the levels of emotional exhaustion experienced among their staff. METHODOLOGICAL DESIGN AND RESEARCH METHODS: A questionnaire was sent to all nurses of a university hospital. Usable returns were received from 625 nurses, giving a response rate of 39.2%. Data were treated using correlation analyses and multiple regressions. The latter modeled stressors and leadership as predictors of nurses' reported emotional exhaustion.

MEASURES: Work stressors were assessed using the Nursing Stress Scale (NSS) which comprises 34 items divided into three subscales (referring to stress from the physical, psychological, and social environment), and the role ambiguity (three items) and conflict (three items) scales. Leadership was measured with the Multifactor Leadership Questionnaire. RESULTS: In regression analyses, work stressors as a whole were found to explain 22% of the variance in emotional exhaustion whereas leadership dimensions explained 9% of the variance in that outcome measure. Stress emanating from the physical and social environment, role ambiguity, and active management-by-exception leadership were significantly associated with increased levels of emotional exhaustion. Transformational and contingent reward leadership did not influence emotional exhaustion.

CONCLUSIONS: This study provided, for the first time, a test of the influence of leadership on burnout among nurses, taking into account the role of work stressors. Future research is needed to examine if the effects

Reported herein can be replicated using the two other dimensions of burnout (depersonalization and reduced personal accomplishment).

12. **The study of :Dai JM, Yu HZ, Wu JH, Xu HH, Shen WR, Wang ZB, Fu H.(2006).**

The title of the study: **Hierarchical regression analysis for relationship between job stress and job burnout in Shanghai employees.**

OBJECTIVE: To identify related factors of job burnout in Shanghai employees.

METHODS: Four hundred fifty-six employees in Shanghai were investigated in this study. Self-administered questionnaires were used to assess job burnout and job stress, based on Maslach Burnout Inventory and the Job Demand-Control model as well as Effort-Reward Imbalance Model. Hierarchical linear regression was employed to analyze the relationship of job burnout to personal characteristics and job stress.

RESULTS: The indexes of three dimensions of job burnout were emotional exhaustion 19.70 +/- 8.92, depersonalization 11.95 +/- 4.45 and reduced personal accomplishment 28.10 +/- 10.08. Job stress was found to be affected differently in three dimensions of job burnout. Job demand, effort and over-commitment had positive impact on emotional exhaustion. Job control had a negative association with emotional exhaustion. There were significant relationship between depersonalization and age, sex and education of employees. Job control, reward and over-commitment affected the index of depersonalization. Education level and social support increased personal accomplishment index.

C- Burnout and its relationship to the social support of the nurses:

1. **The study of Constable JF, &Russell DW. (1986):**

The title of the study: The effect of social support and the work environment upon burnout among nurses.

This paper presents and discusses research findings on the effects of various aspects of the hospital work environment on burnout among nurses, and, in addition, evaluates the effects of social support in reducing and/or mitigating the relationship between negative aspects of the work environment and burnout. A multiple regression approach is employed to test the hypothesized model. The data were collected from a sample of nurses (n = 310) employed at Fitzsimons Army Medical Center (FAMC),

Aurora, Colorado. The major determinants of burnout were found to be low job enhancement (autonomy, task orientation, clarity, innovation, and physical comfort); work pressure; and lack of supervisor support, along with the interaction term involving the combined effects of job enhancement and supervisor support. These predictors, in conjunction with demographic and job-related variables explained 53% of the variance in emotional exhaustion, a central component of the burnout syndrome.

2. **The study of Fong CM. (1990):**

The title of the study: Role overload, social support, and burnout among nursing educators.

The purpose of this study: was to examine the relationships between role overload, social support, and burnout among nursing educators. Ninety percent (N = 141) of nursing educators from eight campuses of the California State University system completed a four-part questionnaire. Later, in-depth interviews were conducted with 30 nursing educators and five chairpersons. The findings indicated that a demanding job correlated, significantly and positively with almost all aspects of burnout (emotional exhaustion, depersonalization of students, and decreased sense of accomplishment). The degree of support from one's chairperson and peers correlated significantly and negatively with almost all aspects of burnout. The findings from the interviews verified these relationships. In the hierarchical regression analyses, a demanding job was the most important predictor of emotional exhaustion. Lack of peer support was the most important predictor of depersonalization towards students. Chairperson support was the most important predictor of a person's sense of accomplishment. Social support did not serve as a buffer against the negative effects of overload on burnout. It was concluded that attempts to alleviate burnout must directly address the extent of overload or the lack of support. Any attempt to mitigate the overload-burnout relationship by merely amplifying the amount of support is not likely to be effective.

3. **The study of Ogus ED. (1990):**

The title of the study: Burnout and social support systems among ward nurses.

This study examined the relationships between stress and social support systems in dealing with burnout among medical and surgical ward nurses. Multiple regression analyses demonstrated main effects for amount of and satisfaction with social support, with burnout as the criterion. That is,

Nurses with high sources of social support and high levels of satisfaction with that support reported less burnout than nurses with few supports and less satisfaction with those supports, regardless of level of work stress. No buffering effects were found for family support. That is, nurses with high work stress and high family support did not experience lower burnout than nurses with high work stress and low family support. Implications of the results are discussed.

4. **The study of Fong CM. (1993):**

The title of the study: A longitudinal study of the relationships between overload, social support, and burnout among nursing educators.

The major purpose of this study was to examine the causal relationships between role overload, social support, and burnout among nursing educators over a period of time. Eighty-four nursing educators from eight campuses of a state university system completed a questionnaire twice, within a two-year interval. Data analyses consistently revealed the following: 1) Emotional exhaustion correlated significantly and positively with a demanding job, time pressure, and feelings of job inadequacy; 2) Burnout (i.e., emotional exhaustion, depersonalization of students, and a sense of decreased accomplishment) correlated significantly and negatively with social support from one's chairperson and peers. Predictor variables from the initial data set were regressed on the burnout data of two years later. The variable--job demands--was the strongest predictor of emotional exhaustion. Chairperson support was the strongest predictor of both depersonalization toward students and a person's sense of accomplishment two years later. The reported chronic exhaustion among educators in this study should be of concern. An awareness of the role of social support and overload as associated with burnout can help educators develop policies to assure peak performance on the job.

5. **The study of :Sundin L, Hochwalder J, Bildt C, Lisspers J.(2006).**

The title of the study: **The relationship between different work-related sources of social support and burnout among registered and assistant nurses in Sweden: A questionnaire survey**.

OBJECTIVE: The main objective of the study was to analyze the relationship (and the specific relationship patterns) between three

different work-related sources of social support and Maslach's three burnout dimensions, while taking the dimensions in the Karasek job-demand-control model, emotional demands, workload outside the work situation and demographic factors into account.

DATA AND METHOD: Data was collected using a questionnaire which was based on validated instruments, in accordance with the job-demand-control model and Maslach's Burnout Inventory. Descriptive statistics, correlation analysis and three hierarchical regression analyses were conducted using a sample of 1561 registered and assistant nurses in Sweden.

RESULTS: The results showed statistically significant correlations between the three support indicators and all three burnout dimensions. In the regression analyses, co-worker and patient support were statistically significantly related to all three burnout dimensions, whereas supervisor support was only statistically significantly related to emotional exhaustion. In accordance with prior findings, high levels of psychological demands were most strongly related to high emotional exhaustion. Further, high levels of emotional demands showed the strongest correlations with high personal accomplishment.

D- Burnout and its relationship to the educational level of the nurses:

1. **The study of Fong CM**. (1993)

The title of the study: **A longitudinal study of the relationships between overload, social support, and burnout among nursing educators.**

The major purpose of this study was to examine the causal relationships between role overload, social support, and burnout among nursing educators over a period of time. Eighty-four nursing educators from eight campuses of a state university system completed a questionnaire twice, within a two-year interval. Data analyses consistently revealed the following: 1) Emotional exhaustion correlated significantly and positively with a demanding job, time pressure, and feelings of job inadequacy; 2) Burnout (i.e., emotional exhaustion, depersonalization of students, and a sense of decreased accomplishment) correlated significantly and negatively with social support from one's chairperson and peers. Predictor variables from the initial data set were regressed on the burnout data of two years later. The variable--job demands--was the strongest predictor of

emotional exhaustion. Chairperson support was the strongest predictor of both depersonalization toward students and a person's sense of accomplishment two years later. The reported chronic exhaustion among educators in this study should be of concern. An awareness of the role of social support and overload as associated with burnout can help educators develop policies to assure peak performance on the job.

2. **The study of Marcia Foley,[a] Julie Lee, [b] Lori Wilson,[c] Virginia Young Cureton, and Daryl Canham.(1998):**

The title of the study**: a Multi-Factor Analysis of Job Satisfaction among School Nurses.**

Although job satisfaction has been widely studied among registered nurses working in traditional health care settings, little is known about the job-related values and perceptions of nurses working in school systems. Job satisfaction is linked to lower levels of job-related stress, burnout, and career abandonment among nurses. This study evaluated the level of job satisfaction among a convenience sample of school nurses practicing in California. The Index of Work Satisfaction (IWS) was the instrument used. Although the sampled school nurses rated autonomy and interaction as the most important and satisfying factors contributing to job satisfaction.

The overall findings indicated that school nurses are relatively dissatisfied with their jobs.

3. **The study of Cam O. (2001).**

The title of the study**: The burnout in nursing academicians in Turkey**.

The purpose of this study was to determine the level of burnout in nursing academicians in Turkey and to investigate the variables which are strongly correlated with the burnout nursing education settings in Turkey. The sample of the study consisted of the nursing academicians working in the schools of nursing at the different universities in Turkey. Although the total number of nursing academicians in Turkey was 179, the subjects who agreed to participate in the research were 135. The Maslach Burnout Inventory (MBI) was used to measure burnout, after having been statistically tested for its validity and reliability in nursing education

settings in Turkey. The multiple regression analysis was carried out in order to determine the main variables correlated with burnout, namely "the predictors" of each of the three components (emotional exhaustion (EE), depersonalization (DP), personal accomplishment (PA)) of burnout. The results indicated that the most significant predictor of EE was work-setting satisfaction, of DP was job pressure, and of PA was job satisfaction in nursing education settings in Turkey. Finally, these findings were compared with of those previous studies in the field.

4. **The study of Nicholl H, &Timmins F. (2005):**

The title of the study**: Program-related stressors among part-time undergraduate nursing students**

AIM: The aim of this paper is to report a study exploring the perceived stressors identified by a group of 70 students who undertook a part-time degree at one Irish university.

METHOD: Quantitative methods were used. While many instruments exist to measure overall stress, this study aimed to explore student's perceptions of specific stressors associated with academic study. We used a questionnaire developed from the literature on the topic.

CONCLUSION: Those involved in the delivery of nurse education programs to part-time students need to consider the impact of the workload on student welfare, and to prepare students for demands of the program.

***E- Burnout and its relationship to the* nurses' experiences**.

1. **The study of Wenderlein FU.(2003):**

The study title**: Work satisfaction and absenteeism of nursing staff--comparative study of 1021 nurse trainees and nurses.**

PURPOSE: To analyze the high level of absenteeism among nursing trainees compared with nursing staff. Unlike previous studies, the present study focused on work satisfaction and motivation. Specifically, combining satisfaction with absenteeism was a novel approach.

METHOD: For assessing work satisfaction, a standardized form with 73 items in four areas was drafted and checked in a pre-test (n = 150). 861 nurses and 159 trainees were interviewed. The absenteeism data given by the nursing staff were compared with the 'missing' records of the personnel department.

RESULTS: In all areas it was found that, in particular, problems of organization, personnel management and working atmosphere in the

Hospital were a burden on the employees. In detail, however, there were considerable differences between nurses and trainees in respect of appraisal. Work organization: Although trainees rated work organization aspects lower than nurses, direct relationship to work satisfaction was less pronounced. For the trainees, improvements are imperative in respect of active self-responsibility. Leadership/co-operation: Trainees rated supervisor behavior and working atmosphere lower than their colleagues. There was a direct relation to satisfaction and absenteeism. Workload/stress: Although their responsibility was less, a larger proportion of the trainees felt stressed. This was directly related to work satisfaction and absenteeism. Fluctuation and turnover: 44% of the trainees would be prepared to work up to the age of retirement, but only 25% of the qualified staff. Nevertheless, three-quarters of the trainees and two-thirds of the nurses would choose the same profession again. Hence, unfavorable local (internal) circumstances led to the discontent and not the profession as such.

2. **The study of Begat I, Ellefsen B, &Severinsson E. (2005):**

The study title**: Nurses' satisfaction with their work environment and the outcomes of clinical nursing supervision on nurses' experiences of well-being** -- a Norwegian study

AIM: This descriptive-correlation study examined nurses' satisfaction with their psychosocial work environment, their moral sensitivity and differences in outcomes of clinical nursing supervision in relation to nurses' well-being by systematically comparing supervised and unsupervised nurses.

METHODS: Nurses were selected from two hospitals (n = 71). Data collection was by means of questionnaires and analyzed by descriptive and inferential statistics.

CONCLUSIONS: the study concludes that ethical conflicts in nursing are a source of job-related stress and anxiety. The outcome of supporting nurses by clinical nursing supervision may have a positive influence on their perceptions of well-being. Clinical nursing supervision has a positive effect on nurse's physical symptoms and their feeling of anxiety as well as having a sense of being in control of the situation. We also conclude that psychosocial work has an influence on nurse's experience of having or not having control and their engagement and motivation.

F- Burnout and its relationship to the sex of the nurses:

1. **The study of Williams CA. (1989):**

The study title**: Empathy and burnout in male and female helping professionals.**

Relationships between empathy and burnout and possible confounding influences of sex and profession were explored in a sample of 492 male and female nurses, social workers, and teachers. Respondents completed Mehrabian's Emotional Empathy Scale, Stotland's Fantasy-Empathy Scale, and the Maslach Burnout Inventory (MBI). There were no main effects of profession on empathy or burnout variables. There was, however, an interaction effect of sex and profession on depersonalization, which was accounted for by subjects in social work and teaching. Women had significantly higher empathy scores than men; however, men had higher scores than male normative groups. Age related negatively to depersonalization and emotional exhaustion for women, whereas percentage of work time spent in direct practice correlated with depersonalization for men. The possibility that empathy and burnout might represent opposite poles of the same underlying construct was examined but not found. Instead, emotional empathy was significantly positively correlated with both emotional exhaustion and personal accomplishment, whereas emotional exhaustion was also positively related to depersonalization. It is hypothesized that high emotional empathy may predispose helping professionals to emotional exhaustion and that emotional exhaustion, if not mediated by personal accomplishment, may lead to the development of depersonalization. This more complex, interactive model of the empathy-burnout relationship needs longitudinal study.

2. **The study of Payne N. (2001):**

The study title**: Occupational stressors and coping as determinants of burnout in female hospice nurses**.

AIMS: Stressors, coping and demographic variables were examined as predictors of burnout in a sample of hospice nurses. The study aimed to investigate the level of burnout among hospice nurses; to ascertain which aspects of nursing work were positively or negatively related to burnout; to examine the relative contributions made by these different variables

And to suggest individual and organizational interventions to reduce levels of burnout. METHODS: Eighty-nine female nurses from nine hospices completed a battery of questionnaires comprising the Maslach Burnout Inventory, Nursing Stress Scale, Ways of Coping Scale and a demographic information form.

RESULTS: In general, the level of burnout (characterized by high emotional exhaustion, high depersonalization of patients and low personal accomplishment) was found to be low.

3. **The study of Brake H, Bloemendal E, Hoogstraten J.(2003).**

The study title**: Gender differences in burnout among Dutch dentists**.

OBJECTIVES: Differences between the sexes in the manifestation of burnout have been reported for different occupational groups. Although some gender-specific explanations for this finding have been forwarded, there is a paucity of studies in which the relation with other work-related gender differences is examined. The objective of this study was to analyze gender differences in burnout among dentists and to identify possible concomitant factors.

METHODS: Male (n = 411) and female (n = 81) Dutch dentists filled out the Dutch version of the Maslach Burnout Inventory (MBI) together with several health and work-related questionnaires.

RESULTS: Results showed male dentists to report a higher score on the depersonalization dimension of the MBI than did female dentists. No gender differences were found on the other dimensions (i.e. emotional exhaustion and personal accomplishment). Moreover, no gender-related differences in experienced work-stress or health-related aspects were found. It was found, however, that male dentists put in working hours and see more patients per week when compared to female dentists. Also, a difference in mean age was found. Our main finding was that the difference in depersonalization disappears when controlling for working hours and age.

G- Burnout and its relationship to the working place of the nurses:

1. **The study of Lewis SL, Bonner PN, Campbell MA, Cooper CL, &Willard A.(1994):**

The title of the study**: Personality, stress, coping, and sense of coherence among nephrology nurses in dialysis settings**

The goal of this study was to examine the relationships among personality types, personal and work-related stress, coping resources, and sense of coherence (SOC) among nephrology nurses in dialysis settings. Nurses (n = 49) from 13 dialysis units in New Mexico completed a demographic data form, Perceived and Nursing Stress Scales, SOC Scale, Coping Resources Inventory, and the Myers-Briggs Type Indicator (MBTI). The results indicated that there was a positive correlation between perceived personal stress and work-related stress, especially work load. Conversely, there were negative correlations between (a) both personal and work-related stress with SOC, and (b) both coping resources and SOC with burnout. High levels of personal and work-related stress were related to inadequate coping resources. Regression analysis indicated that the main contributing factors to emotional exhaustion (a major component of burnout) were low SOC, lack of staff support, personal stress, and heavy work load. Increased utilization of coping resources may facilitate the nurses' management of personal and work-related stressors.

2. The study of Papadatou D, Anagnostopoulos F, Monos D.(1994).

The study title**: Factors contributing to the development of burnout in oncology nursing**.

The purpose of this study was to determine whether oncology nurses experience higher levels of burnout compared to nurses working in general hospitals, and to further identify the personal and environmental factors that contribute to the development of emotional exhaustion, depersonalization and lack of personal accomplishment. Seven tools, measuring a selected set of demographic, psychological and occupational variables, were administered to 217 female nurses who worked in oncology hospitals and 226 nurses who worked in general hospitals in the area of Athens. Measures used in the study included the Maslach Burnout Inventory, the Hardiness Scale, the Ways of Coping Scale, and the Life Style Scale, the Type a Behavior Scale, a Job Stress Questionnaire and a General Information Questionnaire. No statistically significant difference was revealed in the degree of burnout experienced by nurses in oncology and those in general hospitals. Multiple linear regression analysis suggested that personality characteristics seem to predict a greater percentage of the variability of the burnout experienced than occupational and demographic variables. A sense of personal control

Over the things that happen in life and in the work environment was found to protect nurses from emotional exhaustion, depersonalization and lack of personal accomplishment.

3. **The study of Molassiotis A, &Haberman M. (1996):**

The study title: **Evaluation of burnout and job satisfaction in marrow transplant nurses.**

The study examined incidence of burnout syndrome, psychopathology, and job satisfaction in bone marrow transplant nurses, in relation to existence of an informal psychosocial support program for staff needs. Forty nurses participated in the study completing four standardized measures related to burnout, anxiety, depression, satisfaction with aspects of their job, and social support.

