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Burnout Levels and Coping Strategies Among Nurses Working at Psychiatric Hospitals

Prepared By:

M.Sc. Student Ali Hajim Shamkhi

Supervised By:

Prof. Dr. Qahtan Hadi Hussein, PhD

A Thesis

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﴿ أَمَّنْ هُوَ قَٰنِتٌ ءَانَآءَ ٱلَّيْلِ سَاجِدًا وَقَآئِمًا يَحْذَرُ ٱلْءَاخِرَةَ وَيَرْجُوا۟ رَحْمَةَ رَبِّهِۦ ۗ قُلْ

هَلْ يَسْتَوِى ٱلَّذِينَ يَعْلَمُونَ وَٱلَّذِينَ لَا يَعْلَمُونَ ۗ إِنَّمَا يَتَذَكَّرُ أُو۟لُوا۟ ٱلْأَلْبَٰبِ ۝٩ ﴾

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Supervisor Certificate

This is to certify that the thesis entitled **"Burnout levels and coping strategies among nurses working at psychiatric hospitals"** submitted by **M.Sc. student Ali Hajim Shamkhi** to the University of Babylon, College of Nursing, is in partial fulfillment of requirements for the degree of master's in science of nursing. Under our supervision and direction, the student conducted the thesis work.

Signature of the Supervisor:

Prof. Dr. Qahtan H. Hussein, PhD

Date: / /2023

Signature

Head of the Psychiatric and Mental Health Nursing Department:

Prof. Dr. Amean A. Yasir, PhD

Date: / /2023

Committee Certification

We, the members of the Thesis Examination Committee, certify that we have reviewed the thesis entitled **"Burnout levels and Coping Strategies among Nurses Working at Psychiatric Hospitals,"** conducted by the **M.Sc. student Ali Hajim Shamkhi**, and examined the researcher's thesis contents and what is related to them in 2022-2023. We decided that the thesis is accepted in partial fulfillment of the requirements for the degree of master's in science of nursing.

Approved by the Council of the College of Nursing

Signature Member:
Prof. Dr. Fatima Wanas Khudair, PhD
Date: / /2023

Signature Member:
Lecturer Dr. Ali Ahmad Kadhim, PhD
Date: / /2023

Signature of the Dean:
Prof. Dr. Amean A. Yasir, PhD
Date: / / 2023

Signature Chairperson:
Prof. Dr. Amean A. Yasir, PhD
Date: / /2023

Dedication

My parents have always hoped that I would achieve important things, and I have written this in honor of their hopes and dreams for me. with all my love and respect to my brothers, sisters, and daughter. I value and respect your unwavering loyalty, dear wife.

Ali Hajim Shamkhi 2023

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Abstract

Background: Burnout, a state of severe stress causing emotional, mental, and sometimes physical exhaustion in the workplace, is a significant problem for healthcare professionals. The coping strategies, which are cognitive and behavioral efforts made to reduce external and internal demands.

objectives: to assess burnout levels and coping strategies among psychiatric nurses and determine the association between the two.

Materials and methods: employed a quantitative descriptive correlational approach and utilized self-reported questionnaires, namely the Maslach Burnout Inventory and the Brief Cope Scale. Data collection involved a non-probability purposive sampling method and targeted 150 mental health nurses working in Ibn-Rushed and Al-Rashad psychiatric hospitals in Baghdad, Iraq. conducted between September 19th, 2022, and June 1st, 2023.

Results of the study: showed that 39.3% of nurses experienced moderate exhaustion, 58% experienced high depersonalization, and 92% experienced low personal accomplishment. Coping strategies aimed at managing emotions and avoiding stressors resulted in increased exhaustion and depersonalization, while problem-focused strategies decreased these and boosted personal accomplishment. Furthermore, burnout levels varied significantly based on age, gender, education level, marital status, and income. In terms of occupational data, longevity in psychiatric units reduced burnout, whereas additional administrative tasks and external jobs exacerbated it, with no impact from the workplace, shifts, or daily work hours.

Conclusion and recommendations: Burnout is significantly evident among psychiatric nurses in Baghdad, influenced mainly by their coping strategies. Problem-solving approaches are most beneficial. Psychiatric hospitals should introduce training on these coping methods, offer counseling services, and reevaluate nurses' administrative tasks. Strategies like staff rotations and tailored interventions for younger or financially challenged nurses.

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Table of Abbreviations

Abbreviations	Meaning
BOS	Burnout Syndrome
ICD-11	International Classification of Diseases, 11th edition
WHO	World Health Organization
EE	Emotional Exhaustion
DP	Depersonalization
PA	Personal Accomplishment
BOS	Burnout Syndrome
ICD-10	International Classification of Diseases, 10th edition
BM	Burnout Measure
MBI-HSS	Maslach Burnout Inventory Health Services Survey
Likert scale	A psychometric scale commonly used in surveys
Coefficient alpha	A measure of internal consistency or reliability of a scale
DSM-5	Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition
MBI	Maslach Burnout Inventory
ANOVA	Analysis of Variance
n	Sample size
No.	Number
%	Percentage

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Chapter One:

Introduction

Chapter One: Introduction

1.1. Overview:

In contemporary occupational psychology, the phenomenon of burnout has emerged as a critical area of investigation, reflecting the challenges individuals face in a fast-paced, demanding globalized workplace. Historically, burnout syndrome was first described in the 1970s by psychologist Herbert Freudenberger, who observed a unique pattern of physical and emotional exhaustion among professionals, notably those in caregiving and service roles. Since then, the construct has evolved into a multidimensional concept characterized predominantly by three facets: emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment (Cooper, 2018)

Burnout syndrome stems from a complex interplay of individual, interpersonal, and organizational factors (Hofmeyer *et al.*, 2020). It is not merely a response to long hours or a hefty workload but arises from discrepancies between the demands of the job and the resources, both internal and external, to cope with those demands (Dyrbye *et al.*, 2019). Furthermore, an individual's personality, their motivations for entering the profession, and their coping mechanisms can all modulate the experience of burnout (López-López *et al.*, 2019). The consequence of unchecked burnout can be profound, leading not just to decreased job performance but also to serious health complications, both mental (such as depression and anxiety) and physical (including cardiovascular issues and compromised immune function) (Amoafo *et al.*, 2015).

Burnout is pervasive across various professions. However, professions like social work, nursing, teaching, policing, and medicine stand out, as practitioners in these fields often grapple with high burnout rates. This is largely because their roles involve emotionally charged, highly stressful interactions, frequently with challenging clients (Maslach & Jackson, 1986).

The ubiquitous nature of these symptoms across varied professions, from healthcare to education, underscores burnout's pervasive threat (Anderson, 2000). It affects not only the professionals experiencing it but also the institutions they represent and the communities they serve (Rodríguez-Rey *et al.*, 2019). Therefore, understanding the nuances of burnout syndrome is of paramount importance, necessitating comprehensive research and interventions tailored to specific occupational settings (Thrush *et al.*, 2019).

In recent years, the advent of technologically driven workplaces, the blurring of work-home boundaries, and the pervasive nature of connectivity have added new layers to the burnout conversation. These changes have both exacerbated traditional burnout stressors and introduced novel challenges. As the landscape of work continues to evolve, so too must we promote our understanding of burnout and the strategies employed to mitigate its effects (Pastores *et al.*, 2019).