Results indicated that burnout among these nurses was low, and high personal accomplishment from working with marrow transplant patients was the response of the majority. Job satisfaction was also found to be high, with outpatient nurses scoring significantly higher than inpatient nurses in most aspects of job satisfaction. One out of four subjects presented with the psychic manifestations of the anxiety neurosis, suggesting the stressfulness of the marrow transplant environment, which requires a high degree of responsibility and advanced nursing skills. Social support was not found to influence burnout, psychopathology, or job satisfaction. Presence of depression, low personal accomplishment, and dissatisfaction with pay were the variables predicting high emotional exhaustion, one of the main components of burnout. These results were suggestive of less burned out and more satisfied nurses compared to marrow transplant nurses working in environments with no formal or informal staff support programmers. This highlights the need for development of support services for the nursing staff, allowing them to ventilate their feelings, discuss issues of concern to them and seek professional support where necessary.

4. **The study of Kilfedder CJ, Power KG,Wells TJ.(2001)**

The study title**: Burnout in psychiatric nursing.**

INTRODUCTION: Burnout in nursing is of both individual and organizational concern with ramifications for well-being, job

Performance, absenteeism and turnover. Burnout is rarely assessed as part of a comprehensive model of occupational stress, a short-coming which this paper attempts to redress.

METHOD: A randomly selected sample of 510 psychiatric nurses from one Scottish Trust completed a questionnaire based on a psychological model of occupational stress which included the Maslach Burnout Inventory (MBI) as the dependent variable.

FINDINGS: The respondents reported average, low and average levels of emotional exhaustion, depersonalization and personal accomplishment, respectively. The study sample had significantly lower scores on emotional exhaustion and depersonalization than normative data but also significantly lower levels of personal accomplishment than a normative group of physicians and nurses. Only 2.0% of the study sample could be categorized as having high burnout overall (i.e. high emotional exhaustion, high depersonalization, and low personal accomplishment) and they differed significantly from the rest only in terms of males being over-represented. Hierarchical regression analysis revealed that selected explanatory variables accounted for 41.9% of emotional exhaustion, 16.4% of depersonalization and 25.6% of personal accomplishment in the study sample.

5. **The study of Barrett L**, **Yates P**.(2002).

The study title**: Oncology/hematology nurses: a study of job satisfaction, burnout, and intention to leave the specialty**.

The impact of the current nursing shortage on the health care system is receiving attention by both state and federal governments. This study, using a convenience sample of 243 oncology/hematology nurses working in 11 Queensland health care facilities, explored factors that influence the quality of nurses' working lives. Although nurses reported high levels of personal satisfaction and personal accomplishment, results indicated that nearly 40% of registered nurses (RNs) are dealing with workloads they perceive excessive, 48% are dissatisfied regarding pay, and professional support is an issue. Furthermore, emotional exhaustion is a very real concern: over 70% of the sample experienced moderate to high levels. Over 48% of the sample could not commit to remaining in the specialty for a further 12 months. Health care managers and governments should

Implement strategies that can increase nurses' job satisfaction and reduce burnout, thereby enhancing the retention of oncology/hematology nurses.

6. **The study of Vimantaite R**, **Seskevicius A**. (2003).

The study title**: The burnout syndrome among nurses working in Lithuanian cardiac surgery centers**.

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. The aim of this study was to 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). METHODS: The 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.

RESULTS: 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.

7. **The study of Jenkins R**, **Elliott P**. (2004).

The study title**: Stressors, burnout and social support: nurses in acute mental health settings**.

AIMS: This paper reports a study which aims (1) to investigate and compare levels of stressors and burnout of qualified and unqualified

Nursing staff in acute mental health settings; (2) to examine the relationships between stressors and burnout and (3) to assess the impact of social support on burnout and stressor-burnout relationships. BACKGROUND: Several studies have noted that the work of mental health nurses can be highly stressful, but relatively few have focused specifically on staff working in acute inpatient settings. Although many of the pressures faced by this group are similar to those in other nursing specialties, a number of demands relate specifically to mental health settings, including the often intense nature of nurse-patient interaction and dealing with difficult and challenging patient behaviors on a regular basis.

METHODS: A convenience sample of 93 nursing staff from 11 acute adult mental health wards completed the Mental Health Professionals Stress Scale, Maslach Burnout Inventory and House and Wells Social Support Scale. RESULTS: Lack of adequate staffing was the main stressor reported by qualified staff, while dealing with physically threatening, difficult or demanding patients was the most stressful aspect for unqualified staff. Qualified nurses reported significantly higher workload stress than unqualified staff. Approximately half of all nursing staff showed signs of high burnout in terms of emotional exhaustion. A variety of stressors were positively correlated with emotional exhaustion and depersonalization. Higher levels of support from co-workers were related to lower levels of emotional exhaustion. Higher stressor scores were associated with higher levels of depersonalization for staff reporting high levels of social support, but not for those reporting low levels of support (a reverse buffering effect).

8. **The study of Ernst ME, Messmer PR, Franco M, Gonzalez JL. (2004).**

The study title**: Nurses' job satisfaction, stress, and recognition in a pediatric setting.**
PURPOSE: The purpose of this study was to identify a set of factors that describes nursing satisfaction in the pediatric setting.

METHODS: An exploratory descriptive design was used. Surveys were distributed to all nurses employed at a children's hospital in the Southeast. The survey included: nursing satisfaction, organizational work satisfaction, job stress, and nurse recognition scales. Two hundred and forty-nine out of 534 pediatric nurses (46%) responded. Data were analyzed using factor analysis and correlation.

FINDINGS: The results of this survey demonstrated that several factors predict pediatric nurses' job satisfaction and organizational work satisfaction. These factors include: pay, time to do the nursing care, confidence in one's ability, and task requirements. A relationship among nurses' job satisfaction, organizational work satisfaction, job stress, and recognition in the pediatric setting was also found. Nurses with more years of experience and longevity on the unit and at the hospital had more confidence, showed less concern about time demands, and were less concerned about pay and task requirements than younger nurses. Job stress correlated significantly and inversely with age, years as a nurse, and years in the organization. Older nurses were more satisfied with recognition they received than their younger counterparts.

9. **The study of Renzi C, Tabolli S, Ianni A, Di Pietro C, &Puddu P.(2005):**

The study title**: Burnout and job satisfaction comparing healthcare staff of a dermatological hospital and a general hospital.**

OBJECTIVES: To evaluate burnout and job satisfaction of dermatologists and nurses working with dermatological patients compared with physicians and nurses of other specialties.

METHODS: A self-completed anonymous questionnaire was distributed to the personnel of two hospitals in Rome, Italy: a dermatological hospital (IDI) and a general hospital (GH), belonging to the same non-profit organization. Standardized instruments were used to assess burnout (Maslach Burnout Inventory) and job satisfaction. Multiple logistic regressions was used to examine the association between burnout and working in dermatology vs. other specialties, job satisfaction, years of employment and respondents' sex and age.

CONCLUSIONS: Among both physicians and nurses, job satisfaction was associated with a lower likelihood of burnout, independently of clinical specialty and other factors. Burnout was similar for dermatologists and other specialists. Nurses of the GH compared with those working in dermatology had a higher probability of burnout and were significantly less satisfied with the management of their units and with opportunities for personal growth.

10. The study of Bakker AB, Le Blanc PM, Schaufeli WB. (2005)

The study title**: Burnout contagion among intensive care nurses**

AIM: This paper reports a study investigating whether burnout is contagious.

METHODS: A questionnaire on work and well-being was completed by 1849 intensive care unit nurses working in one of 80 intensive care units in 12 different European countries in 1994. The results are being reported now because they formed part of a larger study that was only finally analyzed recently. The questionnaire was translated from English to the language of each of these countries, and then back-translated to English. Respondents indicated the prevalence of burnout among their colleagues, and completed scales to assess working conditions and job burnout.
RESULTS: Analysis of variance indicated that the between-unit variance on a measure of perceived burnout complaints among colleagues was statistically significant and substantially larger than the within-unit variance. This implies that there is considerable agreement (consensus) within intensive care units regarding the prevalence of burnout. In addition, the results of multilevel analyses showed that burnout complaints among colleagues in intensive care units made a statistically significant and unique contribution to explaining variance in individual nurses' and whole units' experiences of burnout, i.e. emotional exhaustion, depersonalization and reduced personal accomplishment. Moreover, for emotional exhaustion and depersonalization, perceived burnout complaints among colleagues was the most important predictor of burnout at the individual and unit levels, even after controlling for the impact of well-known organizational stressors as conceptualized in the demand-control model?

11. **The study of Pinikahana J**, **Happell B**. (2005).

The study title**: Stress, burnout and job satisfaction in rural psychiatric nurses: a Victorian study**.

OBJECTIVE: To measure the level of stress, burnout and job satisfaction in rural psychiatric nurses in Victoria, Australia. METHOD: This present study presents the findings of a research study undertaken with rural psychiatric nurses (n = 136) in two rural mental health services in Victoria. The study designed to measure their level of stress, burnout and

Job satisfaction using the Maslach Burnout Inventory (MBI), the Nursing Stress Scale (NSS) and Job Satisfaction Scale (JSS).

RESULTS: The findings indicated that low number rural psychiatric nurses suffered from 'high' level of burnout and the majority of nurses reported 'low level' of emotional exhaustion and depersonalization scores. On the personal accomplishment subscale, only 11% recorded a 'high' score and 87% recorded 'low' score. On the Nursing Stress Scale, the 'workload' was the highest perceived stressor followed by 'inadequate preparation'.

12. **The study of Quattrin R, Zanini A, Nascig E, Annunziata M, Calligaris L, Brusaferro S.(2006):**

The study title: **Level of burnout among nurses working in oncology in an Italian region**

OBJECTIVES: To estimate the level of burnout among nurses working on oncology wards and to identify the risk factors of burnout and the strategies used to prevent and deal with stress.

METHODS: Head nurses of the oncology wards were personally informed about the aims of the study and were asked to distribute a questionnaire among the staff nurses and collect them after completion. The questionnaire had 58 items divided into three parts: socio-demographic and job characteristics of the population, the Maslach Burnout Inventory modified for Italian healthcare workers, and the respondents' perceptions about coping mechanisms and strategies adopted by the organization to help the nurses cope with stress.

CONCLUSIONS: An important cause of stress reported by nurses is poor organization; therefore, hospitals should focus attention on specific organizational aspects.

13. **The study of Escriba-Aguir V, Martin-Baena D, &Perez-Hoyos S.(2006):**

The study title**: Psychosocial work environment and burnout among emergency medical and nursing staff**.

Objectives: The prevalence of burnout syndrome is increasing among doctors and nurses. The aim of this study was to analyze the relationship between the psychosocial work environment and burnout syndrome

Among emergency medical and nursing staff in Spain. A secondary aim was to determine if the effect of this psychosocial work environment on burnout was different for doctors and nurses.

Methods: A cross-sectional survey was carried out by means of a mail questionnaire among 945 emergency doctors and nursing staff of Spain. The outcome variable was three dimensions of burnout syndrome [emotional exhaustion (EE), personal accomplishment (PA), depersonalization (DP)]. The explanatory variable was that psychosocial work environment evaluated according to Karasek and Johnson's demand-control model. The adjusted odds ratios (OR) and their 95% confidence intervals were calculated by logistical regression.

Conclusions: The presence of risk factors derived from work organization within the work place (psychosocial risk factors) increases the probability of presenting burnout syndrome and, above all, EE.

14. **The study of** :**Edwards D**, **Burnard P**, **Hannigan B**, **Cooper L**, **Adams J**, **Juggessur T**,**Fothergil A**, **Coyle D**.(2006).

The study title: Clinical supervision and burnout: the influence of clinical supervision for community mental health nurses.

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

METHODS: 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 heath nurses working in 11 NHS Trusts responded to the survey.

RESULTS: One hundred and eighty-nine (73%) community mental heath 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 heath nurses surveyed. University analysis showed that those community mental heath 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 heath 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 heath nurses are likely to report lower levels of emotional exhaustion and depersonalization.

15. **The study of Gillespie M**, **Melby V**. (2006).

The study title**: Burnout among nursing staff in accident and emergency and acute medicine: a comparative study**.

This study was designed to identify the prevalence of burnout among nurses working in Accident and Emergency (A & E) and acute medicine, to establish factors that contribute to stress and burnout, to determine the experiences of nurses affected by it and highlight its effects on patient care and to determine if stress and burnout have any effects on individuals outside the clinical setting. A triangulated research design was used incorporating quantitative and qualitative methods. Maslach Burnout Inventory was used. Nurses working in acute medicine experienced higher levels of emotional exhaustion than their A & E counterparts. The overall level of depersonalization was low. High levels of personal accomplishment were experienced less by junior members of staff. Stress and burnout have far reaching effects both for nurses in their clinical practice and personal lives. If nurses continue to work in their current environment without issues being tackled, then burnout will result. The science of nursing does not have to be painful, but by recognition of the existence of stress and burnout we can take the first steps towards their prevention.

§ *COMMENTS ON THE LITRATURE REVIEW:*

As we read from the previews literature that the burnout syndrome is a psychological problem the nurse suffered all over the world, cause serious problems which affects the acts of the nurse in his job.

Many factors could moderate the effects of the burnout like social support and good management.

As we read all the studies share in the presence of burnout but in different ratio ,the main key in this differences is the presence of good administrative procedures or not.

The continuous evaluation to the nursing work by the decision makers.
The Difference from study to other is also the type of support and financial resources in order to alleviate the stressful atmosphere.

The importance of these studies to me is the plan of research that all the studies are follow, and also the tools that has been applied in the research.

Chapter four

Methodology

- *INTRODUCTION*
- *RESEARCH DESIGN.*
- *RESEARCH LOCATION.*
- *RESEARCH POPULATION.*
- *RESEARCH SAMPLE SIZE.*
- *PILOT STUDY.*
- *DESIGN OF STUDY TOOLS.*
- *VALIDITY.*
- *RELIABILITY.*
- *STATISTICAL ANALYSIS.*
- *PROCEDURES OF THE STUDY.*
- *DIFFICULTIES FACED THE RESEARCHER.*
- *SUMMARY.*

§ 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 enters in many stages as follow:

§ Research Design

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, Work stress checklist and Social support checklist also some actual claims cases were collected during the field survey. The forth 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 (nursing) 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 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.

§ Research Location

The research was carried in the hospital located in Gaza city, like Al shifa hospital, ophthalmology hospital, Dorra hospital, and nassier hospital.

§ Research Population

This research targets 650 Nurse in hospitals in the Gaza city.
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.

§ Sample Size Determination

Wood and Haber (1998) defined the sampling as the process of selecting representative units of a population for the study in research investigation.
The objective of the sampling is to provide a practical means of enabling the data collection and processing the components of the research to be carried out with ensuring that the sample provides a good representation of the population (Fellowes and Liu, 1997).
A sample is a small proportion of a population selected for observation and analysis; the samples were selected randomly from the nurses.
Statistical equations were used in order to calculate the sample size for the nurses. Equation (1) was used to determine the sample size of the unlimited population (Creative Research System, 2001):

$$SS = \frac{Z^2 * P * (1-P)}{C^2} \qquad \text{Equation (1)}$$

Where SS = Sample size

Z = Z value (e.g. 1.96 for 95% confidence level)

P = percentage picking a choice, expressed as a decimal (0.50 used for sample size needed)

C = margin of error (8%)

$$SS = \frac{1.96^2 \times 0.5 \times (1-0.5)}{0.08^2} = 150 \text{ nurses}$$

Correction for Finite Population:

$$SS\ \textbf{new} = \frac{SS}{1 + \frac{SS\text{-}1}{POP}} \qquad \text{Equation (2)}$$

Where pop is the population = 650 nursing.

$$SS\ \textbf{new} = \frac{150}{1 + \frac{150-1}{650}} = 122.02 \approx 122$$

The targeted 122 nurslings were selected according to Equation (2). And the following tables illustrate the properties of the samples.

- **Table No. (1) Show that 60.8% from the sample are male, and 39.2% are female.**

Table No (1)

The nurses Sex are:

sex	Frequency	Percent
female	٤٧	٣٩.٢
male	٧٣	٦٠.٨
Total	١٢٠	١٠٠.٠

Table No. (2) Show that 43.3% from the samples the age are less than 30 years, and 38.3% from the samples the age are range from 30-40 years, and 18.3% from the samples the age are greater than 40 years.

Table No (2)

The nurses Age are:

age	Frequency	Percent
Less than 30	٥٢	٤٣.٣
30-40	٤٦	٣٨.٣
Greater than 40	٢٢	١٨.٣
total	١٢٠	١٠٠.٠

Table No. (3) Show that 37.5% from the sample are finishing Diploma, 55.0% from the sample are finishing B.A. or B. S, and 7.5% from the sample are finishing M. A. or M. S

Table No (3)

The nurses Education are:

education	Frequency	Percent
Diploma	٤٥	٣٧.٥
B.A. or B. S.	٦٦	٥٥.٠
M. A. or M. S	٩	٧.٥
total	١٢٠	١٠٠.٠

Table No. (4) Show that 40.8% from the sample, the experience is less than 5 years, and 25.0% from the sample the experience are range from 6-10 years, and 34.2.3% from the samples the experience are greater than or equal 11 years

Table No (4)

The nurses Experience are:

Experience	Frequency	Percent
1-5 years	٤٩	٤٠.٨
6-10 years	٣٠	٢٥.٠
11 year or more	٤١	٣٤.٢
total	١٢٠	١٠٠.٠

Table No.(5) show that 13.3% from the sample work in Neonatal intensive care unit, 1.7 from the sample work in artificial kidney unit, 10.8% from the sample work in cancer unit 8.3% from the sample work in female medical department, 5.0% from the sample work in chest unit department, 7.5% from the sample work in emergency department, 3.3% from the sample work in burn intensive care unit, 9.2% from the sample work in obstetric department, 28.3% from the sample work in medical child departments, 6.7% from the sample work in supersensible, and 5.8% from the sample work in ophthalmology hospital

Table No (5)

The nurse's wards work are:

Section work	Frequency	Percent
Neonatal intensive care unit.	١٦	١٣.٣
The artificial kidney unit.	٢	١.٧
The cancer unit.	١٣	١٠.٨
The female medical department.	١٠	٨.٣
The chest unit department.	٦	٥.٠
The emergency department.	٩	٧.٥
The burn intensive care unit	٤	٣.٣
The obstetric department.	١١	٩.٢
The medical child departments	٣٤	٢٨.٣
The administration unit.	٨	٦.٧
The ophthalmology hospital	٧	٥.٨
Total	١٢٠	١٠٠.٠

Table No. (6) Show that 23.3% from the sample work in Al shifa hospital, 15.0% from the sample work in the ophthalmology hospital, 46.7% from the sample work in Al Dorra hospital, and 15.0% from the sample work in Al nassier hospital.

Table No (6)

The nurses Hospitals are:

Hospital	Frequency	Percent
Al shifa hospital	٢٨	٢٣.٣
The ophthalmology hospital	١٨	١٥.٠
Al Dorra hospital	٥٦	٤٦.٧
Al nassier hospital	١٨	١٥.٠
Total	١٢٠	١٠٠.٠

§ Pilot Study

It is customary practice that the survey instrument should be piloted to measure its validity and reliability and test the collected data. The pilot study was conducted by distributing the prepared questionnaire to panels of experts having experience in the same field of the research to have their remarks on the questionnaire.

Ten expert representing two panels were contacted to assess the questionnaire validity. The first panel, which consisted of six expert's doctors in Islamic university, was asked to verify the validity of the questionnaire topics and its relevance to the research objective. The second panel, which consisted of two experts in statistics, was asked to identify that the instrument used was valid statistically and that the questionnaire was designed well enough to provide relations and tests among variables.

Expert comments and suggestions were collected and evaluated carefully. All the suggested comments and modifications were discussed with the study's 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.

§ DESIGN OF STUDY TOOLS:

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 and open-ended 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). 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 questionnaires design was composed of four tools to accomplish the aim of the research, as follows:

1) **Questionnaire Design and Content to the first tool:**

§ The first section contained information about the sample to include:

- The Sex
- The age.
- The level of education:
- The number of years spent in the work in nursing employment
- The unit which nurses working in.
- The hospital which nurses working in.

2) **Questionnaire Design and Content to the second tool:**

§ The second section contained the Burnout checklist included three main subsections as follows:

- The first subsection (field) was about the Emotional Exhaustion/Depersonalization (EE+DP).

- The second subsection (field) was about the Personal Accomplishment (PA).
- The third subsection (field) was about the Physical Exhaustion (PE).

3) Questionnaire Design and Content to the third tool:

§ The third section contained the Work stress checklist included six main subsections as follows:

- The first subsection (field) was about the stressors due to poor management of the nursing profession.
- The second subsection (field) was about the stressors due to the work environment.
- The third subsection (field) was about the stressors caused by others in the work environment.
- The fourth subsection (field) was about the stressors caused by supervisors and managers.
- The fifth subsection (field) was about the stressors caused by other factors.
- The sixth subsection (field) was about the stressors caused by the nurse himself.

4) Questionnaire Design and Content to the fourth tool:

§ The fourth section contained the Social support checklist included fourth main subsections as follows:

- The first subsection (field) was about the Social support by supervisors. The second subsection (field) was about the Social support by coworkers.

- The third subsection (field) was about the Social support by family.
- The fourth subsection (field) was about the Social support by friends.

§ **Validity :**

Validity refers to the degree to which an instrument measures what it is supposed to be measuring (Pilot and Hungler: 1985).

Validity has a number of different aspects and assessment approaches. There area two ways to evaluate instrument validity: content validity and statistical validity, which include criterion-related validity and construct validity.

§ **Content Validity of the Questionnaires**

Content validity test was conducted by consulting a group of experts.

The group was requested to evaluate and identify whether the questions agreed with the scope of the items and the extent to which these items reflect the concept of the research problem.

A. Internal consistency of the first questionnaire:

Internal consistency of the questionnaires is measured by a scouting sample, which consisted of thirty questionnaires, through measuring the correlation coefficients between each paragraph in one field and the whole filed. A Table No.'s (7.1) below shows the correlation coefficient and p-value for each field items. As show in the table the p- Values are less than 0.05 or 0.01,so the correlation coefficients of this field are significant at $\alpha = 0.01$ or $\alpha = 0.05$, so it can be said that the paragraphs of this field are consistent and valid to be measure what it was set for.

Table (7.1)

The correlation coefficient between each paragraph in the field and the whole field

(Burnout checklist)

Number	The item	Person correlation coefficient	p-value
First: Emotional Exhaustion/Depersonalization (EE+DP)			
1	I've become more callous toward people since I took this job.	٠.٥٠٥	٠.٠٠٤
2	I worry that this job is hardening me emotionally.	٠.٦٤٩	٠.٠٠٠
3	I feel frustrated by my job.	٠.٧٦١	٠.٠٠٠
4	I feel burned out from my work.	٠.٣٩٠	٠.٠٣٣
5	I feel patients blame me for some of their problems.	٠.٧١٥	٠.٠٠٠
6	Working with people directly puts too much stress on me. Working with people all day is really a strain for me.	٠.٥٧٩	٠.٠٠١
7	I feel like I'm at the end of my rope.	٠.٨٥٣	٠.٠٠٠
8	I feel I treat some patients as if they were impersonal 'objects'.	٠.٧٤٤	٠.٠٠٠
9	I don't really care what happens to some patients.	٠.٦٩٤	٠.٠٠٠
Second: Personal Accomplishment (PA)			
10	I have accomplished many worthwhile things in this job.	٠.٦٨١	٠.٠٠٠
11	I can easily create a relaxed atmosphere with my patients.	٠.٤٧٠	٠.٠١٠
12	I deal very effectively with the problems of my patients.	٠.٨٨٠	٠.٠٠٠
13	I feel I'm positively influencing other people's lives through my work.	٠.٨٥٨	٠.٠٠٠
14	In my work, I deal with emotional	٠.٨٧٨	٠.٠٠٠

	problems very calmly.		
15	I can easily understand how my patients feel about things.	٠.٨١١	٠.٠٠٠
16	I feel very energetic.	٠.٧٢٩	٠.٠٠٠
Third : Physical Exhaustion (PE)			
17	I feel emotionally drained from my work.	٠.٥١٢	٠.٠٠٤
18	I feel fatigued when I get up in the morning and have to face another day on the job.	٠.٤٣١	٠.٠١٩
19	I feel I'm working too hard on my job.	٠.٣٧٤	٠.٠٤٢

B. Internal consistency of the second questionnaire:

through measuring the correlation coefficients between each paragraph in one field and the whole filed. A Table No.'s (7.2) below shows the correlation coefficient and p-value for each field items. As show in the table the p- Values are less than 0.05 or 0.01,so the correlation coefficients of this field are significant at $\alpha = 0.01$ or $\alpha = 0.05$, so it can be said that the paragraphs of this field are consistent and valid to be measure what it was set for.

Table (7.2)

The correlation coefficient between each paragraph in the field and the whole field

(Work stress checklist)

The number	The item	Person correlation coefficient	p-value
First: stressors due to poor management of the nursing profession.			
1	The misunderstanding to the nature of nursing profession.	٠.٤٧٦	٠.٠٠٩
2	The absence of communication between the top and the base of the nursing.	٠.٣٨٨	٠.٠٣٤

3	The absence of the environment to solve the problems that face the nurses.	٠.٦٣٢	٠.٠٠٠
4	Absence of creative environment in the profession,	٠.٦٨٩	٠.٠٠٠
5	Absence of the opportunities to the nursing for decision making participation.	٠.٦٢٩	٠.٠٠٠
6	Absence of job description.	٠.٦٢٧	٠.٠٠٠
7	Vague responsibilities.	٠.٧٧٠	٠.٠٠٠
8	The work is distorted and far from good management.	٠.٥٧٨	٠.٠٠١
9	The inappropriate wages according to the nature of the work.	٠.٥٦٣	٠.٠٠١
10	The presence of work overload.	٠.٧٣٨	٠.٠٠٠
11	The high levels of danger and infections.	٠.٧٢٥	٠.٠٠٠
12	Poor control on the danger and infections transmission to the nurses.	٠.٦٦٦	٠.٠٠٠
13	The absence of protective securing measures to the nurse after he has been infected.	٠.٥٤٦	٠.٠٠٢
14	Absence of resources and preparation to deal with patients and their families.	٠.٧٣٦	٠.٠٠٠
15	The presence of anxiety about treatment and care plane.	٠.٧٧٤	٠.٠٠٠
16	The shortage of nursing and resources.	٠.٤٤٩	٠.٠١٥
Second: stressors due to the work environment			
17	Vague future of the profession.	٠.٦٢٠	٠.٠٠٠
18	Absence of opportunities for development and progression of the nurse.	٠.٥٣٩	٠.٠٠٢
19	Vague of the role of nursing profession,	٠.٤٣٠	٠.٠١٨
20	It is difficult to take your holiday or ead.	٠.٥٨٩	٠.٠٠١
21	The work is meaningless.	٠.٥٨٧	٠.٠٠١
22	Misuse of nursing skills.	٠.٦٦٣	٠.٠٠٠
23	Lack of control on the work content.	٠.٥٠٤	٠.٠٠٥
24	The presence of time pressure to achieve the work.	٠.٦٠٤	٠.٠٠٠

25	The continuous shifting without stability.	٠.٥٥٧	٠.٠٠٢
26	Inability to predict the work time.	٠.٥٥٢	٠.٠٠٢
27	Long working time prevents the social interaction.	٠.٦٠٧	٠.٠٠٠
28	Inability to control the over the work time.	٠.٥٠٦	٠.٠٠٥
29	Working through a team.	٠.٥١٧	٠.٠٠٣
30	The conflict between work requirement and home requirement.	٠.٥٠٣	٠.٠٠٥
31	Lack of preparation and resources to deal with gasping or dying people.	٠.٤٣٠	٠.٠١٨
32	Clients don't understand that it is good for them.	٠.٥٠٦	٠.٠٠٤
33	Client's family depends too heavily on you.	٠.٤٢٦	٠.٠١٩
34	Client's family behaves high-handedly.	٠.٦٦٨	٠.٠٠٠
Third: stressors caused by others in the work environment			
35	Bad work environment in the hospital.	٠.٤٩٥	٠.٠٠٦
36	The rigidity of work shifts programs,	٠.٥١٥	٠.٠٠٤
37	A lot of night shifts duty.	٠.٤١٩	٠.٠٢١
38	Absence of personal relation which lead to social isolation.	٠.٥٨٨	٠.٠٠١
39	The presence of conflict with other nurses.	٠.٥٢٨	٠.٠٠٣
40	The presence of conflict with other employers inside the hospital.	٠.٤٤٩	٠.٠١٣
41	The presence of verbal hostility from the client's family towards the nurses.	٠.٦٧٨	٠.٠٠٠
42	The presence of physical hostility from the client's family towards the nurses.	٠.٦٨١	٠.٠٠٠
43	Client's family behaves high-handedly.	٠.٥٢٢	٠.٠٠٣
44	Absence of trust in the care plane that physicians decide and nurses applied.	٠.٣٨٥	٠.٠٣٦
45	Clients don't understand the services that I applied for them.	٠.٣٦٥	٠.٠٤٧
46	Clients behave selfishly or uncooperatively.	٠.٣٧٩	٠.٠٣٩

Fourth: stressors caused by supervisors and managers			
47	Bad relation with the supervisors and the managers.	٠.٤٢٠	٠.٠٢١
48	Bad attitude and behavior of physician towards nurses.	٠.٤٧٦	٠.٠٠٨
49	Supervisors behave selfishly and inconsistently.	٠.٧٤٣	٠.٠٠٠
50	Supervisors don't understand my job.	٠.٦٤٩	٠.٠٠٠
51	Supervisors discriminate from another coworker.	٠.٥٢١	٠.٠٠٣
52	Supervisors force the way of thinking and doing.	٠.٥٢٨	٠.٠٠٣
Fifth: stressors caused by other factors.			
53	Anxiety related to lateness or absence of salaries.	٠.٦٣٢	٠.٠٠٠
54	Anxiety related to Israeli violence and siege.	٠.٦١٨	٠.٠٠٠
55	Anxiety related to martyr or injury of a member of the nurse family.	٠.٥٧٨	٠.٠٠١
56	Anxiety related to death of a member of nurse family.	٠.٧٥٨	٠.٠٠٠
57	Anxiety related to bad health status of a member of nurse family	٠.٦٥٣	٠.٠٠٠
Sixth: stressors caused by the nurse himself.			
58	The nature of profession delay the achievement of religious duties sometimes,	٠.٧٠١	٠.٠٠٠
59	Anxiety related to the presence of social or psychological problems.	٠.٧١٤	٠.٠٠٠
60	Anxiety related to the unstable political problem.	٠.٦٢٩	٠.٠٠٠
61	Anxiety related to the bad health status of the nurse himself.	٠.٥٢٤	٠.٠٠٣

C. Internal consistency of the third questionnaire:

through measuring the correlation coefficients between each paragraph in one field and the whole filed. A Table No.'s (7.3) below shows the correlation coefficient and p-value for each field items. As show in the table

the p- Values are less than 0.05 or 0.01,so the correlation coefficients of this field are significant at $\alpha = 0.01$ or $\alpha = 0.05$, so it can
be said that the paragraphs of this field are consistent and valid to be measure what it was set for.

Table (7.3)

The correlation coefficient between each paragraph in the field and the whole field

(Social support checklist)

The number	The item	Person correlation coefficient	p-value
First: Social support by supervisors:			
1	You can easily talk to your supervisor**.**	٠.٨٩٩	٠.٠٠٠
2	You can rely on your supervisor when there are difficulties.	٠.٦٥٤	٠.٠٠٠
3	Your supervisor recognizes and values your job**.**	٠.٧٥٧	٠.٠٠٠
4	Your supervisor cooperates with you to solve when there are difficulties**.**	٠.٧٧٧	٠.٠٠٠
5	**YOU** receive from you supervisor much support.	٠.٦٦٢	٠.٠٠٠
Second: Social support by coworkers:			
6	You can easily talk to your coworker**.**	٠.٣٩٥	٠.٠٣١
7	You can rely on your coworker when there are difficulties.	٠.٥٣٩	٠.٠٠٢
8	Your coworker recognizes and values your job**.**	٠.٥٤٠	٠.٠٠٢
9	Your coworker cooperates with you to solve when there are difficulties**.**	٠.٤٨٧	٠.٠٠٦
10	**YOU** receive from your coworker much support.	٠.٥٩٩	٠.٠٠٠
Third: Social support by family			

11	You can easily talk to your family**.**	٠.٤٤٨	٠.٠١٥
12	You can rely on your family when there are difficulties.	٠.٦١٥	٠.٠٠٠
13	Your family recognizes and values your job**.**	٠.٤٩٥	٠.٠٠٥
14	Your family cooperates with you to solve when there are difficulties**.**	٠.٥٣٦	٠.٠٠٢
Fourth: Social support by friends			
15	You can easily talk to your friend**.**	٠.٥٢٤	٠.٠٠٤
16	You can rely on your friend when there are difficulties.	٠.٤٦٢	٠.٠١٠
17	Your friend recognizes and values your job.	٠.٤٩٩	٠.٠٠٦
18	Your friend cooperates with you to solve when there are difficulties**.**	٠.٥٣٣	٠.٠٠٢
19	**YOU** receive from your friend much support.	٠.٥٠١	٠.٠٠٦
20	**YOU** receive much support from the social organization**.**	٠.٨٦٣	٠.٠٠٠

- **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).

It is difficult to return the scouting sample of the questionnaire-that is used to measure the questionnaire validity to the same respondents due to the different work conditions to these samples. Therefore two tests can be applied to the scouting sample in order to measure the consistency of the

questionnaire. The first test is the Half Split Method and the second is Cronbach's Coefficient Alpha.

§ Half Split Method

This method depends on finding Pearson correlation coefficient between the means of odd rank questions and even rank questions of each field of the questionnaire. Then, correcting the Pearson correlation coefficients can be done by using Spearman Brown correlation coefficient of correction. The corrected correlation coefficient (consistency coefficient) is computed according to the following equation:

Consistency coefficient = 2r/(r+1), where r is the Pearson correlation coefficient. The normal range of corrected correlation coefficient (2r/ r+1) is between 0.0 and + 1.0 As shown in Table (8), all the corrected correlation coefficients values are between 0.807252 and 0.880555 and the significant (α) is less than 0.05 so all the corrected correlation coefficients are significance at α = 0.05. It can be said that according to the Half Split method, the dispute causes group are reliable.

§ Table (8)

Split-Half Coefficient method

section	Criteria	person-correlation	Spearman-Brown Coefficient	Sig. (2-(Tailed
1	**Burnout checklist**	٠.768٦	0.807252	0.000
2	**Work stress checklist**	٠.7332	0.846065	0.000
3	**Social support checklist**	٠.7866	0.880555	0.000

section	Criteria	person-correlation	Spearman-Brown Coefficient	Sig. (2-(Tailed
Total		**0.7611**	**0.864346**	**0.000**

§ Cronbach's Coefficient Alpha

This method is used to measure the reliability of the questionnaire between each field and the mean of the whole fields of the questionnaire. The normal range of Cronbach's coefficient alpha value between 0.0 and + 1.0, and the higher values reflects a higher degree of internal consistency. As shown in Table (9) the Cronbach's coefficient alpha was calculated for the first field of the causes of claims, the second field of common procedures and the third field of the Particular claims. The results were in the range from 0.8290 and 0.8805, this range is considered high; the result ensures the reliability of the questionnaire.

§ Table (9)

Cronbach's Alpha For Reliability

section	Criteria	No. of Items	Cronbach's Alpha
1	**Burnout checklist**	١٩	0.8319
2	**Work stress checklist**	٦١	0.8290
3	**Social support checklist**	٢٠	0.8805
Total		١٠٠	**0.8496**

§ Statistical Manipulation:

To achieve the research goal, researcher used the statistical package for the Social Science (SPSS) for Manipulating and analyzing the data.

The type of study is descriptive analytic style.

The correlation descriptive style was follow.

- **Statistical methods are as follows:**

1- Frequencies and Percentile.

2- Alpha- Cronbach Test for measuring reliability of the items of the questionnaires

3- Person correlation coefficients for measuring validity of the items of the questionnaires.

4- Spearman –Brown Coefficient

5- One sample t test

6- Independent samples t test

7- One way ANOVA.

- **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.
- The sample was big, so the statistical manipulation was difficult.
- 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 political situation was very bad (the battles between Hamas troops and authority army) the roads are blocked and shooting in the hospitals was done.
- The psychological issue of the researcher plays a role in the difficulties.

- **summary:**

The weak items were excluded from the tools, and the research tools applied on the sample.

Chapter five

Results

§ Introduction:

The questionnaire done, the sample was 120 nurses, the analysis process done in order to explore this phenomena, with a process that start step by step as the follow:

§ Sample Kolmogorov-Smirnov Test:

Kolmogorove- Smirnov test will be used to identify if the data follow normal distribution or not, this test is considered necessary in case testing hypotheses as most parametric Test stipulate data to be normality distributed. Results test as shown in table (10), clarifies that the calculated p-value is greater than the significant level which is equal 0.05 (p-value. > 0.05), this in turn denotes that data follows normal distribution, and so parametric Tests must be used.

Table (10)

One-Sample Kolmogorov-Smirnov Test

section	contents	Kolmogorov-Smirnov Z	P-value
1	**Burnout checklist**	١.٣٣٠	٠.٠٥٨
3	**Social support checklist**	٠.٩٧٢	٠.٣٠١
2	**Work stress checklist**	٠.٧٧٠	٠.٥٩٤
	Total	٠.٦٠٣	٠.٨٦٠

§ Discussion and interpretation of each section's items.