Moreover, the prevalence of burnout syndrome across various sectors cannot be overstated. Recent surveys have shown alarming rates, with some professions, such as medical practitioners and teachers, reporting burnout levels exceeding 50%. Such a high prevalence not only underscores the personal toll but also highlights the larger socio-economic implications. Burnout-related absenteeism, decreased productivity, and increased turnover can result in significant economic costs. Furthermore, in professions directly related to human care, the implications extend beyond economic metrics—burnout healthcare providers, for instance, may offer compromised patient care, leading to adverse health outcomes (West *et al.*, 2018).

Additionally, the social dimensions of burnout have begun receiving increased attention. The syndrome doesn't exist in isolation but often interacts with one's personal life, affecting relationships, family dynamics, and even leisure activities. This interconnectedness underscores the need for a holistic approach to addressing burnout, one that considers not just the individual and their workplace but also their broader social milieu (Maslach & Leiter, 2016).

Within the diverse realm of occupational health, one of the sectors that consistently stands out due to its heightened susceptibility to burnout is healthcare. The confluence of intense emotional engagements, the ethical duty to preserve human life, and the exigencies of an ever-evolving medical environment position healthcare professionals at the crossroads of immense stressors (De Paiva *et al.*, 2017).

The deleterious effects of burnout transcend the personal well-being of healthcare professionals; they extend to patient care quality, healthcare delivery efficiency, and the overall robustness of the medical system (Bruyneel & Smith, 2021). Considering recent global challenges, notably the COVID-19 pandemic, the strains on healthcare systems worldwide have further highlighted the urgency of addressing burnout within the profession (Kirchberger *et al.*, 2020).

The healthcare profession is demanding, characterized by high stress and constant exposure to intense situations. These intense work environments place a heavy burden on healthcare professionals, particularly nurses, who are tasked with managing both the emotional and physical dimensions of health and disease. These requirements can contribute to job dissatisfaction, increased stress levels, and eventually burnout (El-Azzab *et al.*, 2019).

Nursing is a field where workplace stress can arise from a multitude of factors, including personality traits, the structure of the work environment, and communication with serviced clients. Other organizational stressors may include workload, limited recognition and career advancement opportunities, work shift options, professional disagreements, a lack of social support, safety concerns, and inadequate supervision (Chatzigianni *et al.*, 2018). Nurses also encounter unique challenges, such as managing difficult behaviors in nurse-patient relationships, which contribute significantly to emotional pressures.

Within the healthcare profession, psychiatric nurses and other nursing professionals may experience work-related stress, leading to numerous adverse outcomes. These may range from physical conditions such as musculoskeletal pain and disabilities, increased anxiety and depression, reduced job satisfaction,

increased absenteeism, and high turnover intentions, to severe burnout (Yoshizawa *et al.*, 2015).

In 2019, the World Health Organization recognized burnout as an occupational phenomenon, characterized as the outcome of chronic workplace stress (WHO, 2019). It is made up of three dimensions: emotional exhaustion, depersonalization, and decreased personal accomplishment (Dall'Ora *et al.*, 2020; Maslach & Jackson, 1981). While the DSM-5 does not have a specific diagnostic category for "burnout," symptoms that individuals with burnout experience might overlap with other recognized disorders in the manual. For instance, a person with severe burnout may meet criteria for major depressive disorder, adjustment disorder, or anxiety disorder, depending on their specific symptoms and stressors. The ICD-10, published by the World Health Organization, is the primary system for classifying diseases and health conditions worldwide. Unlike the DSM-5, the ICD-10 includes burnout as a distinct concept but places it under problems related to life management difficulty, specifically coded as "Z73.0 Burn-out state of vital exhaustion." It's worth noting that the ICD-10 definition is rather broad and has been subject to critique for its lack of specificity (Febriana *et al.*, 2023)

However, with the release of ICD-11 in 2018, burnout received a more focused description. In ICD-11, burnout is described as a syndrome resulting from chronic workplace stress that has not been successfully managed. It is characterized by three dimensions: feelings of energy depletion or exhaustion, increased mental distance from one's job, or feelings of negativism or cynicism related to one's job and reduced professional efficacy. It's important to note that ICD-11 specifies that burnout is a syndrome related specifically to occupational settings and should not be applied to describe experiences in other areas of life (Shah *et al.*, 2021).

Burnout's inclusion in the ICD-10 and its further elaboration in the ICD-11 underline its recognition as a significant phenomenon in the realm of occupational health. While the DSM-5 doesn't provide a specific category for

burnout, the overlapping symptoms might make it applicable under several other diagnostic categories. In clinical practice and research, it's essential to differentiate burnout from other psychiatric conditions. While the criteria set forth in these classification systems provide frameworks, individual assessment and a holistic understanding of the person's experience are crucial for accurate diagnosis and effective intervention.

Later, (Maslach & Schaufeli, 2018) identified five main attributes of burnout: (a) severe signs of fatigue, encompassing emotional or mental exhaustion, tiredness, and depression; (b) a spectrum of unusual physical discomfort symptoms; (c) the symptoms are directly linked to the work environment; (d) these symptoms appear in individuals who had no prior psychopathology before experiencing burnout; and (e) there's an uptick in counterproductive job duties and hindered work performance as a result of negative attitudes and actions (Halbesleben, 2006) further characterized burnout as a psychological toll resulting from persistent work-related stress.

The impact of burnout on healthcare workers (HCWs) has been substantial, prompting extensive global research into its prevalence within the healthcare sector (Quenot *et al.*, 2012). Studies as early as 2013 reported that burnout prevalence among nurses in European countries ranged from 22% to 40% (Heinen *et al.*, 2013). It can lead to reduced work effectiveness, impaired judgment, and a reduced ability to anticipate accidents, all of which can have a detrimental impact on patient care (Ventura *et al.*, 2015).

Rupert *et al.*, (2015) emphasized the challenges psychologists face that increase their susceptibility to burnout. They stressed the importance of preventing burnout due to its negative consequences, noting that it can reduce one's quality of life, impact work standards, jeopardize client welfare, and present ethical issues by undermining a professional's competence.

In another study focused on nurses in two major hospitals, burnout was termed an "occupational hazard," and it was observed that inadequate coping mechanisms directly correlated with burnout levels (Qi *et al.*, 2014). Notably,

over the past ten years, there has been an interest in studying the link between individual coping strategies and burnout among human service providers. For instance, it's believed that those working with veterans diagnosed with PTSD might be more prone to burnout. This susceptibility isn't just because of organizational pressures but also due to the inherent challenges of caring for such a clientele. Some research even suggests that to handle such stress and burnout, given the significant amount of time nurses spend with patients, they are particularly susceptible to burnout, and these providers might increase their consumption of caffeine, alcohol, and tobacco (McGeary *et al.*, 2014).

The consequences of burnout extend beyond individual nurses, affecting their mental and physical well-being and leading to physical tiredness, heart problems, and mental health issues such as anxiety, depression, and decreased motivation (Salvagioni *et al.*, 2017). Furthermore, poorly organized, and managed work environments can drain employees' energy and mental resources, contributing to increased burnout (Edú-valsania *et al.*, 2022). In the modern world, burnout has become a significant psychosocial risk associated with various occupations, resulting in significant costs for both individuals and organizations. Therefore, understanding the factors that promote mental well-being and the strategies individuals use to cope with stress is essential (Koen *et al.*, 2020; Lazarus & Folkman, 1984).