In the following tables we use a one sample t test to test if the opinion of the respondent in the content of the sentences is positive (weight mean

greater than "60%" and the p-value less than 0.05) or the opinion of the respondent in the content of the sentences are neutral (p- value is greater than 0.05) or the opinion of the respondent in the content of the sentences are negative (weight mean less than "60%" and the p-value less than 0.05)

The answers of the questions of the study are:

- The first question:
  - **What is the prevalence of burnout among the Palestinian nurses in Gaza city?**
- **1- Burnout Checklist (Consist three subsections)**
- **First: Emotional Exhaustion/Depersonalization (EE+DP)**

Table no. (11) which illustrated that the respondent agree that " I've become more callous toward people since I took this job " with weight mean equal " 37.3%", and that " I worry that this job is hardening me emotionally " with weight mean " 40.7%", and that " I feel frustrated by my job " with weight mean " 57.6%", and that " I feel burned out from my work." with weight mean " 63.2%", and that " I feel patients blame me for some of their problems " with weight mean " 51.4%", and that " Working with people directly puts too much stress on me. Working with people all day is really a strain for me " with weight mean " 69.2%", and that " I feel like I'm at the end of my rope " with weight mean " 41.7%", and that " I feel I treat some patients as if they were impersonal 'objects'" with weight mean " 32.9%", and that " I don't really care what happens to some patients " with weight mean " 30.8%".

For general the results for all statements of the field show that the average mean equal 2.45 and the weighted mean equal 49.5% which is less than " 60%" and the value of t test equal -6.35 which is less

than the critical value which is equal 1.98 and the p- value equal 0.000 which is less than 0.05, that means the respondent of the sample Emotional Exhaustion/Depersonalization (EE+DP is low.

Table No. (11)

The results of the subsection (Emotional Exhaustion/Depersonalization (EE+DP))

Number	The Sentence	Not Agree	Rarely	Sometimes	Agree	Strongly Agree	Mean	Weight mean	t-value	P-value
1	I've become more callous toward people since I took this job.	٥١.٧	٢١.٧	١٨.٣	٥.٠	٣.٣	1.87	37.3	-١١.٣٧	٠.٠٠٠
2	I worry that this job is hardening me emotionally.	٥٠.٠	١٥.٠	٢٠.٠	٩.٠	٥.٠	2.03	40.7	٨.٥٧-	٠.٠٠٠
3	I feel frustrated by my job.	١٩.٣	١٤.٣	٣٥.٣	٢١.٠	١٠.١	2.88	57.6	١.٠٤-	٠.٣٠١
4	I feel burned out from my work.	١٧.٨	٧.٦	٢٧.١	٣٥.٦	١١.٩	3.16	63.2	١.٣٨	٠.١٧٠
5	I feel patients blame me for some of their problems.	٢٦.٣	٢٧.١	٢٠.٣	١٦.١	١٠.٢	2.57	51.4	٣.٥٨-	٠.٠٠٠
6	Working with people directly puts too much stress on me. Working with people all day is really a strain for me.	١٠.٣	١٢.٨	٢١.٤	٣١.٦	٢٣.٩	3.46	69.2	٣.٩٣	٠.٠٠٠
7	I feel like I'm at the end of my rope.	٤٨.٣	١٥.٣	٢٠.٣	١١.٩	٤.٢	2.08	41.7	٧.٩٩-	٠.٠٠٠
8	I feel I treat some patients as if they were impersonal 'objects'.	٦٦.٤	١٣.٤	١٢.٦	٤.٢	٣.٤	1.65	32.9	-١٣.٧٩	٠.٠٠٠
9	I don't really care what happens to some patients.	٧١.٤	١٣.٤	٧.٦	٥.٠	٢.٥	1.54	30.8	-١٥.٨٤	٠.٠٠٠
Total							2.48	49.5	٦.٣٥-	٠.٠٠٠

The T critical value =1.98 at significance level 0.05 and degrees of freedom "119"

§ Second: Personal Accomplishment (PA)

Table no. (12) which illustrated that the respondent agree that " I have accomplished many worthwhile things in this job " with weight mean equal " 79.83%", and that " I can easily create a relaxed atmosphere with my patients " with weight mean " 77.17%", and that " I deal very effectively with the problems of my patients " with weight mean " 75.00%", and that " I feel I'm positively influencing other people's lives through my work " with weight mean " 75.08%", and that " In my work, I deal with emotional problems very calmly " with weight mean " 70.26%", and that " I can easily understand how my patients feel about things " with weight mean " 74.02%", and that " I have accomplished many worthwhile things in this job " with weight mean " 74.59%".

For general the results for all statements of the field show that the average mean equal 2.39 and the weight mean equal 47.71% which is less than " 60%" and the value of t test equal -13.03 which is less than the critical value which is equal 1.98 and the p- value equal 0.000 which is less than 0.05, that means the respondent of the sample agree that the Personal Accomplishment (PA) is large

Table No. (12)
The results of the subsection (Personal Accomplishment (PA))

Number	The Sentence	Not Agree	Rarely	Sometimes	Agree	Strongly Agree	Mean	Weight mean	t-value	P-value
10	I have accomplished many worthwhile things in this job.	٥.٠	١.٧	١٣.٣	٤٩.٢	٣٠.٨	3.99	79.83	١١.٠٥	٠.٠٠٠
11	I can easily create a relaxed atmosphere with my patients.	٠.٠	٥.٠	٢٥.٨	٤٧.٥	٢١.٧	3.86	77.17	١١.٥٧	٠.٠٠٠

Number	The Sentence	Not Agree	Rarely	Sometimes	Agree	Strongly Agree	Mean	Weight mean	t-value	P-value
12	I deal very effectively with the problems of my patients.	٠.٠	٣.٣	٣٥.٠	٤٥.٠	١٦.٧	3.75	75.00	١٠.٦٧	٠.٠٠٠
13	I feel I'm positively influencing other people's lives through my work.	١.٧	٤.٢	٢٨.٨	٤٧.٥	١٧.٨	3.75	75.08	٩.٥٦	٠.٠٠٠
14	In my work, I deal with emotional problems very calmly.	٢.٦	١٠.٣	٣٣.٣	٤١.٠	١٢.٨	3.51	70.26	٥.٩٤	٠.٠٠٠
15	I can easily understand how my patients feel about things.	٠.٩	٦.٨	٢٥.٦	٥٤.٧	١٢.٠	3.70	74.02	٩.٤٦	٠.٠٠٠
16	I have accomplished many worthwhile things in this job.	٢.٤	٢.٤	٣٦.٥	٣٧.٦	٢١.٢	3.73	74.59	٧.٤٣	٠.٠٠٠
Total							**2.39**	**47.71**	**-١٣.٠٣**	٠.٠٠٠

The T critical value =1.98 at significance level 0.05 and degrees of freedom "119"

§ Third : Physical Exhaustion (PE)

Table no. (13) which illustrated that the respondent agree that " I feel emotionally drained from my work " with weight mean equal " 45.6%", and that " I feel fatigued when I get up in the morning and have to face another day on the job " with weight mean " 65.1%", and that " I feel I'm working too hard on my job " with weight mean " 84.4%"

For general the results for all statements of the field show that the average mean equal 3.26 and the weight mean equal 65.3% which is greater than " 60%" and the value of t test equal 3.84 which is less than

the critical value which is equal 1.98 and the p- value equal 0.000 which is less than 0.05, that means the respondent of the sample agree that the Physical Exhaustion (PE) is large

Table No. (13)

The results of the subsection (Physical Exhaustion (PE))

Number	The Sentence	Not Agree	Rarely	Sometimes	Agree	Strongly Agree	Mean	Weight mean	t-value	P-value
17	I feel emotionally drained from my work.	٣٩.٠	١٦.٩	٢٥.٤	١٤.٤	٤.٢	2.28	45.6	٦.٣١-	٠.٠٠٠
18	I feel fatigued when I get up in the morning and have to face another day on the job.	١٤.٤	١٢.٧	٢٢.٩	٣٣.١	١٦.٩	3.25	65.1	٢.١٤	٠.٠٣٤
19	I feel I'm working too hard on my job.	٠.٩	١.٧	١٠.٣	٤٨.٧	٣٨.٥	4.22	84.4	١٧.٢٤	٠.٠٠٠
Total							**3.26**	**65.3**	**٣.٨٤**	٠.٠٠٠

The T critical value =1.98 at significance level 0.05 and degrees of freedom "119"

§ 2- Work stress checklist:

The answer of the second question which was:

- **What's the relation between burnout and stress among the nurses?**

- **First: stressors due to poor management of the nursing profession.**

Table no. (14) which illustrated that the respondent agree that " The misunderstanding to the nature of nursing profession " with weight mean equal " 71.69%", and that " The absence of communication between the top and the base of the nursing " with weight mean " 80.85%", and that " The absence of the environment to solve the problems that face the nurses " with weight mean " 85.50%", and that " Absence of creative environment in the profession " with weight mean " 83.33%", and that " Absence of the opportunities to the nursing for decision making participation " with weight mean " 85.50%", and that " Absence of job description " with weight mean " 88.24%", and that " Vague responsibilities " with weight mean " 80.34%", and that " The work is distorted and far from good management " with weight mean " 76.61%", and that " The inappropriate wages according to the nature of the work " with weight mean " 79.32%", and that " The presence of work overload " with weight mean " 83.86%", and that " The high levels of danger and infections " with weight mean " 83.53%", and that " Poor control on the danger and infections transmission to the nurses " with weight mean " 77.93%", and that " The absence of protective securing measures to the nurse after he has been infected " with weight mean " 86.89%", and that

" Absence of resources and preparation to deal with patients and their families " with weight mean " 80.17%", and that " The presence of anxiety about treatment and care plane " with weight mean " 70.59%", and that " The shortage of nursing and resources " with weight mean " 85.21%",

For general the results for all statements of the field show that the average mean equal 4.06 and the weight mean equal 81.26% which is greater than " 60%" and the value of t test equal 17.47 which is greater than the critical value which is equal 1.98 and the p- value equal 0.000 which is less than 0.05, that means the respondent of the sample agree that there exist a stressors due to poor management of the nursing profession

Table No. (14)

The results of the subsection (stressors due to poor management of the nursing profession)

Number	The Sentence	Not Agree	Rarely	Sometimes	Agree	Strongly Agree	Mean	Weight mean	t-value	P-value
1	The misunderstanding to the nature of nursing profession.	١٧.٨	٥.١	٧.٦	٣٩.٨	٢٩.٧	3.58	71.69	٤.٤٧	٠.٠٠٠
2	The absence of communication between the top and the base of the nursing.	٥.٩	٤.٢	٩.٣	٤٠.٧	٣٩.٨	4.04	80.85	١٠.٣٢	٠.٠٠٠
3	The absence of the environment to solve the problems that face the nurses.	٠.٨	٢.٥	٨.٣	٤٥.٠	٤٣.٣	4.28	85.50	١٧.٧٢	٠.٠٠٠
4	Absence of creative environment in the profession,	٥.٠	١.٧	٨.٣	٤١.٧	٤٣.٣	4.17	83.33	١٢.٦٩	٠.٠٠٠
5	Absence of the opportunities to the	٠.٠	٤.٢	١٥.٠	٢٥.٨	٥٥.٠	4.28	85.50	١٣.٩١	٠.٠٠٠

Number	The Sentence	Not Agree	Rarely	Sometimes	Agree	Strongly Agree	Mean	Weight mean	t-value	P-value
	nursing for decision making participation.									
6	Absence of job description.	١.٧	٢.٥	٥.٩	٣٢.٨	٥٧.١	4.41	88.24	١٨.١٦	٠.٠٠٠
7	Vague responsibilities.	٥.١	٢.٥	١٥.٣	٣٩.٨	٣٧.٣	4.02	80.34	١٠.٥٦	٠.٠٠٠
8	The work is distorted and far from good management.	٩.٣	٣.٤	١٦.١	٣٧.٣	٣٣.٩	3.83	76.61	٧.٤٧	٠.٠٠٠
9	The inappropriate wages according to the nature of the work.	٦.٨	٤.٢	١٣.٦	٣٦.٤	٣٩.٠	3.97	79.32	٩.١٥	٠.٠٠٠
10	The presence of work overload.	٠.٠	٤.٤	١٣.٢	٣٦.٨	٤٥.٦	4.19	83.86	١٣.٠٤	٠.٠٠٠
11	The high levels of danger and infections.	١.٧	٤.٢	١٦.٠	٣١.١	٤٧.١	4.18	83.53	١٣.٣٤	٠.٠٠٠
12	Poor control on the danger and infections transmission to the nurses.	٢.٦	٤.٣	٢٦.٧	٣٣.٦	٣٢.٨	3.90	77.93	٩.٦٧	٠.٠٠٠
13	The absence of protective securing measures to the nurse after he has been infected.	٠.٠	٣.٤	٧.٦	٤٠.٣	٤٨.٧	4.34	86.89	١٩.٢٠	٠.٠٠٠
14	Absence of resources and preparation to deal with patients and their families.	٠.٠	٦.٧	٢١.٠	٣٧.٠	٣٥.٣	4.01	80.17	١٢.٠١	٠.٠٠٠
15	The presence of anxiety about treatment and care plane.	١٠.١	٣.٤	٢٨.٦	٣٩.٥	١٨.٥	3.53	70.59	٥.٠٦	٠.٠٠٠
16	The shortage of nursing and resources.	٤.٢	٠.٨	٩.٢	٣٦.١	٤٩.٦	4.26	85.21	١٤.١٨	٠.٠٠٠
Total							**4.06**	**81.26**	١٧.٤٧	٠.٠٠٠

The T critical value =1.98 at significance level 0.05 and degrees of freedom "119"

§ Second: stressors due to the work environment

Table no. (15) which illustrated that the respondent agree that " Vague future of the profession " with weight mean equal " 73.16%", and that " Absence of opportunities for development and progression of the nurse " with weight mean " 74.92%", and that " Vague of the role of nursing profession " with weight mean " 72.44%", and that " It is difficult to take your holiday or ead." with weight mean " 68.57%", and that " The work is meaningless " with weight mean " 53.39%", and that " Misuse of nursing skills " with weight mean " 60.00%", and that " Lack of control on the work content." with weight mean " 61.71%", and that " The presence of time pressure to achieve the work " with weight mean " 67.23%", and that " The continuous shifting without stability " with weight mean " 80.70%", and that " Inability to predict the work time " with weight mean " 64.58%", and that " Long working time prevents the social interaction " with weight mean " 78.82%", and that " Inability to control the over the work time " with weight mean " 70.68%", and that " Working through a team " with weight mean " 72.14%", and that " The conflict between work requirement and home requirement " with weight mean " 69.40%", and that " Lack of preparation and resources to deal with gasping or dying people " with weight mean " 63.36%", and that " Clients don't understand that it is good for them " with weight mean " 74.62%", and that " Client's family depends too heavily on you " with weight mean " 71.79%", and that " Client's family behaves high-handedly " with weight mean " 79.49%",

For general the results for all statements of the field show that the average mean equal 3.42 and the weight mean equal 68.44% which is greater than " 60%" and the value of t test equal 7.16 which is

greater than the critical value which is equal 1.96 and the p- value equal 0.000 which is less than 0.05, that means the respondent of the sample agree that there exist a stressors due to the work environment

Table No. (15)
The results of the subsection (stressors due to the work environment)

Number	The Sentence	Not Agree	Rarely	Sometimes	Agree	Strongly Agree	Mean	Weight mean	t-value	P-value
17	Vague future of the profession.	٨.٥	٤.٣	٢٤.٨	٣٧.٦	٢٤.٨	3.66	73.16	٦.١٧	٠.٠٠٠
18	Absence of opportunities for development and progression of the nurse.	٩.٣	٧.٦	١٧.٨	٢٩.٧	٣٥.٦	3.75	74.92	٦.٣٥	٠.٠٠٠
19	Vague of the role of nursing profession,	١٣.٤	٤.٢	٢١.٨	٢٧.٧	٣٢.٨	3.62	72.44	٥.٠٦	٠.٠٠٠
20	It is difficult to take your holiday or ead.	١٠.٩	٤.٢	٣٧.٠	٢٦.٩	٢١.٠	3.43	68.57	٣.٩٣	٠.٠٠٠
21	The work is meaningless.	٣٢.٢	٧.٦	٣١.٤	١٨.٦	١٠.٢	2.67	53.39	٢.٦٣-	٠.٠٠٠
22	Misuse of nursing skills.	١٢.٦	١٦.٠	٣٧.٠	٢٧.٧	٦.٧	3.00	60.00	٠.٠٠٠	١.٠٠٠
23	Lack of control on the work content.	٦.٨	١٧.١	٤١.٠	٣٠.٨	٤.٣	3.09	61.71	٠.٩٦٠	٠.٣٣٨
24	The presence of time pressure to achieve the work.	١٤.٣	٤.٢	٣١.١	٣١.٩	١٨.٥	3.36	67.23	٣.١٦	٠٠٢.
25	The continuous shifting without stability.	٧.٠	٢.٦	١٣.٩	٣٣.٠	٤٣.٥	4.03	80.70	٩.٦٨	٠.٠٠٠
26	Inability to predict the work time.	١٢.٧	١١.٩	٣٤.٧	٢١.٢	١٩.٥	3.23	64.58	١.٩٨	٠.٠٥٠
27	Long working time prevents the social interaction.	٤.٢	٣.٤	٢٤.٤	٣٠.٣	٣٧.٨	3.94	78.82	٩.٦١	٠.٠٠٠
28	Inability to control the over the work time.	٥.١	١١.٩	٢٤.٦	٤١.٥	١٦.٩	3.53	70.68	٥.٤٣	٠.٠٠٠
29	Working through a team.	٦.٨	٨.٥	٢٤.٨	٣٦.٨	٢٣.١	3.61	72.14	٥.٧٧	٠.٠٠٠
30	The conflict between work requirement and home requirement.	٦.٠	٧.٧	٣٩.٣	٢٧.٤	١٩.٧	3.47	69.40	٤.٧١	٠.٠٠٠

Number	The Sentence	Not Agree	Rarely	Sometimes	Agree	Strongly Agree	Mean	Weight mean	t-value	P-value
31	Lack of preparation and resources to deal with gasping or dying people.	١٠.٩	١٥.١	٣٢.٨	٢٨.٦	١٢.٦	3.17	63.36	١.٥٧	٠.١١٩
32	Clients don't understand that it is good for them.	٢.٥	٥.٩	٢٥.٢	٤٨.٧	١٧.٦	3.73	74.62	٨.٧٨	٠.٠٠٠
33	Client's family depends too heavily on you.	٦.٠	٧.٧	٢٥.٦	٤٢.٧	١٧.٩	3.59	71.79	٦.٠٢	٠.٠٠٠
34	Client's family behaves high-handedly.	٦.٠	٠.٠	٣٦.٥	٢٥.٦	٤١.٩	3.97	79.49	٩.٤٩	٠.٠٠٠
Total							**3.42**	**68.44**	٧.١٦	٠.٠٠٠

The T critical value =1.98 at significance level 0.05 and degrees of freedom "119"

- **Third: stressors caused by others in the work environment**

Table no. (16) which illustrated that the respondent agree that " Bad work environment in the hospital " with weight mean equal " 75.50%", and that " The rigidity of work shifts programs " with weight mean " 67.97%", and that " A lot of night shifts duty " with weight mean " 69.49%", and that " Absence of personal relation which lead to social isolation " with weight mean " 56.44%", and that " The presence of conflict with other nurses " with weight mean " 59.50%", and that " The presence of conflict with other employers inside the hospital " with weight mean " 61.85%", and that " The presence of verbal hostility from the client's family towards the nurses " with weight mean " 69.32%", and that " The presence of physical hostility from the client's family towards the nurses " with weight mean " 55.46%", and that " Client's family behaves high-handedly " with weight mean " 70.25%", and that "Absence of trust in the care plane that physicians decide and nurses

applied " with weight mean " 63.70%", and that " Clients don't understand the services that I applied for them " with weight mean " 67.90%", and that " Clients behave selfishly or uncooperatively " with weight mean " 68.40%"

For general the results for all statements of the field show that the average mean equal 3.43 and the weight mean equal 68.54 which is greater than " 60%" and the value of t test equal 6.17 which is greater than the critical value which is equal 1.98 and the p- value equal 0.000 which is less than 0.05, that means the respondent of the sample agree that there exist a stressors caused by others in the work environment.

Table No. (16)
The results of the subsection (stressors caused by others in the work environment)

Number	The Sentence	Not Agree	Rarely	Sometimes	Agree	Strongly Agree	Mean	Weight mean	t-value	P-value
35	Bad work environment in the hospital.	٦.٣	٥.٤	٢١.٦	٣٧.٨	٢٨.٨	3.77	75.50	٧.٣٠	٠.٠٠٠
36	The rigidity of work shifts programs,	١٠.٢	١١.٩	٢٨.٨	٢٦.٣	٢٢.٩	3.40	67.97	٣.٤٧	٠.٠٠١
37	A lot of night shifts duty.	٩.٣	٦.٨	٢٨.٠	٣٩.٠	١٦.٩	3.47	69.49	٤.٥٣	٠.٠٠٠
38	Absence of personal relation which lead to social isolation.	٢٢.٠	٢١.٢	٢٠.٣	٢٥.٤	١١.٠	2.82	56.44	١.٤٥-	٠.١٤٩
39	The presence of conflict with other nurses.	١٤.٣	١٧.٦	٣٧.٠	١٨.٥	١٢.٦	2.97	59.50	٠.٢٣-	٠.٨٢٠
40	The presence of conflict with other employers inside	١٣.٤	١٦.٨	٣١.٩	٢٢.٧	١٥.١	3.09	61.85	٠.٨١٠	٠.٤١٨

Number	The Sentence	Not Agree	Rarely	Sometimes	Agree	Strongly Agree	Mean	Weight mean	t-value	P-value
	the hospital									
41	The presence of verbal hostility from the client's family towards the nurses.	٥.٩	١٢.٧	٣٢.٢	٢٧.١	٢٢.٠	3.47	69.32	٤.٤٢	٠.٠٠٠
42	The presence of physical hostility from the client's family towards the nurses.	١٨.٥	٢٥.٢	٢٨.٦	١٦.٠	١١.٨	2.77	55.46	١.٩٧-	٠.٠٥٢
43	Client's family behaves high-handedly.	١٠.٩	٨.٤	٢٦.٩	٢٦.١	٢٧.٧	3.51	70.25	٤.٣٦	٠.٠٠٠
44	Absence of trust in the care plane that physicians decide and nurses applied.	١٠.٩	١٨.٥	٢٦.٩	٢٨.٦	١٥.١	3.18	63.70	١.٦٥	٠.١٠١
45	Clients don't understand the services that I applied for them.	٣.٤	٦.٧	٥٠.٤	٢٦.١	١٣.٤	3.39	67.90	٤.٦٧	٠.٠٠٠
46	Clients behave selfishly or uncooperatively.	٢.٥	١٦.٠	٣٦.١	٢٧.٧	١٧.٦	3.42	68.40	٤.٤٢	٠.٠٠٠
Total							**3.43**	**68.54**	٦.١٧	٠.٠٠٠

The T critical value =1.98 at significance level 0.05 and degrees of freedom "119"

§ Fourth: stressors caused by supervisors and managers

Table no. (17) which illustrated that the respondent agree that " Bad relation with the supervisors and the managers " with weight mean equal " 58.14%", and that " Bad attitude and behavior of physician towards nurses " with weight mean " 60.34%", and that " Supervisors behave selfishly and inconsistently " with weight mean " 62.69%", and that " Supervisors don't understand my job." with weight mean " 56.81%", and that " Supervisors discriminate from another coworker " with weight mean " 66.67%", and that " Supervisors force the way of thinking and doing " with weight mean " 64.44%".

For general the results for all statements of the field show that the average mean equal 3.23 and the weight mean equal 64.66% which is greater than " 60%" and the value of t test equal 2.62 which is greater than the critical value which is equal 1.98 and the p- value equal 0.010 which is less than 0.05, that means the respondent of the sample agree that there exist stressors caused by supervisors and managers

Table No. (17)

The results of the subsection (stressors caused by supervisors and managers)

Number	The Sentence	Not Agree	Rarely	Sometimes	Agree	Strongly Agree	Mean	Weight mean	t-value	P-value
47	Bad relation with the supervisors and the managers.	٢٠.٣	١٦.٩	٣١.٤	١٤.٤	١٦.٩	2.91	58.14	-٠.٧٥	٠.٤٥٣
48	Bad attitude and behavior of physician towards nurses.	١١.١	١٩.٧	٤٠.٢	١٤.٥	١٤.٥	3.02	60.34	٠.١٦	٠.٨٧٥
49	Supervisors behave selfishly and inconsistently.	١٤.٣	١٥.١	٣١.١	٢١.٨	١٧.٦	3.13	62.69	١.١٤	٠.٢٥٥
50	Supervisors don't understand my job.	٢٣.٥	١٣.٤	٣١.١	١٩.٣	١٢.٦	2.84	56.81	-١.٣١	٠.١٩٢
51	Supervisors discriminate from another coworker.	٨.٥	٨.٥	٣٩.٣	٢٨.٢	١٥.٤	3.33	66.67	٣.٢٦	٠.٠٠١
52	Supervisors force the way of thinking and doing.	١١.١	١٥.٤	٣٤.٢	١٨.٨	٢٠.٥	3.22	64.44	١.٩٢	٠.٠٥٨
Total							**3.23**	**64.66**	**٢.٦٢**	**٠.٠١٠**

The T critical value =1.98 at significance level 0.05 and degrees of freedom "119"

- **Fifth: stressors caused by other factors.**

Table no. (18) which illustrated that the respondent agree that " Anxiety related to lateness or absence of salaries " with weight mean equal " 85.08%", and that " Anxiety related to Israeli violence and siege " with weight mean " 85.55%", and that " Anxiety related to martyr or injury of a member of the nurse family " with weight mean " 81.36%", and that " Anxiety related to death of a member of nurse family " with weight mean " 81.68%", and that " Anxiety related to bad health status of a member of nurse family " with weight mean " 78.80%".

For general the results for all statements of the field show that the average mean equal 3.99 and the weight mean equal 79.82% which is greater than " 60%" and the value of t test equal 14.02 which is less than the critical value which is equal and the p- value equal 0.000 which is less than 0.05, that means the respondent of the sample agree that the stressors caused by other factors

Table No. (18)

The results of the subsection (stressors caused by other factors)

Number	The Sentence	Not Agree	Rarely	Sometimes	Agree	Strongly Agree	Mean	Weight mean	t-value	P-value
53	Anxiety related to lateness or absence of salaries.	٠.٨	٢.٥	١٣.٦	٣٦.٤	٤٦.٦	4.25	85.08	١٦.٠٤	٠.٠٠٠
54	Anxiety related to Israeli violence and siege.	0.8	٠.٨	١٦.٠	٣٤.٥	٤٧.٩	4.28	85.55	١٦.٩٤	٠.٠٠٠
55	Anxiety related to martyr or injury of a member of the nurse family.	٥.١	٠.٨	١٠.٢	٥٠.٠	٣٣.٩	4.07	81.36	١١.٩٩	٠.٠٠٠
56	Anxiety related to death of a member of nurse family.	٤.٢	٠.٠	١٦.٠	٤٢.٩	٣٧.٠	4.08	81.68	١٢.٤١	٠.٠٠٠
57	Anxiety related to bad health status of a member of nurse family	٤.٣	١.٧	١٥.٤	٥٣.٠	٢٥.٦	3.94	78.80	١٠.٩٢	٠.٠٠٠
Total							**3.99**	**79.82**	**١٤.٠٢**	٠.٠٠٠

The T critical value =1.98 at significance level 0.05 and degrees of freedom "119"

§ **Sixth: stressors caused by the nurse himself.**

Table no. (19) which illustrated that the respondent agree that " The nature of profession delay the achievement of religious duties sometimes " with weight mean equal " 64.71%", and that " Anxiety related to the presence of social or psychological problems " with weight mean " 67.06%", and that " Anxiety related to the unstable political problem " with weight mean " 78.15%", and that " Anxiety related to the bad health status of the nurse himself " with weight mean " 70.92%".

For general the results for all statements of the field show that the average mean equal 3.63 and the weight mean equal 72.69% which is greater than " 60%" ant the value of t test equal 8.39 which is greater than the critical value which is equal and the p- value equal 0.000 which is less than 0.05, that means the respondent of the sample agree that the stressors caused by the nurse himself

Table No. (19)

The results of the subsection (stressors caused by the nurse himself)

Number	The Sentence	Not Agree	Rarely	Sometimes	Agree	Strongly Agree	Mean	Weight mean	t-value	P-value
58	The nature of profession delay the achievement of religious duties sometimes,	٨.٤	١٦.٨	٢٨.٦	٣٥.٣	١٠.٩	3.24	64.71	٢.٣٠	٠.٠٢٣
59	Anxiety related to the presence of social or psychological problems.	٤.٢	١٤.٣	٣١.٩	٤١.٢	٨.٤	3.35	67.06	٣.٩٧	٠.٠٠٠
60	Anxiety related to the unstable political problem.	١.٧	٥.٩	١٥.١	٥٤.٦	٢٢.٧	3.91	78.15	١١.٣٤	٠.٠٠٠

Number	The Sentence	Not Agree	Rarely	Sometimes	Agree	Strongly Agree	Mean	Weight mean	t-value	P-value
61	Anxiety related to the bad health status of the nurse himself.	٥.٠	١٠.٩	٢٧.٧	٣٧.٠	١٩.٣	3.55	70.92	٥.٥٢	٠.٠٠٠
Total							**3.63**	**72.69**	**٨.٣٩**	**٠.٠٠٠**

The T critical value =1.98 at significance level 0.05 and degrees of freedom "119"

§ Social support checklist

The answer of the third question which was:

- **What's the relation between burnout and social support of the nurses?**
- **First: Social support by supervisors:**

Table no. (20) which illustrated that the respondent agree that " You can easily talk to your supervisor " with weight mean equal " 76.47%", and that " You can rely on your supervisor when there are difficulties " with weight mean " 68.07%", and that " Your supervisor recognizes and values your job " with weight mean " 62.52%", and that " Your supervisor cooperates with you to solve when there are difficulties " with weight mean " 66.89%", and that " **YOU** receive from you supervisor much support " with weight mean " 59.50%".

For general the results for all statements of the field show that the average mean equal 3.14 and the weight mean equal 62.90 and the p-value equal 0.093 which is greeter than 0.05, that means the respondent of the sample about the Social support by supervisors is neutral

Table No. (20)

The results of the subsection (Social support by supervisors)

Number	The Sentence	Not Agree	Rarely	Sometimes	Agree	Strongly Agree	Mean	Weight mean	t-value	P-value
1	You can easily talk to your supervisor**.**	٣.٤	١.٧	١٧.٦	٦٣.٩	١٣.٤	3.82	76.47	١١.١٠	٠.٠٠٠
2	You can rely on your supervisor when there are difficulties.	٧.٦	٤.٢	٣٤.٥	٤٧.٩	٥.٩	3.40	68.07	٤.٦٣	٠.٠٠٠
3	Your supervisor recognizes and values your job**.**	١٠.١	١٨.٥	٢٦.٩	٣٧.٨	٦.٧	3.13	62.52	١.٢٤	٠.٢١٧
4	Your supervisor cooperates with you to solve when there are difficulties**.**	٦.٧	١٢.٦	٢٨.٦	٤٣.٧	٨.٧	3.34	66.89	٣.٦٥	٠.٠٠٠
5	**YOU** receive from you supervisor much support.	١٢.٦	١٣.٤	٤٢.٠	٢٧.٧	٤.٢	2.97	59.50	٠.٢٦-	٠.٧٩٣
Total							**3.14**	**62.90**	**١.٦٩**	**٠.٠٩٣**

The T critical value =1.98 at significance level 0.05 and degrees of freedom "119"

§ Second: Social support by coworkers:

Table no. (21) which illustrated that the respondent agree that " You can easily talk to your coworker " with weight mean equal " 78.98%", and that " You can rely on your coworker when there are difficulties " with weight mean " 73.73%", and that " Your coworker recognizes and values your job " with weight mean " 66.61%", and that " Your coworker cooperates with you to solve when there are difficulties " with weight mean " 71.19%", and that " **YOU** receive from your coworker much support " with weight mean " 65.17%".

For general the results for all statements of the field show that the average mean equal 3.45 and the weight mean equal 68.97 which is greater than " 60%" and the value of t test equal 6.96 which is greater than the critical value which is equal 1.98 and the p- value equal 0.000 which is less than 0.05, that means the respondent of the sample agree that there exist a Social support by coworkers

Table No. (21)
The results of the subsection (Social support by coworkers)

Number	The Sentence	Not Agree	Rarely	Sometimes	Agree	Strongly Agree	Mean	Weight mean	t-value	P-value
6	You can easily talk to your coworker**.**	١.٧	٥.١	١١.٠	٦١.٠	٢١.٢	3.95	78.98	١٢.٤٩	٠.٠٠٠
7	You can rely on your coworker when there are difficulties.	١.٧	٥.١	٢٩.٧	٥٠.٠	١٣.٦	3.69	73.73	٨.٩٤	٠.٠٠٠
8	Your coworker recognizes and values your job**.**	٥.١	١٣.٦	٣٢.٢	٤١.٥	٧.٦	3.33	66.61	٣.٦٧	٠.٠٠٠
9	Your coworker cooperates with you to solve when there are difficulties**.**	١.٧	٥.١	٣٥.٦	٥٠.٨	٦.٨	3.56	71.19	٧.٩١	٠.٠٠٠
10	**YOU** receive from your coworker much support.	٣.٤	١٠.٣	٤٨.٣	٣٢.٨	٥.٢	3.26	65.17	٣.٢٩	٠.٠٠١
Total							**3.45**	**68.97**	**٦.٩٦**	**٠.٠٠٠**

The T critical value =1.98 at significance level 0.05 and degrees of freedom "119"

§ Third: Social support by family

Table no. (22) which illustrated that the respondent agree that " You can easily talk to your family " with weight mean equal " 84.07%", and that " You can rely on your family when there are difficulties " with weight mean " 75.46%", and that " Your family recognizes and values your job "

with weight mean "79.66%", and that "Your family cooperates with you to solve when there are difficulties "with weight mean " 78.99%".

For general the results for all statements of the field show that the average mean equal 3.92 and the weight mean equal %78.49 which is greater than " 60%" and the value of t test equal 11.81 which is greater than the critical value which is equal 1.98 and the p- value equal 0.000 which is less than 0.05, that means the respondent of the sample agree that there exist a Social support by family.

Table No. (22)

The results of the subsection (Social support by family)

Number	The Sentence	Not Agree	Rarely	Sometimes	Agree	Strongly Agree	Mean	Weight mean	t-value	P-value
11	You can easily talk to your family**.**	١.٧	٥.١	٦.٨	٥.١	١.٧	4.20	84.07	١٤.٥٠	٠.٠٠٠
12	You can rely on your family when there are difficulties.	٥.٩	٨.٤	١٧.٦	٣٨.٧	٢٩.٤	3.77	75.46	٧.٤١	٠.٠٠٠
13	Your family recognizes and values your job**.**	٥.٠	٥.٠	١٤.٣	٣٧.٨	٣٧.٨	3.98	79.66	٩.٨٥	٠.٠٠٠
14	Your family cooperates with you to solve when there are difficulties**.**	٥.٩	٣.٤	١٤.٣	٤٢.٩	٣٣.٦	3.95	78.99	٩.٦٦	٠.٠٠٠
Total							**3.92**	**78.49**	١١.٨١	٠.٠٠٠

The T critical value =1.98 at significance level 0.05 and degrees of freedom "119"

§ Fourth: Social support by friends

Table no. (23) which illustrated that the respondent agree that " You can easily talk to your friend " with weight mean equal " 83.70%", and that " You can rely on your friend when there are difficulties " with weight mean " 74.62%", and that " Your friend recognizes and values your job " with weight mean " 74.92%", and that " Your friend cooperates with you to solve when there are difficulties " with weight mean " 74.62%", and that " You receive from your friend much support " with weight mean " 68.97%", and that " YOU receive much support from the social organization " with weight mean " 43.19%".

For general the results for all statements of the field show that the average mean equal 3.53 and the weight mean equal 70.62% which is greater than " 60%" and the value of t test equal 7.76 which is greater than the critical value which is equal 1.98 and the p- value equal 0.000 which is less than 0.05, that means the respondent of the sample agree that there exist a Social support by friends.

Table No. (23)

The results of the subsection (Social support by friends)

Number	The Sentence	Not Agree	Rarely	Sometimes	Agree	Strongly Agree	Mean	Weight mean	t-value	P-value
15	You can easily talk to your friend.	٠.٠	٣.٤	١١.٨	٤٧.٩	٣٧.٠	4.18	83.70	١٦.٧٩	٠.٠٠٠
16	You can rely on your friend when there are difficulties.	٢.٥	٧.٦	٢٦.٩	٤٠.٣	٢٢.٧	3.73	74.62	٨.١٤	٠.٠٠٠
17	Your friend recognizes and values your job.	٠.٠	١٠.٢	٢٧.١	٤٠.٧	٢٢.٠	3.75	74.92	٨.٨٣	٠.٠٠٠
18	Your friend cooperates with you to solve when	٠.٠	٩.٢	٢٧.٧	٤٣.٧	١٩.٣	3.73	74.62	٩.٠٦	٠.٠٠٠

Number	The Sentence	Not Agree	Rarely	Sometimes	Agree	Strongly Agree	Mean	Weight mean	t-value	P-value
	there are difficulties									
19	You receive from your friend much support.	٢.٦	١٢.١	٣٩.٧	٢٩.٣	١٦.٤	3.45	68.97	٤.٨٨	٠.٠٠٠
20	YOU receive much support from the social organization.	٣٩.٥	٢٧.٧	١٦.٠	١٠.٩	٥.٩	2.16	43.19	٧.٤٦-	٠.٠٠٠
Total							**3.53**	**70.62**	٧.٧٦	٠.٠٠٠

The T critical value =1.98 at significance level 0.05 and degrees of freedom "119"

- **What's the relation between burnout and educational level of the nurses?**

There is no relation between burnout and educational level of the nurses without statistical differences.

- **What's the relation between burnout and the nurses' experiences?**

There is no relation between burnout and the nurses' experiences without statistical differences.

- **What's the relation between burnout and the sex of the nurses?**

There is no relation between burnout and the nurses' **sex** without Statistical differences.

- **What's the relation between burnout and the age of the nurses?**

There is no relation between burnout and the nurses' age without Statistical differences.

- **What's the relation between burnout and the working place of the nurses?**

There is no relation between burnout and the nurses' working place without statistical differences

§ The Study hypothesis:

1: The researcher predicts higher rates in total score of burnout at significant level ($a = 0.05$) among the Nurses.