When an individual's engagement with their work setting compromises their well-being and exhausts their coping capacities, stress often emerges as the primary precipitant (Montero-Marin *et al.*, 2014). Among the myriad factors influencing the intensity and prevalence of burnout, coping strategies stand out as significant determinants (González-Morales *et al.*, 2010). In challenging work scenarios, without efficient coping mechanisms, individuals—especially those acutely aware of the ramifications of their inadequacies—become increasingly vulnerable to emotional exhaustion and burnout (Montero-Marin *et al.*, 2014).

Recognizing the looming threat of burnout is vital. By being aware, human service professionals can preemptively address issues in their work

environment that might detrimentally affect their colleagues, clients, or themselves. Additionally, understanding coping strategies and attitudes towards seeking professional assistance can be instrumental in mitigating burnout levels.

The concept of "coping" encompasses cognitive and behavioral techniques individuals employ to navigate adversities, ensuring mental equilibrium (Lazarus *et al.*, 1986). Defined by their intricate, three-tiered structure, coping strategies are bespoke responses to specific stress stimuli. The strategies inherently merge an individual's situational perception with their confidence in handling the predicament, with the latter aspect being subsidiary. Significantly, the evaluation of coping sidesteps normative value assessments, concentrating purely on actions mobilized to address the issue (Lazarus & Folkman, 1987; Mealer, 2019)

Scholars (Lazarus & Folkman, 1987) distinguish coping into two cardinal frameworks: problem-focused and emotion-focused coping. The former aspires to directly transform the stressful setting, endeavoring to lessen or expunge the attendant stress through proactive measures, such as confrontation or compromise. In juxtaposition, emotion-focused coping targets unsettling emotions, aiming to diminish their ramifications by recalibrating emotional and cognitive reactions to the context. This could encompass meditation, physical exercise, or cognitive distractions (González-Morales *et al.*, 2010; Lazarus & Folkman, 1987; Shin *et al.*, 2014). Despite the perceived adaptability of problem-focused coping, individuals often seamlessly weave both emotion-focused and problem-focused strategies when navigating multifaceted stressors Ben-Zur *et al.*, 2012)

The absence of robust coping mechanisms can incrementally erode an individual's holistic well-being. Several studies underscore the significance of effective coping mechanisms, suggesting that constructive strategies, such as social support and optimism, bolster mental resilience, potentially mitigating adversities like stress or depression (Babapour *et al.*, 2022).

The effectiveness of a particular coping strategy can vary based on context. For nurses in psychiatric settings, where patient interactions are deeply emotional and often unpredictable, a blend of problem-focused and emotion-focused coping might be most effective. Emotion-focused strategies can help nurses manage their own emotional reactions, ensuring they remain empathetic and compassionate. Simultaneously, problem-focused strategies can empower them to address tangible challenges in their environment, ensuring a smoother workflow and reducing stressors (X. Li *et al.*, 2014).

In conclusion, understanding the spectrum of coping strategies and their applicability to specific contexts is pivotal. By fostering an environment that acknowledges and supports the dynamic nature of coping, healthcare institutions can ensure the well-being of their professionals and the quality of care delivered to patients.

1.2. Important of The Study:

Across global healthcare settings, nursing professionals have been identified as particularly susceptible to burnout, given the emotionally and physically taxing nature of their duties. In psychiatric settings, the challenges become even more pronounced. Nurses routinely work with patients experiencing severe emotional and psychological distress, necessitating high levels of empathy, patience, and resilience. Psychiatric nurses employed in secure wards are tasked with managing a patient group that necessitates heightened surveillance and multifaceted treatment approaches (Fabri & Loyola, 2014) .

This situation subjects these nurses to a range of distinctive and challenging occupational stressors. Existing empirical studies have shown that nurses in various psychiatric specialties face considerable stress (Celebi, 2014). However, after a thorough review of the literature, no studies were identified that specifically addressed the perceived stress, coping mechanisms, and burnout among registered psychiatric nurses in secure psychiatric settings. As a

result, this research sought to explore the perceived stress factors, coping methods, and burnout rates of nurses in these secure psychiatric environments (Konstantinou *et al.*, 2018; Zhang *et al.*, 2020)

Baghdad, the capital city of Iraq, presents a distinct context. Decades of socio-political instability, conflict, and economic strain have had repercussions on the overall healthcare system, potentially intensifying the stressors faced by nurses (Al-Hawdrawi *et al.*, 2017). Despite the critical nature of this issue, there is a paucity of in-depth research focusing on the burnout levels and coping mechanisms of nurses in psychiatric hospitals in Baghdad.

The significance of investigating burnout levels and coping strategies among nurses working in psychiatric hospitals in Baghdad, Iraq, is multifaceted and profound, both in terms of individual well-being and wider societal and health system implications.

1.3. Objectives of the Study:

1. to measure the levels of burnout among nurses working in psychiatric hospitals.
2. to assess the levels of coping strategies that are more frequently utilized by nurses working in psychiatric hospitals.
3. to find out the relationship between burnout levels among nurses and the coping strategies they employ.
4. to investigate the differences in burnout levels among nurses regarding sociodemographic characteristics such as age, gender, education level, residency, marital status, presence of children, and monthly income.
5. to predict the burnout levels because of occupational factors such as years of employment, workplace, additional administrative tasks in the hospital, additional jobs outside the hospital, working shift, and daily working hours.

1.4. Research questions:

1. What are the prevalent levels of burnout among nurses working in psychiatric hospitals?
2. Which coping strategies are most frequently utilized by nurses working in psychiatric hospitals?
3. Is there a significant correlation between the levels of burnout and the coping strategies employed by nurses working in psychiatric hospitals?
4. Are there significant differences in burnout levels between psychiatric nurses regarding sociodemographic characteristics?
5. Can occupational characteristics predict burnout among nurses in psychiatric hospitals?

1.5. Definitions of the Terms:

1.5.1. Burnout:

1.5.1.1. Theoretical Definition:

"Burnout syndrome" refers to a state of physical, emotional, and mental exhaustion caused by prolonged exposure to chronic stressors, particularly in the workplace, such as a high workload, a lack of control or autonomy, insufficient support, and conflicting demands (Maslach & Leiter, 2016; Xia *et al.*, 2023).

1.5.1.2. Operational Definition:

In the context of psychiatric nursing, burnout syndrome is quantitatively measured using the MBI-Human Services Survey (MBI-HSS), developed by (Maslach & Jackson, 1981). This survey comprises 22 specific items structured as statements, directing the respondent to assess their feelings in relation to diverse situations. These items operationalize burnout symptoms such as persistent emotional, physical, and mental exhaustion stemming from prolonged exposure to high-stress environments, particularly those demanding continuous interactions with patients suffering from intricate mental health disorders.

1.5.2. Coping:

1.5.2.1. Theoretical Definition:

Coping refers to constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person (McGeary *et al.*, 2014)

1.5.2.2. Operational Definition:

In the study context, the coping strategies employed by psychiatric nurses in response to work-related stress are quantitatively evaluated using the "Brief COPE Questionnaire" devised by (Carver, 1997). This questionnaire aids in gauging the extent to which different coping mechanisms are implemented by mental health nurses. For measurement purposes, these strategies are discernible and quantifiable, falling into distinct categories: problem-oriented, affective-oriented, and avoidant-focused coping methods.

1.5.3. Psychiatric Nurse:

1.5.3.1. Theoretical Definition:

A nurse is a person with an academic degree, or a nurse is a licensed healthcare professional who is trained in the art and science of caring for individuals, families, and communities. Nursing is a holistic profession that focuses on promoting health, preventing illness, and treating patients across the lifespan (Buppert, 2020).

1.5.3.2. Operational Definition:

The operational definition of the nurse, in this context, refers to a specialized professional who provides care to patients with mental health disorders. They work in various settings, including hospitals, clinics, community health centers, and private practices. Their responsibilities encompass patient assessment, the development and implementation of treatment plans, medication administration, psychotherapy, and patient and family education about mental health conditions and treatments.

Chapter Two:

Review of Literature

Chapter Two: Review of Literature

2.1. Overview:

Since the inception of the burnout concept, studies have focused on individuals engaged in providing services to others, recognizing them as particularly susceptible to experiencing burnout. The three dimensions of burnout included, emotional exhaustion, depersonalization, and reduced personal accomplishment, will be explored in conjunction with relevant research on these dimensions and the overall burnout syndrome (Maslach *et al.*, 2017).

Furthermore, the literature reviewed will address additional concerns associated with burnout, such as diminished job performance, increased turnover rates, decreased organizational commitment, lower job satisfaction, elevated healthcare costs, and reduced levels of creativity and innovation within organizations. These consequences of burnout represent significant issues that have been extensively discussed in scholarly works (Liu & Aungsuroch, 2019).

The purpose of this chapter is to clarify burnout syndrome and coping strategies utilized for managing it in the psychiatric nursing field to offer a thorough comprehension of the topic.

2.2. Burnout Syndrome:

Research on burnout can be traced back to the late 1970s and 1980s. According to (W. Schaufeli & Enzmann, 1998), The term "burnout" was coined by Freudenberger to describe a social pattern he observed among volunteers at the organization where he was employed. (Freudenberger, 1974) adopted the term, which was previously used informally to describe chronic substance abuse, to characterize the condition of the volunteers he worked with. These individuals exhibited signs of emotional exhaustion, a lack of motivation and commitment to the organization, and reported physical symptoms such as fatigue, frequent headaches, and gastrointestinal problems. In 1975,

Freudenberger defined burnout as a state of fatigue resulting from one's dedication to something that fails to meet their expectations.

During the 1980s, the examination of burnout entered a phase of empirical inquiry characterized by the publication of books and articles, as well as the development of standardized measures to assess burnout (Maslach & Jackson, 1986). In recent years, there has been a growing emphasis on burnout, specifically among mental health professionals (Krischer *et al.*, 2010).

The practical origins of the definition of burnout syndrome led to its inclusion of various individual difficulties and sparked controversy and academic discussion, especially among healthcare professionals like nurses. In recent years, there has been an increasing recognition of the prevalence of burnout syndrome in healthcare workers and its potential impact on mental health, retention of experienced personnel, and patient outcomes. As a result, professional societies and organizations have been actively engaging in discussions regarding the characterization, understanding, measurement, and identification of burnout syndrome among healthcare providers, with a focus on the broader healthcare workforce (Mealer, 2019).

According to Maslach, "burnout" is a psychological condition in which individuals experience emotional exhaustion, depersonalization, and low personal accomplishment. This phenomenon is often observed in professionals who work in fields that require frequent interactions with others (Maslach & Jackson, 1986). Chronic stress not being well managed in the workplace can result in a significant and consequential psychosocial disorder referred to as "occupational burnout" (Raudenská *et al.*, 2020).

2.2.1. Components of the Burnout Syndrome:

2.2.1.1. Emotional Exhaustion:

refers to the state of feeling drained and diminished in emotional and mental energy due to the demands of one's job, leading to physical exhaustion

and emotional strain (Maslach *et al.*, 2001; Wangui & Muthee, 2018; Joint Commission, 2019).

2.2.1.2. Depersonalization:

is a mental state in which a person adopts an unsympathetic and uninvolved demeanor towards those they are serving, such as responding to patients with cynicism or attributing their problems solely to their own actions (Wilkinson *et al.*, 2017).

2.2.1.3. Low Personal Accomplishment:

A tendency among healthcare workers to have negative self-perceptions and dissatisfaction with their accomplishments is indicated by low personal accomplishment (PA). Unlike the other domains mentioned earlier, previous studies have shown that a lower average score on the PA sub-scale is associated with more severe burnout symptoms (Dall'Ora *et al.*, 2020).

2.2.2. Symptoms of the Burnout syndrome:

2.2.2.1. Physical Symptoms:

When individuals experience burnout, they often feel drained and lacking in energy, which can make it difficult to complete tasks or focus on work-related activities. This physical exhaustion can also lead to other symptoms, including depression, insomnia, and sleeping more than usual. In addition to exhaustion, burnout can also cause physical symptoms such as headaches, gastrointestinal problems, and lingering colds or flu. Individuals who are experiencing burnout may also notice weight loss or gain, trouble breathing, high blood pressure, hyperlipidemia, and sometimes even cardiovascular illness, all of which have been associated with stress. These physical symptoms can be a sign that an individual's body is under too much stress and can be an indication that it's time to take a step back and focus on self-care. It's important to note that burnout can also have a significant impact on an individual's sexual health. Burnout can

cause sexual dysfunction and impair speech, making it difficult for individuals to communicate effectively with their partners (Luo *et al.*, 2019).

2.2.2.2. Psychological Symptoms:

Burnout not only affects an individual's physical health but can also lead to a range of psychological symptoms. One of the most common psychological symptoms is rigidity toward change, which can lead to a loss of flexibility and adaptability. Individuals who experience burnout may also feel a loss of emotions, such as apathy, which can impact their ability to connect with others and engage in activities they once enjoyed. Cynicism and negativism are also common psychological symptoms of burnout. Individuals may feel emotionally exhausted, lose emotional control, and experience low morale and a sense of futility. They may also experience a loss of patience and irritability, which can impact their relationships with others (Fischer *et al.*, 2020).

Inability to cope with unwanted stress and feelings of anger, bitterness, resentment, and disgust are also common psychological symptoms of burnout. Individuals may feel bored, have a reduced self-concept, and begin dehumanizing clients by labeling them. They may also experience an absence of optimism and disillusionment, a sense of despair, and an incapacity to make good decisions, which can lead to feelings of helplessness and insecurity. Blame emotion, lost opportunity, depressed mood, detachment, and heightened anxiety can also be symptoms of burnout. Some individuals may become overconfident and take unusually high risks, while others may feel a sense of stagnation and lack of progress. Finally, individuals may feel like they need to be everything to everyone, leading to feelings of omniscience and a loss of charisma (Aulsbrook, 2021).

2.2.2.3. Behavioral Symptoms:

Burnout can also manifest in a range of behavioral symptoms that can impact an individual's job performance, relationships, and overall well-being. One of the most common behavioral symptoms of burnout is low job

performance and low job satisfaction. Individuals may experience a decreased sense of motivation and interest in their work, which can impact their ability to perform at their best. Another common behavioral symptom of burnout is decreased communication and withdrawal. Individuals may become less engaged with their colleagues and clients, leading to a breakdown in relationships and collaboration. They may also experience high job turnover and leave their position, leading to a lack of continuity and stability within the workplace. Increased absenteeism is another behavioral symptom of burnout. Individuals may begin to take more sick days or take time off work to avoid the stress and pressure they are experiencing (Shin *et al.*, 2014).