We apply a one sample t test and the results in table no. (24) which show that for all statements of the field the average mean equal 2.51 and the weight mean equal 50.1% which is less than " 60%" and the value of t test equal -10.25 which is less than the critical value which is equal -1.98 and the p-value equal 0.000 which is less than 0.05, that means we fail to reject the hypotheses, so respondent of the sample agree that there exist a moderate rates of burnout with significant level ($a == 0.05$)

Table No. (24)

The results of the first section (Burnout checklist) and there's subsections

section	The Sentence	Mean	Weight mean	t-value	P-value
1	Emotional Exhaustion/Depersonalization (EE+DP)	2.48	49.5	٦.٣٥-	٠.٠٠٠
2	Personal Accomplishment (PA)	2.39	47.71	١٣.٠٣-	٠.٠٠٠
3	Physical Exhaustion (PE)	3.26	65.3	٣.٨٤	٠.٠٠٠
Total		**2.51**	**50.1**	**١٠.٢٥-**	٠.٠٠٠

The T critical value =1.98 at significance level 0.05 and degrees of freedom "119"

2: The researcher predicts higher rates of stressed nurses with significant statistical level at ($a == 0.05$) that positively related to the total score of burnout.

We apply a one sample t test and the results in table no. (25) which show that for all statements of the field the average mean equal 3.59 and the weight mean equal 71.90% which is greater than " 60%" and the value of t test equal 11.39 which is greater than the critical value which is equal 1.98 and the p- value equal 0.000 which is less than 0.05, that means we fail to reject the hypotheses, so respondent of the sample agree that there exist higher rates of stressed nurses that positively related to burnout with significant level ($a == 0.05$)

Table No. (25)
The results of the second section (Work stress checklist) and there's subsections

section	The Sentence	Mean	Weight mean	t-value	P-value
1	**stressors due to poor management of the nursing profession**	4.06	81.26	١٧.٤٧	٠.٠٠٠
2	**stressors due to the work environment**	3.42	68.44	٧.١٦	٠.٠٠٠
3	**stressors caused by others in the work environment**	3.43	68.54	٦.١٧	٠.٠٠٠
4	**stressors caused by supervisors and managers**	3.23	64.66	٢.٦٢	٠.٠٠٠
5	**stressors caused by other factors**	3.99	79.82	١٤.٠٢	٠.٠٠٠
6	**stressors caused by the nurse himself**	3.63	72.69	٨.٣٩	٠.٠٠٠
Total		**3.59**	**71.90**	١١.٣٩	٠.٠٠٠

The T critical value =1.98 at significance level 0.05 and degrees of freedom "119"

3: The researcher predict higher rates of social support that positively related with the total score of burnout level at significant level ($a == 0.05$).

We apply a one sample t test and the results in table no. (26) Which show that for all statements of the field the average mean equal 3.49 and the

weight mean equal 69.85% which is greater than " 60%" and the value of t test equal 9.527 which is greater than the critical value which is equal 1.98 and the p- value equal 0.000 which is less than 0.05, that means we fail to reject the hypotheses, so the respondent of the sample agree that there exist social support that positively related with the decrease of burnout level with significant level ($a == 0.05$)

Table No. (26)

The results of the third section (Social support checklist)

And there are subsections

section	The Sentence	Mean	Weight mean	t-value	P-value
1	**Social support by supervisors**	3.14	62.90	١.٦٩٢	٠.٠٩٣
2	**Social support by coworkers**	3.45	68.97	٦.٩٥٨	٠.٠٠٠
3	**Social support by family**	3.92	78.49	١١.٨١٢	٠.٠٠٠
4	**Social support by friends**	3.53	70.62	٧.٧٦٣	٠.٠٠٠
Total		**3.49**	**69.85**	**٩.٥٢٧**	٠.٠٠٠

The T critical value =1.98 at significance level 0.05 and degrees of freedom "119"

4: The researcher predict no significant statistical differences at level ($a == 0.05$) in the burnout total score due to the sex of the nurse.

To test the hypotheses we use the independent sample t test and the result in table no. (27) which show that the P-Value for each field and whole statements are greater than 0.05 and the absolute value of T less than the T critical value (=1.98) , so we fail to reject the hypotheses and conclude

that there are no significant statistical differences at significant level ($a == 0.05$) in the level of burnout due to the sex of the nurse

Table No. (27)
Independent samples T test due to sex

Section	Sex	No.	Mean	Standard deviation	T value	P – value
Burnout checklist	Male	٧٣	٢.٥١٦١	٠.٥٤٩٣٧	0.242	0.809
	Female	٤٧	٢.٤٩٢٢	٠.٤٩٥٦٦		
Work stress checklist	Male	٧٣	٣.٥٦٥٩	٠.٥٤٨٦٩	-0.691	0.491
	Female	٤٧	٣.٦٣٩٩	٠.٦٠٩٥٥		
Social support checklist	Male	٧٣	٣.٥٥٨٥	٠.٥٢٧٥٨	1.624	0.107
	Female	٤٦	٣.٣٨٧٣	٠.٦٠٧٩٥		
Total	Male	٧٣	٣.٣٨٥٥	٠.٤١٠٣٤	0.169	0.866
	Female	٤٧	٣.٣٧٢٥	٠.٤١٩٩٦		

The T critical value =1.98 at significance level 0.05 and degrees of freedom "118"

5: The researcher predict no significant statistical differences at significant level ($a == 0.05$) in the burnout total score due to the age of the nurse.

To test the hypotheses we use the one way ANOVA test and the result in table no. (28) And table no. (29), which show that the P-Value for each field and a whole statements are greater than 0.05 and the value of F test less than the critical value F (=3.01 at degrees of freedom "2,117" and significance level 0.05), so we fail to reject the hypotheses and conclude that there are no significant statistical differences at significant level ($a == 0.05$) in the level of burnout **due** to the age of the nurse

Table No. (28)

One way ANOVA test due to the age of the nurse

Section	Source of variance	Sum of Squares	df	Mean Square	F	P - value
Burnout checklist	Between Groups	0.365	٢	0.182	0.652	0.523
	Within Groups	32.683	١١٧	0.279		
	Total	33.048	٢			
Work stress checklist	Between Groups	0.453	١١٧	0.226	0.688	0.504
	Within Groups	38.472	٢	0.329		
	Total	38.925	١١٧			
Social support checklist	Between Groups	0.299	٢	0.149	0.466	0.629
	Within Groups	37.201	١١٧	0.321		
	Total	37.499	٢			
Total	Between Groups	0.199	١١٧	0.099	0.581	0.561
	Within Groups	20.042	٢	0.171		
	Total	20.241	١١٧			

Table no. (29)

Descriptive statistics for age

section	**Mean (**age)		
	Less than 30 year	**30-40 year**	**Greater than 40 year**
Burnout checklist	2.5618	2.4894	2.4130
Work stress checklist	3.5988	3.6482	3.4741
Social support checklist	3.5226	3.4293	3.5497
Total	3.4133	3.3818	3.2999

6: The researcher predict no significant statistical differences at significant level ($a = 0.05$) in the burnout total score due to the educational level of the nurse.

To test the hypotheses we use the one way ANOVA test and the result in table no. (30) And table no. (31), which show that the P-Value for each field and a whole statements are greater than 0.05 and the value of F test less than the critical value F (=3.01 at degrees of freedom "2,117" and significance level 0.05), so we fail to reject the hypotheses and conclude that there are no there are no significant statistical differences at significant level ($a == 0.05$) in the level of burnout due to the educational level of the nurse.

Table No. (30)

One way ANOVA test due to the education of the nurse

Section	Source of variance	Sum of Squares	df	Mean Square	F	P - value
Burnout checklist	Between Groups	٠.٧٢٠	٢	٠.٣٦٠	١.٣٠٣	٠.٢٧٦
	Within Groups	٣٢.٣٢٧	١١٧	٠.٢٧٦		
	Total	٣٣.٠٤٨	٢			
Work stress checklist	Between Groups	٠.٣٥٦	١١٧	٠.١٧٨	٠.٥٣٩	٠.٥٨٥
	Within Groups	٣٨.٥٦٩	٢	٠.٣٣٠		
	Total	٣٨.٩٢٥	١١٧			
Social support checklist	Between Groups	١.١٨٧	٢	٠.٥٩٣	١.٨٩٥	٠.١٥٥
	Within Groups	٣٦.٣١٣	١١٧	٠.٣١٣		
	Total	٣٧.٤٩٩	٢			
Total	Between Groups	٠.١٥٣	١١٧	٠.٠٧٦	٠.٤٤٥	٠.٦٤٢
	Within Groups	٢٠.٠٨٨	٢	٠.١٧٢		
	Total	٢٠.٢٤١	١١٧			

The critical value F=3.01 at degrees of freedom "2,117" and significance level 0.05

Table no. (31)
Descriptive statistics for education

section	Mean (education)		
	Diploma	B.A. or B. S.	M. A. or M. S
Burnout checklist	٢.٤٣١٢	٢.٥٧٥٨	٢.٣٧٨٢
Work stress checklist	٣.٦١٠٧	٣.٦١٠٢	٣.٤٠٣٧
Social support checklist	٣.٤٣٧٢	٣.٤٨٢٥	٣.٨٣٣٣
Total	٣.٣٥٤٠	٣.٤٠٩٩	٣.٢٩٦١

7- The researcher predict no significant statistical differences at significant level ($a == 0.05$) in the burnout total score due to the Nurses' experiences.

To test the hypotheses we use the one way ANOVA test and the result in table no. (32), and table No. (33), which show that the P-Value for each field and a whole statements are greater than 0.05 and the value of F test less than the critical value F (=3.01 at degrees of freedom "2,117" and significance level 0.05), so we fail to reject the hypotheses and conclude that there are no significant statistical differences at significant level ($a == 0.05$) in the burnout due to the Nurses' experiences.

Table No. (32)

One way ANOVA test due to the experience of the nurse

Section	Source of variance	Sum of Squares	df	Mean Square	F	P - value
Burnout checklist	Between Groups	٠.٥١٨	٢	٠.٢٥٩	٠.٩٣٢	٠.٣٩٧
	Within Groups	٣٢.٥٢٩	١١٧	٠.٢٧٨		
	Total	٣٣.٠٤٨	٢			
Work stress checklist	Between Groups	٠.٢٨٤	١١٧	٠.١٤٢	٠.٤٣٠	٠.٦٥٢
	Within Groups	٣٨.٦٤١	٢	٠.٣٣٠		
	Total	٣٨.٩٢٥	١١٧			
Social support checklist	Between Groups	٠.٠٢٥	٢	٠.٠١٢	٠.٠٣٩	٠.٩٦٢
	Within Groups	٣٧.٤٧٥	١١٧	٠.٣٢٣		
	Total	٣٧.٤٩٩	٢			
Total	Between Groups	٠.١٠٧	١١٧	٠.٠٥٤	٠.٣١٢	٠.٧٣٣
	Within Groups	٢٠.١٣٣	٢	٠.١٧٢		
	Total	٢٠.٢٤١	١١٧			

The critical value F=3.01 at degrees of freedom "2,117" and significance level 0.05

Table no. (33)

Descriptive statistics for experience

section	Mean (experience)		
	1-5 years	6-10 years	11 year or more
Burnout checklist	٢.٥٧٧٧	٢.٥٠٢١	٢.٤٢٥٤
Work stress checklist	٣.٥٧٧٨	٣.٦٧٧٣	٣.٥٥٤٩
Social support checklist	٣.٤٩٥٤	٣.٥١٢٣	٣.٤٧٤٥
Total	٣.٣٩٧٧	٣.٤٠٨٣	٣.٣٣٩٣

8: The researcher predict no significant statistical differences at significant level ($a == 0.05$) in the burnout total score due to the working place (hospitals) of the nurses.

To test the hypotheses we use the one way ANOVA test and the result in table no. (34),and table No.(35), which show that the P-Value for each field and a whole statements are greater than 0.05 and the value of F test less than the critical value F (=2.63 at degrees of freedom "3,116" and significance level 0.05) , so we fail to reject the hypotheses and conclude that there are no significant statistical differences at significant level ($a == 0.05$) in the burnout due to the working place of the nurses(hospitals)

Table No. (34)

One way ANOVA test due to the working place of the nurses of the nurse

Section	Source of variance	Sum of Squares	df	Mean Square	F	P - value
Burnout checklist	Between Groups	١.٧٨٢	٣	٠.٥٩٤	٢.٢٠٤	٠.٠٩١
	Within Groups	٣١.٢٦٥	١١٦	٠.٢٧٠		
	Total	٣٣.٠٤٨	٣			
Work stress checklist	Between Groups	١.٣٨٥	١١٦	٠.٤٦٢	١.٤٢٧	٠.٢٣٨
	Within Groups	٣٧.٥٣٩	٣	٠.٣٢٤		
	Total	٣٨.٩٢٥	١١٦			
Social support checklist	Between Groups	١.٤٤٩	٣	٠.٤٨٣	١.٥٤٠	٠.٢٠٨
	Within Groups	٣٦.٠٥١	١١٦	٠.٣١٣		
	Total	٣٧.٤٩٩	٣			
Total	Between Groups	٥٨٤.	١١٦	٠.١٩٥	١.١٤٩	٠.٣٣٣
	Within Groups	١٩.٦٥٧	٣	٠.١٦٩		
	Total	٢٠.٢٤١	١١٦			

The critical value F=2.63 at degrees of freedom "3,116" and significance level 0.05

Table no. (35)
Descriptive statistics for working place of the nurses

section	Mean (experience)			
	Al shifa hospital	The ophthalmology hospital	Al Dorra hospital	Al nassier hospital
Burnout checklist	٢.٧٠١٩	٢.٥٠٣٢	٢.٤٧١٢	٢.٣١٧٤
Work stress checklist	٣.٧٥١٠	٣.٤٣١٠	٣.٦٠٤٥	٣.٤٨٥٨
Social support checklist	٣.٣٨٩٠	٣.٥٦٧١	٣.٤٤٦٠	٣.٧١٩٧
Total	**٣.٤٩٦٨**	**٣.٣٠٠٠**	**٣.٣٦٩٧**	**٣.٣١٢٩**

§ Summary:

From the answers on the questions and the hypotheses we find that:

- The prevalence of Nurses total score of burnout percentage is 50.2%.
- The prevalence of Nurses suffering from work stress is 71.9% from the sample.
- The presence of Nurses social support is 69.8% from the sample.
- The variables age, sex, work place, experience &educational level did not affect in the burnout total score.

Chapter six

§*Discussion of results.*

§ *Recommendations & implications.*

§ Introduction:

After the results delivered from the previous chapter we need to discuss these results in order to compare the study with the historical background of the other research results in this field.

§ *Discussion:*

§ *The first question:*

What is the prevalence of burnout among the Palestinian nurses in Gaza city?

To find answer on this question my hypothesis was :The researcher predicts higher rates in total score of burnout at significant level ($a = 0.05$) among the Nurses.

- ***The result of my research is:***

We apply a one sample t test and the results show that for all statements of the field the average mean equal 2.51 and the weight mean equal 50.1% which is less than " 60%" and that means we fail to reject the hypotheses, so respondent of the sample agree that there exist a moderate rates of burnout with significant level ($a == 0.05$) and that due to:

- Its clear from all the studies which done before that social support from the moderating factors that decrease the burnout level, & this study show that social support is high.
- Another factor that may interfere with decreasing the burnout level is the high presence of religious nurses in the field which may fight the symptoms of burnout by continuous remembering them self that we must thank gad, we do the best to take the wages from gad, we must not surrender to this feeling or show them because they are from the despaired feeling that the devil generate them.
- Other factor was the psychological strengthening which generate from the Trans generation trauma resistance.
- According to the presence of Israeli occupation with all criminal behaviors acts towards the Palestinian, they develop the tolerance to the psychological strength, which appears in all traumas.

Many studies disagree with this hypothesis like the study of Li Calzi S (2006) indicate the level of burnout experienced was medium-low &Emotional exhaustion was more prevalent among physiotherapists, while depersonalization was higher among physicians while Hall L.2006 show an overall 'low to average' level of burnout, suggesting that New Zealand nurses.

But Many studies agree with this hypothesis like the study of Bakker AB.(2000*)* reported higher levels on two of the three core dimensions of burnout (i.e. emotional exhaustion and depersonalization) than those who did not experience such an imbalance, Lee H(2003) find 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 , Vimantaite R, & Seskevicius A. (2006) indicate the majority of the nurses working in the centers of cardiac surgery experience physical and psychological fatigue, emotional stress.

- ***The Second question:***

What's the relation between burnout and stress among the nurses?

To find answer on this question my hypothesis was: The researcher predicts higher rates of stressed nurses with significant statistical level at ($a == 0.05$) that positively related to the total score of burnout.

- ***My study results were:***

We apply a one sample t test and the results show that for all statements of the field the average mean equal 3.59 and the weight mean equal 71.90% which is greater than " 60%" and the value of t test equal 11.39 , so respondent of the sample agree that there exist higher rates of stressed nurses that positively related to burnout with significant level ($a == 0.05$) and that due to:

- The political situation which drop his shadow on all the life situations.

- The presence of stigma from the nurse job which cause a source of streets in the work between the patient and the nurse and between the nurses them selves.
- The nature of this job, the shifting, the night duty, the poor management of the job, and many other factors.
- The nature of the disease make the people anxious towered others and towered the medical team.
- The occupation presence and all the difficulties that the siege develops from the shortage of supplies , the prevention of patient transformation will all transferred to the nurse that work with this patient with all great demands that they wants.

Many studies agree with this hypothesis like the study of Lewis SL (1994) indicated that there was a positive correlation between perceived personal stress and work-related stress, especially work load, Oehler JM (1992) Discriminate function analysis revealed that job stress was the strongest significant predictor of burnout, followed by state anxiety, coworker support, Greenglass ER.(2001) show that, in hospitals undergoing restructuring, workload is the most significant and consistent predictor of distress in nurses, as manifested in lower job satisfaction, professional efficacy, and job security. Greater workload also contributed to depression, cynicism, and anxiety.

Other studies disagree with this hypothesis like the study of Stordeur S, (2006) In regression analyses, work stressors as a whole were found to explain 22% of the variance in emotional exhaustion whereas leadership dimensions explained 9% of the variance in that outcome measure.

§ ***The third question:***

What's the relation between burnout and social support of the nurses?

To find answer on this question the hypothesis was: The researcher predict higher rates of social support that positively related with the total score of burnout level at significant level ($a == 0.05$).

- ***The result of my research is:***

We apply a one sample t test and the results show that for all statements of the field the average mean equal 3.49 and the weight mean equal

69.85% which is greater than " 60%" and the value of t test equal 9.527 that means we fail to reject the hypotheses, so the respondent of the sample agree that there exist social support that positively related with the decrease of burnout level with significant level ($a == 0.05$) and that due to many things:

- The religious type of Gaza city that increase the strength of social chains between all the families.
- The nature of trauma that we all live in increase the social support ,because its known that in case of danger all people become together.