They may also lose enthusiasm for their job, leading to a lack of engagement and productivity. Burnout can also lead to increased drug and alcohol use as individuals attempt to cope with their stress levels. Marital and family conflict may also increase as individuals struggle to balance their personal and professional responsibilities. Lack of focus on the job, accident-proneness, increased complaints about the job, forgetfulness, and poor concentration can also be symptoms of burnout (Labrague, 2021).

2.2.3. Measuring the Burnout Syndrome:

The dimensions of the burnout syndrome, namely emotional exhaustion, depersonalization, and reduced personal accomplishment, are encompassed within the Maslach Burnout Inventory (MBI) (Maslach & Jackson, 1981). It has been observed that an increasing number of studies have adopted the MBI as a standardized measure to assess burnout symptoms. Criticism has been raised by (Pastores *et al.*, 2019) regarding the dimensions of the MBI that measure exhaustion, depersonalization, and cynicism. Similarly, some researchers argue that burnout should solely include emotional exhaustion and depersonalization as its subscales.

There have even been suggestions that burnout is a unidimensional phenomenon (Barnes *et al.*, 2019). However, the MBI remains widely used in burnout research due to its development through extensive in-depth interviews

and the conceptualization of burnout as a syndrome with distinct antecedents and consequences for each of its three dimensions. The adoption of a unidimensional perspective would hinder the examination of critical aspects related to the antecedents and consequences specific to each dimension of burnout (Aryankhesal *et al.*, 2019).

The development of the MBI initially involved an extensive and in-depth interview process. Subsequently, the items were researched and statistically validated to reflect a three-dimensional construct. The MBI has been adapted to various languages and applied across professions and cultural contexts. Accordingly, in a study by (Shin *et al.*, 2014) discovered that utilized the MBI to assess the level of burnout. In fact, articles employing the MBI represented a larger percentage (87.80%) among burnout studies compared to those using other measures (e.g., Copenhagen Burnout Inventory, Utrecht Burnout Scale, Oldenburg Burnout Inventory, Burnout Measure).

2.2.4. Diagnosing the Burnout Syndrome:

Given the mounting cases, there is an imperative to understand the diagnostic framework. Despite the subjective and objective diagnostic criteria available, a unified diagnostic approach remains a topic of debate.

2.2.4.1. Subjective and Objective Diagnostic Criteria:

Subjective diagnostic criteria primarily revolve around self-reporting, encompassing symptoms such as extreme fatigue, difficulty concentrating, irritability, and unwarranted physical symptoms of distress. An evident decrease in self-esteem also flags the onset of burnout. Objective criteria, on the other hand, are externally assessed, most notably by superiors or peers in a work environment. A considerable decline in work performance sustained over months often signals burnout. However, these symptoms should be distinct from those resulting from underlying major psychopathologies like depression, anxiety, or PTSD. External influences, such as family-related issues, shouldn't be a contributing factor. (Maslach & Schaufeli, 2018) postulated that burnout,

despite its distinct symptoms, does not necessitate a separate category in DSM-5, but can be perceived as a subtype of adjustment disorders, specifically with work inhibition (Papazian *et al.,* 2018) .

2.2.4.2. DSM-5 Context:

The DSM-5 doesn't recognize burnout as a distinct diagnostic entity. Yet, many symptoms resonating with burnout interlap with conditions like adjustment disorders, major depressive disorder, and anxiety disorders, incorporated within the DSM-5. This overlap suggests that patients exhibiting burnout symptoms might be diagnosed with one of these disorders, hinting at DSM-5's potential to understand burnout's underlying psychopathologies without distinctly categorizing it (De Hert, 2020).

2.2.4.3. ICD-10 Context:

The ICD-10 adopts a broader diagnostic stance. It identifies burnout as a "state of vital exhaustion", coded as "Z73.0". This classification portrays burnout as stemming from unmanaged chronic workplace stress. Core characteristics include energy depletion, negativism, or cynicism towards one's job, and dwindling professional efficacy. Notably, ICD-10 emphasizes the occupational confines of burnout, cautioning against its application to other life areas (Kelly *et al.*, 2021).

2.2.5. Factors Contributing to Burnout syndrome:

2.2.5.1. Factors Related to nursing Occupation:

Occupational factors are those elements present in the context of employment that play a vital role in causing burnout among nurses' staff. These factors have been found to have the greatest impact on burnout while working as a nurse, as described below:

1. **Work overload:**

Work overload refers to the volume of work a nurse must complete in each time frame. Nurses globally have a myriad of duties to fulfill that must be

completed within a specific work shift. Unfortunately, in many healthcare facilities, the nurse-to-patient ratio is uneven, which exacerbates their duties. Consequently, nurses experience a great deal of pressure, leading to stress, as they strive to complete numerous tasks within a limited time frame. Studies have demonstrated that time constraints and an imbalanced nurse-to-patient ratio can have an adverse effect on the standard of care people receive. Nurses who experience heavy workloads often report dissatisfaction with their jobs, feelings of depersonalization, and eventually burnout.

2. **Shift Work:**

Nurses usually work various shifts, such as morning, evening, and night shifts, over the course of their career. This leads to a disturbance in their personal lives, as they must adjust their routines to accommodate these changing schedules. This disruption poses a significant challenge to nurses who must balance work and personal lives, especially those with families. A lack of proper balance between work performed in shifts and pause days can lead to tiredness, exhaustion, and ultimately burnout (Montgomery *et al.*, 2015).

3. **Integrative Team Relationships:**

A multidisciplinary staff is comprised of various healthcare workers, including nurses, doctors, physiotherapists, laboratory specialists, and others, each with their own distinct roles but working together towards a common objective. Successful teamwork has been demonstrated to enhance work attitudes, productivity, and contentment. Conversely, ineffective collaboration seems to have been linked Failure in teamwork is currently caused by an absence of confidence or harassment. All these things can influence performance and may lead to strain and exhaustion related to work (H. Li *et al.*, 2018).

According to literature, an unsatisfactory relationship between nurses and doctors can result in frustration at work and distress, resulting in subpar patient care. The deterioration of the nurse-doctor relationship often leads to work frustration. In addition, registered nurses who do not receive support from other

members of the healthcare community are more likely to experience emotional exhaustion, low job satisfaction, and, eventually, burnout (Zhao *et al.*, 2015).

4. **Personnel and Material Resources:**

The nursing profession is plagued by high levels of stress and burnout, which are exacerbated by understaffing and a lack of adequate resources. The lack of resources has a considerable impact on nurses' ability to perform their jobs effectively. Due to the high demands of nursing work, understaffing places additional pressure on licensed practical nurses who are currently employed (H. Shin *et al.*, 2014). The inability of nurses to effectively carry out their responsibilities is hampered by both a lack of resources and an insufficient staffing level. This results in negative consequences for patients due to the detrimental effect on the physical and mental health of nurses. Depersonalization, emotional and physical exhaustion, and ultimately frustration with one's job are all factors that have been linked to a shortage of staff and resources among nurses (Adriaenssens *et al.*, 2015).

5. **Differences in Job Roles:**

Depending on their specialty and level of training, nurses may be responsible for a wide range of tasks. The nursing profession is constantly evolving, and nurses may be assigned tasks that are not traditionally part of their role. This has led to conflicts in job descriptions for nurses. If not addressed, this can lead to nurse burnout, which is characterized by a decrease in job satisfaction and an increase in negative attitudes toward the nursing profession (Dall'Ora *et al.*, 2020).

Some nurses may feel uncertain about their roles and responsibilities because their job titles lack clarity (Oser *et al.*, 2013). Since the employee's responsibilities aren't specified, they're left in a state of limbo. When job responsibilities aren't clearly defined, it can lead to stress, poor output, and employee dissatisfaction (Nantsupawat *et al.*, 2017).

6. **Acknowledgment, Respect, and Valuing Agency:**

Respect and value are important to nurse in the workplace, and they also want to have a voice in workplace decisions that affect them (Mathew *et al.*, 2013). When nurses have a say in the decision-making process, they feel empowered and more in control of their work. This sense of control is crucial in reducing pressure and stress levels in the nursing profession, which in turn can prevent job dissatisfaction (Karanikola & Papathanassoglou, 2013).

Disrespect from coworkers, physical and emotional violence from unhappy patients and their families, and the risk of harm from substance abuse are just a few of the demoralizing challenges that nurses face over the course of their careers. Because of these difficulties, many nurses feel unappreciated and have a negative outlook on their chosen career. Additionally, they may experience depersonalization (Fischer *et al.*, 2020). Research indicates that appreciating and empowering nurses leads to exceptional job performance. Conversely, being undervalued contributes to nurses' stress, physical and emotional exhaustion, and eventual burnout (H. Wei *et al.*, 2020).

2.2.5.2. Organizational factors:

Organizational factors refer to the factors at the administrative level of medical centers that can contribute to nurses experiencing burnout.

1. **Management of The Organization:**

Organizational management involves coordinating and directing resources within an organization to achieve its goals. This includes planning, controlling, leading, and organizing activities. Hospitals may have different levels of management, including upper management and unit-level management. Organizational management factors that contribute to nurse burnout include low pay, a negative work environment, insufficient resources, and a deficiency of preventative measures (Ridenour *et al.*, 2015).

2. **Inadequate Participation of Nurses in Making Decisions:**

The problem of inadequate participation of nurses in the decision-making process within healthcare organizations means that the top-level management,

who hold decision-making power, are responsible for making important decisions that directly impact the nurses' work environment, such as policies, salaries, appointments, nurse-patient ratios, shifts, and patient safety. However, when nurses are not included in these decision-making processes, they may feel dissatisfied with their jobs, which can lead to burnout and other negative consequences (Sinclair *et al.*, 2017).

3. Unit Management in Healthcare Facilities:

The management at the unit level comprises supervisors, head nurses, and charge nurses, referring to the individuals who oversee and are responsible for the daily operations and functions of a specific unit within the facility, such as a particular floor or department. This level of management is responsible for ensuring that the unit is running smoothly and efficiently and that patients receive high-quality care. They may also be responsible for managing staffing, budgeting, and ensuring compliance with healthcare regulations and policies. Effective management at this level is essential for ensuring that the unit can provide the best possible care to patients while also maintaining a positive and supportive work environment for nurses and other healthcare workers (Paiva *et al.*, 2017).

2.2.5.3. Factors Related to Personal Traits:

The five-factor personality trait theory, often known as the language-based personality model, consists of five traits, including characteristics of receptivity, introversion, extraversion, conscientiousness, and emotional acuity (Bakker *et al.*, 2006).

One of the five-factor personality traits is openness, which refers to an individual's capacity to interact positively with others, communicate effectively, build trust, and establish good relationships with colleagues. Conversely, individuals who exhibit neurotic traits tend to be easily agitated, exhibit moodiness, suffer from anxiety or depression, harbor fears, feel jealous, and

may experience loneliness. These individuals often experience heightened levels of stress in response to various stressors (la Fuente-Solana *et al.*, 2017).

Openness is a personality trait that involves having good social skills, being able to express oneself effectively, and building trusting relationships with co-workers. On the other hand, individuals with neurotic traits tend to experience moodiness, frustration, depression, fear, jealousy, and loneliness, and they tend to respond poorly to stressors(A. Kumar *et al.*, 2021).

Extraversion, another personality trait, is characterized by enthusiasm, assertiveness, and talkativeness. These individuals tend to thrive in group settings and are energized by social interactions. The opposite of extraversion is introversion, which involves being reserved and experiencing a decrease in energy during social interactions. Introverts typically enjoy spending time alone and may have trust issues (Howell, 2021).

Conscientiousness is a personality trait that describes individuals who are goal-oriented, highly organized, objective, and driven by goals. Emotional intelligence, on the other hand, refers to understanding and controlling one's own and other people's emotional states. Both extraversion and emotional intelligence are traits that can contribute to personal achievement (O'Connell & Dowling, 2013).

According to studies, burnout can be caused by an individual's lack of openness, extraversion, and conscientiousness or by their overabundance of neuroticism. This shows how character traits are crucial to avoiding burnout (Hilton & Whiteford, 2010).

2.2.5.4. Factors Related to Social Interactions:

Social factors pertain to the common traits that individuals in a community share, such as their profession, financial status, age, marital status, gender, education, religion, and more. Research studies have demonstrated that various social factors, including age, job position, job-related stressors such as workload, encounters with conflicts, exposure to death situations, ambiguous

job roles, and personality, are significant predictors of burnout. Furthermore, the studies showed a correlation between burnout and factors such as age, duration of employment, and educational attainment (Acker, 2010).

The age of a nurse is an important element in identifying the level of burnout suffered. Although some studies suggest that younger nurses are more likely to experience burnout, there is no clear evidence to support the idea that age, emotional exhaustion, detachment, and burnout all correlate with one another. Different studies have indicated that burnout is a problem for nurses of all ages (la Fuente *et al.*, 2015).

According to research, depersonalization is observed in both male and female nurses. Emotional exhaustion, on the other hand, is found to be more prevalent among female nurses. However, there is no significant discussion in these articles regarding the impact of other factors such as social class, religion, marital status, or income on burnout (S. M. Waddill-Goad, 2019).

2.2.6. Consequences of the Burnout Syndrome:

2.2.6.1. The impact of burnout on nurses' personal well-being:

1. **Low Quality of Life:**

An association has been discovered between burnout among nurses and their psychological health. When nursing staff experience burnout in their jobs, it adversely impacts their subjective wellbeing. The constant effort and energy expended in dealing with work pressure can lead to physical and mental health problems, which ultimately affect their overall sense of wellbeing (Qu & Wang, 2015). Nurses experiencing burnout tend to have a diminished sense of personal accomplishment and self-esteem, which results in negative emotions such as anger, apathy, and hostility in the workplace. This can eventually have effects on psychological health, work effectiveness, and well-being (Abraham & D'silva, 2013).

Work overload and other job requirements can take a serious toll on nurses' psychological, physical, and emotional well-being. Many nurses' health

is negatively affected by job strain, which can lead to burnout. The rise in burnout levels is often accompanied by alterations in depressive symptoms and an inclination to quit the nursing profession entirely. In new nursing graduates, burnout is linked to a sense of inadequacy in their preparation for the job as well as the high level of performance expected, leading to feelings of depression (Rudman & Gustavsson, 2011). According to (Nowakowska & Wolniewicz, 2017) There are mental and emotional symptoms of burnout among nurses. Physical manifestations of psychological reactions include elevated blood pressure, persistent fatigue, and gastrointestinal distress. However, mood swings, stress, and anxiousness characterize the emotional responses (Waddill Goad, 2016).