All the studies agree with this hypothesis like the study of Constable JF(1986) find the major determinants of burnout were found to be low job enhancement, Fong CM. (1990) indicated that a demanding job correlated, significantly and positively with almost all aspects of burnout (emotional exhaustion, depersonalization of students, and decreased sense of accomplishment) & Ogus ED. (1990) find That is, nurses with high sources of social support and high levels of satisfaction with that support reported less burnout than nurses with few supports and less satisfaction with those supports, regardless of level of work stress , Sundin (2006) showed statistically significant correlations between the three support indicators and all three burnout dimensions.

§ ***The fourth question:***

What's the relation between burnout and the sex of the nurses?

To find answer on this question the hypothesis was: The researcher predicts no significant statistical differences at level ($a == 0.05$) in the burnout total score due to the sex of the nurse.

- ***The result of my research is:***

To test the hypotheses we use the independent sample t test and the result which show that the P-Value for each field and whole statements are greater than 0.05 and the absolute value of T less than the T critical value (=1.98), so we fail to reject the hypotheses and conclude that there are no

significant statistical differences at significant level ($a == 0.05$) in the level of burnout due to the sex of the nurse**.**

The researched shows that there are no differences in the level of burnout due to these factors and that due to:

- The Gaza city hospitals are so close so all the variables affects them all in the same percentage.
- The entire sample suffers from the same factors with out discrimination.

Many studies disagree with this hypothesis like the study of Williams CA. (1989) Women had significantly higher empathy scores than men; however, men had higher scores than male normative groups & Brake H(2003) showed male dentists to report a higher score on the depersonalization dimension of the MBI than did female dentists.

But other studies incongruence with this hypothesis likes the study of Payne N. (2001) find the level of burnout (characterized by high emotional exhaustion, high depersonalization of patients and low personal accomplishment) was found to be low.

§ ***The fifth question:***

What's the relation between burnout and the age of the nurses?

To find answer on this question the hypothesis was: The researcher predicts no significant statistical differences at significant level ($a == 0.05$) in the burnout total score due to the age of the nurse.

- ***The result of my research is:***

To test the hypotheses we use the one way ANOVA test and the result, which show that the P-Value for each field and a whole statements are greater than 0.05 and the value of F test less than the critical value F (=3.01 at degrees of freedom "2,117" and significance level 0.05), so we fail to reject the hypotheses and conclude that there are no significant statistical differences at significant level ($a == 0.05$) in the level of burnout due to the age of the nurse.

The researched shows that there are no differences in the level of burnout due to these factors and that due to:

- The Gaza city hospitals are so close so all the variables affects them all in the same percentage.
- The entire sample suffers from the same factors with out discrimination.

Many studies disagree with this hypothesis like the study of Williams CA. (1989) which find that Age related negatively to depersonalization and emotional exhaustion for women, whereas percentage of work time spent in direct practice correlated with depersonalization for men.

§ ***The sixth question:***

What's the relation between burnout and educational level of the nurses?
To find answer on this question the hypothesis was: The researcher predicts no significant statistical differences at significant level ($a = 0.05$) in the burnout total score due to the educational level of the nurse.

-The result of my research is:
To test the hypotheses we use the one way ANOVA test and the result show that the P-Value for each field and a whole statements are greater than 0.05 and the value of F test less than the critical value F (=3.01 at degrees of freedom "2,117" and significance level 0.05), so we fail to reject the hypotheses and conclude that there are no there are no significant statistical differences at significant level ($a == 0.05$) in the level of burnout due to the educational level of the nurse.

The researched shows that there are no differences in the level of burnout due to these factors and that due to:

- The Gaza city hospitals are so close so all the variables affects them all in the same percentage.
- The entire sample suffers from the same factors with out discrimination.

-Many studies disagree with this hypothesis like the study of Fong CM. (1993) find Emotional exhaustion correlated significantly and positively

with a demanding job, time pressure, and feelings of job inadequacy & Burnout (i.e., emotional exhaustion, depersonalization of students, and a sense of decreased accomplishment) correlated significantly and negatively with social support from one's chairperson and peers ,& Cam O. (2001) indicated that the most significant predictor of EE was work-setting satisfaction, of DP was job pressure, and of PA was job satisfaction in nursing education settings in Turkey.

§ ***The seventh question:***

What's the relation between burnout and the nurses' experiences?

To find answer on this question the hypothesis was: The researcher predicts no significant statistical differences at significant level ($a == 0.05$) in the burnout total score due to the Nurses' experiences.

- ***The result of my research is:***

To test the hypotheses we use the one way ANOVA test and the result show that the P-Value for each field and a whole statements are greater than 0.05 and the value of F test less than the critical value F (=3.01 at degrees of freedom "2,117" and significance level 0.05), so we fail to reject the hypotheses and conclude that there are no significant statistical differences at significant level ($a == 0.05$) in the burnout due to the Nurses' experiences.

The researched shows that there are no differences in the level of burnout due to these factors and that due to:

- The Gaza city hospitals are so close so all the variables affects them all in the same percentage.
- The entire sample suffers from the same factors with out discrimination.

Many studies disagree with this hypothesis like the study of Wenderlein FU. (2003) find extremely high absenteeism of nursing trainee's calls for action on the part of school and hospital management.

§ The eight question :

What's the relation between burnout and the working place of the nurses?

To find answer on this question the hypothesis was: The researcher predicts no significant statistical differences at significant level ($a == 0.05$) in the burnout total score due to the working place (hospitals) of the nurses.

- ***The result of my research is:***

To test the hypotheses we use the one way ANOVA test and the result in table no. (34),and table No.(35), which show that the P-Value for each field and a whole statements are greater than 0.05 and the value of F test less than the critical value F (=2.63 at degrees of freedom "3,116" and significance level 0.05) , so we fail to reject the hypotheses and conclude that there are no significant statistical differences at significant level ($a == 0.05$) in the burnout due to the working place of the nurses(hospitals)

The researched shows that there are no differences in the level of burnout due to these factors and that due to:

- The Gaza city hospitals are so close so all the variables affects them all in the same percentage.
- The entire sample suffers from the same factors with out discrimination.

Many studies disagree with this hypothesis like the study of Lewis SL (1994) which indicated that there was a positive correlation between perceived personal stress and work-related stress, especially work load, the study of Vimantaite R, (2003) 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, Jenkins R, (2004) find also approximately half of all nursing

staff showed signs of high burnout in terms of emotional exhaustion & Bakker AB (2005) showed that burnout complaints among colleagues in intensive care units made a statistically significant and unique contribution to explaining variance in individual nurses' and whole units' experiences of burnout.

But Many studies agree with this hypothesis like the study of Papadatou D(1994) which find no statistically significant difference was revealed in the degree of burnout experienced by nurses in oncology and those in general hospitals ,Molassiotis A, &Haberman M. (1996) indicated that burnout among these nurses was low, Kilfedder CJ, (2001) had significantly lower scores on emotional exhaustion and depersonalization than normative data but also significantly lower levels of personal accomplishment than a normative group of physicians and nurses Barrett L, Yates (2002) indicate that over 70% of the sample experienced moderate to high levels. Over 48% of the sample could not commit to remaining in the specialty for a further 12 months ,Pinikahana (2005) indicated that low number rural psychiatric nurses suffered from 'high' level of burnout and the majority of nurses reported 'low level' of emotional exhaustion and depersonalization scores &Edwards D (2006) 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 heath nurses surveyed but Gillespie M, Melby V. (2006) shows that Nurses working in acute medicine experienced higher levels of emotional exhaustion than their A & E counterparts.

§ Recommendations & implications:

§ Nurse-nurse:

1. Better time management.

2. Building good social support from friends and family.

3. The recommendation for this study are that if nurses and other healthcare professionals are able to determine stressors and burnout in the work environment then they may be better able to handle problems when, and even before, they arise.

4. The identification of effective coping skills may be useful to deal with the work stress and the burnout symptoms.

§ Organization-nurse management:

1. Develop management philosophy and practice.
2. Redesign management systems.

3. Nurse Managers of the hospitals should be workers to help manage work stress, and burnout level.

4. The decision makers should be working to use this information to decrease the stressors and burnout that their employees face in the work environment.

5. This information would be particularly helpful to the nurse manager of the ministry of health &hospitals because many of the burnout symptoms & work stressors reported by the participants were the result of managerial issues.

6. Improved management systems.

7. Staff selection procedures.

8. improved nurse training,

9. Health promotion or employee counseling.

10. Organization development.

11. Redesign jobs and reorganize work systems.

12. Redesign of work technology and work environments.

13. Develop the structure and culture of the hospital organization.

§ Functional management:

1. Develop selection and placement systems.

2. Develop appraisal systems and career development structures.

3. Develop education and training functions.

4. Enhance occupational health function.

5. Improve health and safety systems.

6. The need for further research is needed in this area of research to Increase nursing's' body of knowledge, to increase the efficacy of patient care, and to decrease the burnout levels and work stress among nurse.

7. Development of organizational function and allocation of staff to wards.

8. Development of management function and style of management.

9. Review of communication and inter-group support at ward level.

10. Review and development of nurse training; and nurse counseling.

11. Choice of a suitable strategy to alleviate the burnout level and the work stress level.

12. Application of supervision program to deal with these psychological problems.

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

14. Seek support and commitment of hospital board and management, senior nursing and medical staff, and the relevant unions and professional associations.

15. Inform staff involved, and explain and market strategy to them, securing their involvement and ownership of intervention.

16. Develop realistic expectations from all stakeholders, based on informed understanding of problems, covering extent of change and timing.

17. Identify and secure necessary resources for intervention and for follow through (particularly if successful).

18. Provide clear, timely and meaningful communication with all staff involved during the development of the control intervention.

19. Establish a systematic basis for monitoring and evaluation of control strategies.

20. Develops programs to reduce burnout in the hospitals.

21. Need more researches to be done and more studies on this subjects.

STUDY ABSTRACTS

§*ENGLISH ABSTRACT.*

§*ARABIC ABSTRACT.*

Abstract

- The study aims to assess the psychological factors associated with burnout among nurses.
- The Study trying to test these hypotheses:

1. The researcher predict higher rates in total score of burnout at significant level ($a = 0.05$) among the Nurses.
2. The researcher predict higher rates of stressed nurses with significant statistical level at ($a == 0.05$) that positively related to the total score of burnout.
3. The researcher predicts higher rates of social support that positively related with the total score of burnout level at significant level ($a == 0.05$).
4. The researcher predict no significant statistical differences at level ($a == 0.05$) in the burnout total score due to the sex of the nurse.
5. The researcher predict no significant statistical differences at significant level ($a == 0.05$) in the burnout total score due to the age of the nurse.
6. The researcher predict no significant statistical differences at significant level ($a = 0.05$) in the burnout total score due to the educational level of the nurse.
7. The researcher predict no significant statistical differences at significant level ($a == 0.05$) in the burnout total score due to the Nurses' experiences.
8. The researcher predict no significant statistical differences at significant level ($a == 0.05$) in the burnout total score due to the working place (hospitals) of the nurses.

- In order to test these 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 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($a == 0.05$).
- The recommendations of the study are: Improve the management systems, Redesign jobs and reorganize work system according to job description, Improve health safety systems & activate psychological counseling.

ملخص الدراسة

- هدفت الدراسة الى بحث العوامل النفسية المرتبطة بالاحتراق الوظيفي بين التمريض في مدينة غزة .
- حاولت الدراسة اختبار الفرضيات الاتية:

١- توجد فروق دالة احصائية عند مستوى دلالة (0.05) في درجة الاحتراق الوظيفي بين الممرضين.

٢- توجد فروق دالة احصائية عند مستوى دلالة (0.05) في مستوى ضغوط العمل لها علاقة ايجابية بدرجة الاحتراق الوظيفي بين الممرضين .

٣- توجد فروق دالة احصائية عند مستوى دلالة (0.05) في مستوى الدعم الاجتماعي لها علاقة عكسية بدرجة الاحتراق الوظيفي بين الممرضين.

٤- لا توجد فروق دالة احصائية عند مستوى دلالة (0.05) في درجة الاحتراق الوظيفي تعزى لمتغير الجنس بين الممرضين.

٥- لا توجد فروق دالة احصائية عند مستوى دلالة (0.05) في درجة الاحتراق الوظيفي تعزى لمتغير العمر بين الممرضين.

٦- لا توجد فروق دالة احصائية عند مستوى دلالة (0.05) في درجة الاحتراق الوظيفي تعزى لمتغير مستوى التعليم بين الممرضين.

٧- لا توجد فروق دالة احصائية عند مستوى دلالة (0.05) في درجة الاحتراق الوظيفي تعزى لمتغير سنوات الخبرة بين الممرضين.

٨- لا توجد فروق دالة احصائية عند مستوى دلالة (0.05) في درجة الاحتراق الوظيفي تعزى لمتغير مكان العمل بين الممرضين.

- لاختبار هذه الفرضيات تم اتباع المنهج الوصفي التحليلي ،وقد كانت و قد كانت عينة الدراسة تتكون من ١٢٢ ممرض و ممرضة موزعين على ٥ مستشفيات و هي مستشفى الشفاء، مستشفى العيون ، مستشفى النصر للأطفال و مستشفى الدرة للأطفال و مستشفى الطب النفسي ، بما يتضمن ذلك من اقسام مختلفة مثل قسم العناية المركزة لحديثي الولادة (الحضانة) .قسم الكلية الصناعية ، قسم الأورام و الدم ،قسم باطنة حريم ،قسم الصدرية ،قسم الطواريء ، وحدة العناية المكثفة للحروق ،قسم الولادة ،قسم العناية المركزة للأطفال ،قسم الإدارة ،قسم الباطنة للأطفال .

- تم استخدام عدة مقاييس لقياس الفرضيات مثل :مقياس الاحتراق الوظيفي للتمريض ، مقياس ضغوط العمل للتمريض ،مقياس الدعم الإجتماعي للتمريض ،مقياس لقياس العمر و الجنس و المستوى التعليمي و سنوات الخبرة .

- تم استخدام الاختبارات الاحصائية مثل:اختبار ألفا – كرونباخ لقياس الثبات في المقياس ،معامل ارتباط بيرسون لقياس الصدق في المقياس ، سبيرمان – براون ،اختبار العينة الأحادية ت ،و العينة المستقلة ،و اختبار طريقة انوفا.

- وجدت نتائج الدراسة كالاتي: مستوى الاحتراق الوظيفي لدى الممرضين كان بنسبة ٥٠%، مستوى ضغوط العمل كان مرتفعاً بنسبة ٧٢% و قد وافق الفرضية الخاصة به ،مستوى الدعم الاجتماعي كان مرتفعاً بنسبة ٧٠% و قد وافق الفرضية الخاصة به ،مستوى الاحتراق الوظيفي لم يكن ذا دلالة احصائية عند المستوى $(a == 0.05)$ بالمقارنة مع المتغيرات الجنس، العمر ، سنوات الخبرة ،مكان العمل.
- أهم التوصيات لهذه الدراسة هي : تحسين النظام الإداري ،اعادة تصميم نظام عمل وفق منظومة التوصيف الوظيفي ، تحسين منظومة الأمان الصحي وتفعيل نظام الإرشاد النفسي للموظفين.

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Appendices

§*Arabic checklist.*

01. BURNOUT CHECKLIST (ARABIC).

02. WORK STRESS CHECKLIST (ARABIC).

03. SOCIAL SUPPORT CHECKLIST (ARABIC).

§*English checklist.*

04. BURNOUT CHECKLIST.

05. WORK STRESS CHECKLIST.

06. SOCIAL SUPPORT CHECKLIST.

§*The judgmental professionals Table.*

Appendix 1

بسم الله الرحمن الرحيم

أخي الممرض .... أختي الممرضة ....

كل التحية و التقدير لكم بما تبذلونه من جهد لخدمة المرضى ليلاً و نهاراً، برغم الظروف الصعبة التي نعيشها ....

أتقدم اليكم أنا زميلكم الممرض أدهم عزات العمصي الطالب بكلية التربية بالجامعة الإسلامية لنيل الماجستير في الصحة النفسية بهذه الإستبانة لقياس ظاهرة الإحتراق الوظيفي و ما يصاحبها من عوامل نفسية بين طبقة التمريض راجياً من سيادتكم المشاركة و المساعدة من خلال وضع اشارة صح او خطا أمام العبارة التي تناسبك

وأود أن أحيطكم علماً بأن الإجابات سوف تكون سرية ، ولأغراض البحث العلمي ، و لذلك فأرجو منك أن تجيبوا بصراحة و بموضوعية ،علماً بأن نتائج هذه الدراسة سوف يكون لصالح المجتمع الفلسطيني .

يمكنك الإعتذار عن المشاركة اذا لم ترغب و لكم جزيل الشكر لتعاونك معنا.

رقم الإستمارة _____ .

الجنس : ذكر _____ انثى _____ .

العمر : _____ .

الشهادة العلمية الحاصل عليها :

دبلوم _____ بكالوريوس _____ ماجستير _____ .

سنوات الخبرة في مجال التمريض بعد التخرج : _____ .

القسم الذي تعمل فيه : _____ .

المستشفى _____ .

_____ _____

مقياس الإحتراق الوظيفي للتمريض

تعليمات تعبئة الإستمارة : فيما يلي عدد من العبارات التي تقيس بعض مظاهر السلوك، أرجو منك قراءة كل سؤال بدقة و فهم ، علماً بانه يوجد لكل إجابة ٥ خيارات:
لا أوافق : اذا كانت العبارة لا تناسبك تماماً .نادراً ، اذا كانت العبارة في بعض المرات القليلة جداً تلائمك ،أحياناً : اذا كانت العبارة تناسبك في بعض الأوقات .أوافق : اذا كانت العبارة تناسبك في أغلب الأوقات .أوافق بشدة : اذا كانت العبارة تنطبق عليك في جميع الأوقات و الحالات بشكل تام .

ضع اشارة صح في المربع امام العبارة التي تناسبك :

الرقم	العبارة	لا أوافق	نادراً	أحياناً	أوافق	أوافق بشدة
أولاً: الإعياء العاطفي						
١.	أنا أصْبَحتُ أكثرَ قساوةً نحو الناسِ منذ أن عملت في هذا العمل.					
٢.	أشعر بالخوف أن هذا العمل يقسِي مشاعري					
٣.	أشعر بأني مُحبطاً في عملي					
٤.	أشعر بأني محترق وظيفياً					
٥.	أشعر بأن المرضى يَلُومونَني على البعض مِنْ مشاكِلِهم.					
٦.	أشعر بأن العَمَل مَع الناسِ يَضِعُ إجهادَ أكثر من اللازمَ مباشرة عليّ و أن العَمَل مَع الناسِ طِوال النهار حقاً هوإجهاد لي.					
٧.	أشعر كأني على وشك السقوط من علو.					
٨.	أشْعرُ بأنّ طريقتي تعاملي مع بَعْض المرضى كما لو أنَّهم مجرد أشياء					
٩.	أشعر بأني غير مهتم حقاً بما قد يحدث لبعض المرضى					
ثانياً : الإنجاز الشخصي						
١٠.	أشعر بأني أنجزتُ العديد مِنْ الأشياءِ النافعةِ في هذا العمل					
١١.	أشعر بأني يُمْكِنُ أنْ أخْلقَ بسهولة جوّاً مريحاً مَع مرضاي.					
١٢.	أشعر بأني أتعاملُ بشكل فعال مع مشاكل مرضاي.					