2. Work-Life Balance, Family, and Friends:

The impact of burnout on nurses is extensive and affects different areas of their lives. This includes negative consequences for their interpersonal and family relationships, leading to an overall pessimistic outlook on life. Negative effects on psychological health have been linked to burnout in the nursing profession, with emotional exhaustion being a primary symptom of burnout (Papathanasiou, 2015).

Nursing burnout lowers standards of living for both nurses and their families. This is mainly because nurses have a hard time finding a work-life balance due to their rigid shift schedules and hours. When nurses spend a lot of time in a stressful setting like a hospital, they are more likely to experience burnout, especially if they work for an unsupportive employer. Nurses who experience higher levels of burnout are more likely to experience negative emotions like anger, fear, and hopelessness, which can lead to mental health problems or even suicide. Nurses and their families experience a decline in quality of life as the severity of their health issues increases (Fradelos *et al.*, 2014).

3. Substance Abuse and the Misuse of Drugs and Medication:

Nurses' personal and work lives are negatively impacted by burnout, which may lead one to experiment with drugs and alcohol as a coping mechanism for high levels of stress at work. Nurses who lack effective coping mechanisms may turn to alcohol, which can have adverse effects on their health and job performance. This behavior can result in absenteeism and an inability to provide adequate care for patients, jeopardizing their safety (Banovcinova & Baskova, 2014). According to (Abraham & D'silva, 2013) Nurses who experience burnout may turn to the abuse of medication.

2.2.6.2. Impact on Nursing Care, Patients, and the Organization:

Nursing burnout has a bad impact on patient care. Nurses are more likely to experience burnout when they do not receive high levels of support from clients or family members in hospital settings. Burnout leads to a disengagement from providing compassionate care, which impairs nurses' ability to deliver quality nursing care (Russell, 2016).

The quality of care delivered by nurses deteriorates when they experience burnout. Nurses suffering from burnout find it challenging to establish and maintain effective relationships with patients and their families. Deleterious client effects, quality of care, medication mistakes, and infection rates are all strongly correlated with burnout among healthcare professionals (R. Wei *et al.*, 2017).

Many nurses leave the profession because of burnout because they become unhappy in their jobs and find the stress to be too much. When nurses aren't happy in their jobs, it can affect their confidence and make it hard for them to take care of patients. This can have repercussions for their productivity and the standard of care they give their patients (Poghosyan *et al.*, 2010).

2.2.6.3. Negative Impact on Work Performance:

This section details the impact of burnout on nurses' perception and execution of their job responsibilities.

1. **Unhappiness with Job:**

the impact of burnout on nurses' job satisfaction and their attitude towards work. When nurses experience high levels of burnout, they tend to have a negative perception of their work, particularly when caring for patients. Burnout results in reduced motivation among nurses, which leads to job dissatisfaction and increased frustration. Nurses become less focused in their decision-making and less concerned about the consequences of their actions. Nurses who suffer from burnout typically put forth minimal effort in their work and rely on traditional methods instead of being innovative and creative (Konstantinou *et al.*, 2018). Those nurses who are more burned out are also less likely to report feeling satisfied or happy in their jobs (Qu & Wang, 2015). According to (Abraham & D'silva, 2013) Nurses' care for patients is commendable, but it is disheartening that they are not appreciated, and their lives become unfulfilling. This feeling leads to a reduction in their motivation and enthusiasm for work, which ultimately results in job dissatisfaction.

2. **Shortage of nurses resulting from high turnover rates:**

The shortage of nurses across the globe has been attributed to burnout, among other factors. The shortage is due in part to low job satisfaction, elevated caregiver turnover, insufficient personnel, a shrinking workforce, and rising health care requirements. The problems of burnout and nursing shortages have been on the rise simultaneously. The first few years after nursing school are the most stressful for new nurses, making them more likely to experience burnout and consider leaving the profession (Gustavsson *et al.*, 2010).

Nurses may choose to quit their jobs and pursue less stressful careers due to the overwhelming work-related stress they experience. Others may continue working, but the possibility of resigning due to burnout remains high. Nurses in African countries who experienced high levels of burnout syndrome and mental anguish were more likely to leave their jobs, according to a study (Pienaar & Bester, 2011).

According to (Kar & Suar, 2014) When nurses experience burnout, they may become less dedicated to their workplace. This is especially true if they feel

emotionally drained and have a diminished sense of personal accomplishment. The term "organizational commitment" is used to describe the degree to which nurses feel a sense of belonging and dedication to their institution of employment. If nurses feel they are not able to use their skills and have their needs met at work, they may decide it is no longer worthwhile to remain in their current position. Consequently, they become less committed and detached from the hospital. Nurses who work in stressful environments may develop negative attitudes towards work politics and shift work, leading to burnout, a lack of dedication to their work, and a strong desire to leave their current position. Whenever a nurse's emotional reserves are low, they may develop a cold demeanor and withdraw from their patients and coworkers. At some point, individuals may dread going to work and consider quitting since they no longer enjoy their profession. Nurses who are experiencing burnout sometimes have trouble staying at one job for very long for reasons like a heavy workload, long working hours, a lack of support from coworkers, and taking care of critically ill patients. Because of these issues, nurses often look for other jobs in hopes of finally finding one they enjoy. As a result, they are unable to put in the extra hours and look for better opportunities elsewhere (Ruiz Fernández *et al.*, 2020).

3. **Work performance:**

High-burnout Nurses may find it difficult to deal with time constraints and more work since they are emotionally weary. Failure to perform well under time constraints can have serious consequences, including the risk of making mistakes that endanger patients. Negative emotions take up a lot of mental space when nurses are overwhelmed, and burnout can make it harder for them to make good decisions, which is bad for patients (Teng *et al.*, 2010).

When nurses face high levels of stress, they become emotionally exhausted and start to detach themselves from their clients and patients, as stated by (Pienaar & Bester, 2011). According to (Banovcinova & Baskova, 2014) Burnout resulting from high levels of stress can lead to a change in nurses' attitudes towards work, which can have a negative impact on patient

care. According to (Abraham & D'silva, 2013) The quality of instruction and nurses' dedication to their professions can both suffer when burnout makes it difficult for them to communicate with and guide students (Nantsupawat *et al.*, 2016), Nursing burnout is strongly associated with underreporting of adverse patient outcomes and a decline in the quality of care provided.

4. Employee absences and sick leave:

Nurses who experience burnout are more likely to have poor attendance at work. The physical exhaustion resulting from a high workload and burnout can lead to increased absenteeism. To avoid work, nurses suffering from burnout often take numerous sick leaves, frequently seeing a doctor for a medical excuse. Emotional exhaustion associated with burnout leads to job dissatisfaction, which can further result in absenteeism. This situation creates work overload as fewer nurses show up for their shift, which can cause nurses to become detached from their work, colleagues, and patients (Konstantinou *et al.*, 2018).