الرقم	العبـــارة	لا أوافق	نـادراً	أحياناً	أوافق	أوافق بشدة
١٣.	أَشْعرُ باني أُؤثرُ على حياةِ الناس الآخرين بشكل إيجابي خلال عملِي.					
١٤.	أشعر بأني في عملِي، أتعاملُ مع المشاكلِ العاطفيةِ بشكل هادئ جداً.					
١٥.	أشعر بأنه يُمْكِنُ أنْ أفْهمَ بسهولة ما يشْعرُبه مرضاي حول الأشياءِ.					
١٦.	أبْدو نشيطاً جداً.					
ثالثاً : الإعياء الجسدي						
١٧.	أشعر بأن هذا العمل يجعلني جافّ عاطفياً.					
١٨.	أشعربالإرْهَاق عندما أنْهضُ في الصباحِ وأنه يَجِبُ علي أنْ أُواجهَ يومَ آخرَ في العمل					
١٩.	أَشْعرُ بأني أعْملُ بجدّ خلال عملي .					

Appendix 2

ثانياً : مقياس ضغوط العمل في مهنة التمريض

تعليمات تعبئة الإستمارة : فيما يلي عدد من العبارات التي تقيس بعض مظاهر السلوك، أرجو منك قراءة كل سؤال بدقة و فهم ، علماً بانه يوجد لكل إجابة ٥ خيارات:
لا أوافق : اذا كانت العبارة لا تناسبك تماماً .نادراً : اذا كانت العبارة في بعض المرات القليلة جداً تلائمك .أحياناً : اذا كانت العبارة تناسبك في بعض الأوقات .أوافق : اذا كانت العبارة تناسبك في أغلب الأوقات .أوافق بشدة : اذا كانت العبارة تنطبق عليك في جميع الأوقات و الحالات بشكل تام .ضع اشارة صح في المربع امام العبارة التي تناسبك :

الرقم	العبـــــارة	لا أوافق	نادراً	أحياناً	أوافق	أوافق بشدة
أولاً : ضغوط نفسية بسبب سوء التنظيم الإداري للمهنة:						
١.	الفهم الخاطيء لطبيعة مهنة التمريض .					
٢.	عدم وجود تواصل بين القمة و القاعدة في التمريض					
٣.	عدم توفر البيئة لحَلّ المشكلات التي تواجه التمريض					
٤.	عدم توفر البيئة للتطوير و الإبداع في المهنة					
٥.	عدم اعطاء الفرصة لدى التمريض للمشاركة في صنع القرار					
٦.	عدم وجود توصيف وظيفي لمهنة التمريض					
٧.	عدم وضوح المسؤوليات					
٨.	العمل مُمَزَّق و بعيد عن الادارة الجيدة					
٩.	عدم تناسب الراتب مع طبيعة العمل					
١٠.	وجود العملِ الزائدَ عن طاقة الممرض					
١١.	المستويات العالية للخَطورة و العدوى					
١٢.	قلة السيطرةِ على الخَطورة و العدوى					
١٣.	عدم وجود شبكة أمان لحماية الممرض بعد تعرضه للعدوى					
١٤.	عدم توفير الامكانات والتحضيراتِ للتَعَامُل مع المرضى و عائلاتهم					
١٥.	وجود القلق حول العلاج والعنايةِ بالمريض					
١٦.	وجود نَقْص في التمريض والمصادرَ					
ثانياً : ضغوط نفسية بسبب بيئة العمل داخل المهنة:						
١٧.	وجود حيرةٍ في مستقبل المهنةِ					
١٨.	ركود المهنةِ و عدم وجود الفرص لتقدم التمريض					
١٩.	وجود غموض في دور المهنة					

الرقم	العبـــــارة	لا أوافق	نادراً	أحياناً	أوافق	أوافق بشدة
٢٠.	صعوبةأخذ الاجازات و الاعياد					
٢١.	العمل بلا معنى					
٢٢.	سوء إستعمال المهارات التمريضيةِ					
٢٣.	قلة السيطرةِ على محتوى العملِ					
٢٤.	وجود ضغط الوقتِ وعدم كفايته لانجازالعمل					
٢٥.	الدوام المتقلّب و عدم الاستقرار					
٢٦.	عدم توقع أوقات الدوام					
٢٧.	وجود الساعات الطويلة في العمل التي تعيق المناسبات الإجتماعية					
٢٨.	قلة السيطرةِ على ساعاتِ العمل					
٢٩.	العمل من خلال فريق					
٣٠.	تضاربُ متطلباتَ العملِ مع متطلبات البيتِ					
٣١.	عدم توفير الامكانات والتحضيراتِ للتَعَامُل مع حالات موتِ أواحْتَضار المرضى					
٣٢.	المرضى لا يفهمون بأنّه جيدُ لهم ما يقوم به الممرض/ة.					
٣٣.	تَعتمدُ عائلةُ المرضى بشدّة على التمريض					
٣٤.	تصرّفُ عائلةُ المريض و كانهم يملكون الممرض/ة .					
ثالثاً : ضغوط نفسية سببها الاخرون داخل بيئة العمل:						
٣٥.	بيئة العمل سيئة داخل المستشفى					
٣٦.	عدم وجود مرونة في جداول المستشفى					
٣٧.	كثرة العمل بالمناوبات الليلية					
٣٨.	عدم وجود العِلاقات الشخصية في العمل مما يؤدي الى عزلة إجتماعية					
٣٩.	وجود الصراع مَع أفراد التمريض الأخرين					
٤٠.	وجود الصراع مَع الموظّفين الآخرين داخل المستشفى					
٤١.	وجود العنف اللفظي من أهل المريض نحو التمريض					
٤٢.	وجود العنف الجسدي من أهل المريض نحو التمريض					
٤٣.	يَتصرّفُ المرضى كانهم يملكون التمريض.					
٤٤.	عدم توفر الثقة في الخطة العلاجية التي يقررها الأطباء وينفذها التمريض.					

الرقم	العبـــــــــارة	لا أوافق	نادرا	أحياناً	أوافق	أوافق بشدة
٤٥.	المرضى لا يَفهمونَ الذي أقدمه لهم من خدمات .					
٤٦.	يَتصرّفُ المريضُ بشكل أناني أو بدون تعاون.					
رابعاً : ضغوط نفسية سببها المشرفين والمدراءِ :						
٤٧.	العلاقة سيّئة مَع المشرفين والمدراء					
٤٨.	سلوك ومواقف الأطباءِ السيئة نحو التمريض					
٤٩.	يَتصرّفُ المشرفونُ بشكل أناني من منطلق المصلحة الشخصية.					
٥٠.	المشرفون لا يَفْهمونَ عملي.					
٥١.	يُميّزُ المشرفونُ مِنْ زميلِ العمل الآخرِ.					
٥٢.	يُجبرُ المشرفونُ التمريض على طريقة التفكير والعْملُ بحسب ما يريدون.					
خامساً: ضغوط نفسية سببها عوامل خارجية						
٥٣.	وجود القلقِ بسبب عدم توفر الرواتب					
٥٤.	وجود القلق بسبب العنف الاسرائيلي و الحصارالمستمر					
٥٥.	وجود القلق بسبب استشهاد أو اصابة أحد أفراد عائلة الممرض/ة					
٥٦.	وجود القلق بسبب وفاة أحد افراد عائلة الممرض/ة					
٥٧.	وجود القلق بسبب الوضع الصحي السيء لأحد أفراد عائلة الممرض/ة					
سادساً : ضغوط نفسية سببها و مصدرها من الممرض نفسه						
٥٨.	طبيعة المهنة التي تعيق اداء الواجبات الدينية في بعض الاوقات					
٥٩.	وجود القلق بسبب المشاكل الإجتماعيةِ و النفسيةِ لدى الممرض/ة					
٦٠.	وجود القلق بسبب الوضع السياسي المتقلب .					
٦١.	وجود القلق بسبب الوضع الصحي السيء لدى الممرض/ة					

Appendix 3

ثالثاً: مقياس المساندة الإجتماعية لدى التمريض

تعليمات تعبئة الإستمارة : فيما يلي عدد من العبارات التي تقيس بعض مظاهر السلوك، أرجو منك قراءة كل سؤال بدقة و فهم ، علماً بانه يوجد لكل إجابة ٥ خيارات:
لا أوافق : اذا كانت العبارة لا تناسبك تماماً .نادراً : اذا كانت العبارة في بعض المرات القليلة جداً تلائمك .

أحياناً : اذا كانت العبارة تناسبك في بعض الأوقات .أوافق : اذا كانت العبارة تناسبك في أغلب الأوقات .أوافق بشدة : اذا كانت العبارة تنطبق عليك في جميع الأوقات و الحالات بشكل تام .

ضع اشارة صح في المربع امام العبارة التي تناسبك :

الرقم	العبـــــارة	لا أوافق	نادراً	أحيانا	أوافق	أوافق بشدة
أولاً: الدعم الإجتماعي مِن قِبل المشرفين:						
١.	يُمْكِنُ بسهولة أنْ تَتكلّمَ مع مشرفِكَ					
٢.	بالإمكان أنْ تَعتمدُ على مشرفِكَ عندما تواجهك صعوبات					
٣.	مشرفكَ يَعترفُ بانجازك ويُقيّمُ عملك					
٤.	مشرفكَ يَتعاونُ مَعك للحَلّ عندما تواجهك صعوبات					
٥.	يقدم لك مشرفك الدعم الكافي					
ثانياً: الدعم الإجتماعي مِن قِبل زملاءِ العمل:						
٦.	يُمْكِنُ بسهولة أنْ تَتكلّمَ مع زميل عملكَ					
٧.	يُمْكِنُ أنْ تَعتمدَ على زميل عملكَ عندما تواجهك صعوبات					
٨.	زميل عملكَ يَعترفُ بانجازك ويُقيّمُ عملك					
٩.	زميل عملكَ يَتعاونُ مَعك للحَلّ عندما تواجهك صعوبات					
١٠.	يقدم لك زميل عملكَ الدعم الكافي					
ثالثاً : الدعم الإجتماعي مِن قِبل العائلةِ:						
١١.	يُمْكِنُ بسهولة أنْ تَتكلّمَ مع عائلتِكَ					

الرقم	العبـــــارة	لا أوافق	نادراً	أحيانا	أوافق	أوافق بشدة
١٢.	يمكن أنْ تَعتمدُ على عائلتِكَ عندما تواجهك صعوبات					
١٣.	عائلتكَ تَعترفُ بانجازاتك وتُقيّمُ عملك					
١٤.	تَتعاونُ مَعك عائلتكَ للحَلّ عندما تواجهك صعوبات					
رابعاً: الدعم الإجتماعي مِن قِبل الأصدقاءِ						
١٥.	يُمْكِنُ بسهولة أنْ تَتكلّمَ مع صديقِكَ					
١٦.	يمكن أنْ تَعتمدُ على صديقِكَ عندماتواجهك صعوبات					
١٧.	صديقكَ يَعترفُ بانجازاتك ويُقيّمُ عملك					
١٨.	يَتعاونُ مَعك صديقكَ للحَلّ عندما تواجهك صعوبات					
١٩.	تَستلمُ مِنْ صديقِكَ الدعم الكافي					
٢٠.	تقدم لك المؤسسات الاجتماعية الدعم الكافي					

Appendix 4

English checklist

- *Background Information*

The following pages are questions that will be collected and used as part of this research to achieve the master degree in community mental health. Read each question carefully and answer all questions to your best ability. Please circle or write in the appropriate number.

Sex: Male _____ Female _____

Your age: _____

Please indicate your level of education:

Diploma _____

B.A. or B. S. _____

M. A. or M. S._____

The number years you have worked in this nursing employment _____

What unit do you currently work in? _____

The hospital you working in _____

_____ _____

1-Burnout checklist

NUMBER	THE SENTENCE	NOT AGREE	RARELY	SOMETIMES	AGREE	STRONGLY AGREE
First: Emotional Exhaustion/Depersonalization (EE+DP)						
1.	I've become more callous toward people since I took this job.					
2.	I worry that this job is hardening me emotionally.					
3.	I feel frustrated by my job.					
4.	I feel burned out from my work.					
5.	I feel patients blame me for some of their problems.					
6.	Working with people directly puts too much stress on me. Working with people all day is really a strain for me.					
7.	I feel like I'm at the end of my rope.					
8.	I feel I treat some patients as if they were impersonal 'objects'.					
9.	I don't really care what happens to some patients.					
Second: Personal Accomplishment (PA)						
10.	I have accomplished many worthwhile things in this job.					
11.	I can easily create a relaxed atmosphere with my patients.					
12.	I deal very effectively with the problems of my patients.					
13.	I feel I'm positively influencing other people's lives through my work.					
14.	In my work, I deal with emotional problems very calmly.					
15.	I can easily understand how my patients feel about things.					

_____ _____

NUMBER	THE SENTENCE	NOT AGREE	RARELY	SOMETIMES	AGREE	STRONGLY AGREE
16.	I feel very energetic.					
Third : Physical Exhaustion (PE)						
17.	I feel emotionally drained from my work.					
18.	I feel fatigued when I get up in the morning and have to face another day on the job.					
19.	I feel I'm working too hard on my job.					

Appendix 5

2-Work stress checklist

The number	The sentences	Not agree	rarely	Some times	agree	Not agree
First: stressors due to poor management of the nursing profession.						
١.	The misunderstanding to the nature of nursing profession.					
٢.	The absence of communication between the top and the base of the nursing.					
٣.	The absence of the environment to solve the problems that face the nurses.					
٤.	Absence of creative environment in the profession,					
٥.	Absence of the opportunities to the nursing for decision making participation.					
٦.	Absence of job description.					
٧.	Vague responsibilities.					
٨.	The work is distorted and far from good management.					
٩.	The inappropriate wages according to the nature of the work.					
١٠.	The presence of work overload.					
١١.	The high levels of danger and infections.					
١٢.	Poor control on the danger and infections transmission to the nurses.					
١٣.	The absence of protective securing measures to the nurse after he has been infected.					
١٤.	Absence of resources and preparation to deal with patients and their families.					
١٥.	The presence of anxiety about treatment and care plane.					
١٦.	The shortage of nursing and resources.					
Second: stressors due to the work environment						
١٧.	Vague future of the profession.					
١٨.	Absence of opportunities for development and progression of the nurse.					
١٩.	Vague of the role of nursing profession,					

The number	The sentences	Not agree	rarely	Some times	agree	Not agree
٢٠.	It is difficult to take your holiday or ead.					
٢١.	The work is meaningless.					
٢٢.	Misuse of nursing skills.					
٢٣.	Lack of control on the work content.					
٢٤.	The presence of time pressure to achieve the work.					
٢٥.	The continuous shifting without stability.					
٢٦.	Inability to predict the work time.					
٢٧.	Long working time prevents the social interaction.					
٢٨.	Inability to control the over the work time.					
٢٩.	Working through a team.					
٣٠.	The conflict between work requirement and home requirement.					
٣١.	Lack of preparation and resources to deal with gasping or dying people.					
٣٢.	Clients don't understand that it is good for them.					
٣٣.	Client's family depends too heavily on you.					
٣٤.	Client's family behaves high-handedly.					
Third: stressors caused by others in the work environment						
٣٥.	Bad work environment in the hospital.					
٣٦.	The rigidity of work shifts programs,					
٣٧.	A lot of night shifts duty.					
٣٨.	Absence of personal relation which lead to social isolation.					
٣٩.	The presence of conflict with other nurses.					
٤٠.	The presence of conflict with other employers inside the hospital.					
٤١.	The presence of verbal hostility from the client's family towards the nurses.					
٤٢.	The presence of physical hostility from the client's family towards the nurses.					
٤٣.	Client's family behaves high-handedly.					

The number	The sentences	Not agree	rarely	Some times	agree	Not agree
٤٤.	Absence of trust in the care plane that physicians decide and nurses applied.					
٤٥.	Clients don't understand the services that I applied for them.					
٤٦.	Clients behave selfishly or uncooperatively.					
Fourth: stressors caused by supervisors and managers						
٤٧.	Bad relation with the supervisors and the managers.					
٤٨.	Bad attitude and behavior of physician towards nurses.					
٤٩.	Supervisors behave selfishly and inconsistently.					
٥٠.	Supervisors don't understand my job.					
٥١.	Supervisors discriminate from another coworker.					
٥٢.	Supervisors force the way of thinking and doing.					
Fifth: stressors caused by other factors.						
٥٣.	Anxiety related to lateness or absence of salaries.					
٥٤.	Anxiety related to Israeli violence and siege.					
٥٥.	Anxiety related to martyr or injury of a member of the nurse family.					
٥٦.	Anxiety related to death of a member of nurse family.					
٥٧.	Anxiety related to bad health status of a member of nurse family					
Sixth: stressors caused by the nurse himself.						
٥٨.	The nature of profession delay the achievement of religious duties sometimes,					
٥٩.	Anxiety related to the presence of social or psychological problems.					
٦٠.	Anxiety related to the unstable political problem.					
٦١.	Anxiety related to the bad health status of the nurse himself.					

Appendix 6

3-Social support checklist

The number	The sentence	Not agree	rarely	Some times	agree	Strongly agree
First: Social support by supervisors:						
1.	You can easily talk to your supervisor**.**					
2.	You can rely on your supervisor when there are difficulties.					
3.	Your supervisor recognizes and values your job**.**					
4.	Your supervisor cooperates with you to solve when there are difficulties**.**					
5.	**YOU** receive from you supervisor much support.					
Second: Social support by coworkers:						
6.	You can easily talk to your coworker**.**					
7.	You can rely on your coworker when there are difficulties.					
8.	Your coworker recognizes and values your job**.**					
9.	Your coworker cooperates with you to solve when there are difficulties**.**					
10.	**YOU** receive from your coworker much support.					
Third: Social support by family						
11.	You can easily talk to your family**.**					
12.	You can rely on your family when there are difficulties.					
13.	Your family recognizes and values your job**.**					
14.	Your family cooperates with you to solve when there are difficulties**.**					
Fourth: Social support by friends						
15.	You can easily talk to your friend**.**					
16.	You can rely on your friend when there are difficulties.					

_____ _____

The number	The sentence	Not agree	rarely	Some times	agree	Strongly agree
17.	Your friend recognizes and values your job.					
18.	Your friend cooperates with you to solve when there are difficulties**.**					
19.	**YOU** receive from your friend much support.					
20.	**YOU** receive much support from the social organization**.**					

Appendix 7

§ ***The judgmental professionals Table.***

number	The professional	SPECIALITY	The place of work
01.	DR.SAMIER QUTTA.	PSYCHOLOGYST.	ISLAMIC UNIVERSITY /GAZA.
02.	DR.ATEF EL AGA.	PSYCHOLOGYST.	ISLAMIC UNIVERSITY /GAZA.
03.	DR.NABEL DOKHAN.	PSYCHOLOGYST.	ISLAMIC UNIVERSITY /GAZA.
04.	DR.YOSEF EL JESH.	PUBLIC HEALTH PROFESSIONAL	ISLAMIC UNIVERSITY /GAZA.
05.	DR .BASHER EL HAJJAR.	MENTAL HEALTH PROFESSIONAL.	ISLAMIC UNIVERSITY /GAZA.
06.	DR.SALEH ABU HATAB.	PSYCHOLOGYST.	GAZA COMMUNITY MENTAL HEALTH PROGRAM

تمت بحمد الله