5. Leaders' nurses' burnout:

The role of nurse leaders in maintaining a healthy work environment is crucial. Through their interactions with junior staff and their understanding of nursing work, knowledge, and skills, they have the power to shape working conditions. Leaders in the nursing profession are counted on to foster a positive working atmosphere by being approachable and decisive. Nurses under the supervision of a nurse who is experiencing or at risk of burnout can suffer as a result. The lower-level nurses may be more susceptible to burnout as a result. Furthermore, the high turnover rate among current nurse leaders due to burnout makes it difficult to train their successors (Kelly & Adams, 2018). Observed by (Kanste, 2008) There is both a positive and negative correlation between nursing leadership and nurse burnout. Nursing staff that experience passive leadership are more likely to experience burnout, especially in the areas of emotional weariness and depersonalization.

Changing their mindset can be a way for nurses to reduce stress, fatigue, and the likelihood of burnout. A no-barriers mindset, which is used by world-class adventurers, can also be adopted by nurses. This type of mindset promotes a community approach to problem-solving and idea-sharing to accomplish difficult objectives (Rowden-Racette, 2013).

Nursing can be compared to an extreme adventure, as it involves dealing with unpredictable situations and inherent stress every day. Accomplishing challenging tasks may lead to a questioning of one's beliefs and values, and it may require a shift in mindset to achieve success.

2.2.7. Describing of Burnout in the Nursing Profession Workplace:

Healthcare workers face the risk of burnout, a recently recognized occupational illness that is gaining attention from global research. Burnout has bad outcomes for both the wellness of the body and mind of healthcare professionals and their patients, resulting in reduced quality of care. It is a psychological state that results from the inability to cope with work-related stress through typical means, which can occur due to prolonged exposure to psychological factors (Sabbah *et al.*, 2012).

Burnout is often associated with factors such as long working hours, job dissatisfaction, a lack of autonomy, and poor organizational structures. These are commonly believed to be the main causes of burnout (Bria *et al.*, 2012; S. Kumar, 2016). In addition, an imbalance between one's work and personal life is a factor that can contribute to burnout in healthcare professionals (la Fuente *et al.*, 2018).

The prevalence of burnout among healthcare professionals varies across studies and is associated with different sociodemographic factors, including age, gender, marital status, and work experience. These variations in prevalence rates can be attributed to individual factors such as work-related stress and environmental factors. To reduce the risk of burnout, strategies can be implemented at three levels: modifying the organizational structure and work processes; enhancing professional development programs; and taking

individual-level actions to manage stress and promote healthy behaviors (Bhurtun *et al.*, 2019; Krasner *et al.*, 2009).

Multiple studies have associated burnout with a range of behavioral markers, including increased medical errors, decreased motivation, higher rates of absenteeism and sick leave, earlier retirement, alcohol misuse, and an uptick in negative workplace behaviors like smoking, excessive coffee intake, and workplace accidents (West *et al.*, 2016).

2.2.8. Prevention of burnout in the nursing profession:

In nursing and healthcare, the areas outlined by Maslach and Leiter (2016) could be addressed to improve the social environment. These areas include workload, control, reward, community, fairness, and values. To address workload, it is necessary to have reasonable and safe workloads that can be achieved. Control can be improved by engaging the workforce and allowing them to be involved. Adequate compensation and recognition can address reward issues, while teamwork and meaningful relationships can promote a sense of community. Discrimination and favoritism should be eliminated for fairness, and aligned passion and purpose can address values. Though it may seem difficult to address the social environment of healthcare on a global scale, small changes made by nurses and healthcare leaders could have a positive impact on a single department, division, organization, health system, and ultimately a region, county, state, or even a country.

2.3. Coping strategies:

Coping refers to the strategies and actions individuals use to deal with stressful demands that they face both internally and externally. Depending on how coping is utilized, it can either protect or harm (Mealer, 2020).

When discussing coping, one might do so from two distinct vantage points. One view emphasizes taking action to alter one's surroundings (problem-focused coping), while the other emphasizes shifting one's outlook on the world around them (emotion-focused coping) (Javadi-Pashaki & Darvishpour, 2019;

Lazarus, 1993). Another facet of coping is avoidance, categorized as either person-oriented (i.e., seeking social diversion through other people) or task-oriented (i.e., seeking distraction through other activities) (Endler & Parker, 1994; Simpson *et al.*, 2019).

Individual experience, developmental implications, and present traits are the three criteria that determine whether a coping strategy is adaptive or maladaptive. Whether or not a coping strategy is helpful depends on whether it prevents the individual from becoming overwhelmed by the demand (Skinner *et al.*, 2003).

The psychological reactions to stressful situations can be influenced by the coping strategies employed (McPherson *et al.*, 2003). The use of passive coping strategies, such as ruminating, avoiding thought, isolating oneself, blaming oneself, having a bad attitude, having negative social interactions, not communicating with others, not being emotionally invested in one's own well-being, and drinking, has been linked to a negative effect on one's psychological response (Colville *et al.*, 2015; Naushad *et al.*, 2019; Rodríguez *et al.*, 2019).

The preventive role of social support and optimism on perceived stress, anxiety, and depression was identified as having a positive impact on mental health (Smith *et al.*, 2008). Several studies have examined the distinguishing features of nurses who do not cope well with stress. These features include disruptions in sleep, impairment in relationships, a lack of concentration, an increased incidence of illnesses, and the eventual development of burnout (McCloskey & Taggart, 2010).

The work of (Abdalrahim, 2013) It is argued that psychiatric nurses are less likely to have unfavorable outcomes if they engage in problem-solving coping strategies rather than emotionally focused, negative coping strategies including wishful thinking, self-blame, and avoidance. Therefore, in psychiatric nurses, problem-solving coping relates to high job satisfaction and excellent health, whereas avoidance coping is linked to low mental health.

Although having coping techniques is helpful, this is not a guarantee that stress will be effectively managed. Some examples of these reactions include looking for help, wishing things were different, blaming oneself, avoiding the issue, and solving it. Different people have different coping processes, and people's coping styles can shift over time and between different situations. Because of this, it is essential to determine efficient strategies for supporting mental health nurses in managing stress (Song *et al.*, 2018).

The coping strategies employed by individuals in response to stressful demands are influenced by the resources available to them. The likelihood of developing maladaptive coping techniques, such as substance misuse, increases when the demands of stress exceed the available resources. This is especially true when people are unequipped with appropriate coping mechanisms to deal with the stresses, they face on the job (Litt *et al.*, 2009).

Nurses' occupational stress might have an adverse effect on their productivity. Mental health nurses are stereotyped as having the highest rates of burnout in the nursing profession. Attending stress management workshops and therapeutic training sessions, as well as employing behavioral and relaxation approaches to cope with occupational pressures, has been found useful by some mental health nurses in addressing this issue (Cai *et al.*, 2008).

Conclusions from the research by (Sherring & Knight, 2009), According to studies, mental health nurses who feel valued and appreciated at work and have a voice in organizational decisions are less likely to burn out emotionally. Also, mental health nurses who receive regular clinical supervision have been found to experience less burnout and lessen the effects of job-related stress.

The perception of a job in a positive light is often linked to an individual's satisfaction with their work, which can foster positive emotions towards the job. A positive relationship between healthcare professionals and their work environment can have therapeutic benefits for the well-being of these professionals and their patients. By maintaining a positive working environment, healthcare professionals can achieve better healthcare outcomes

and uphold the integrity of the healthcare profession (Christodoulou *et al.*, 2017).

Certain personal coping styles, such as avoidance strategies, self-blame, and substance use, have been linked to higher levels of burnout (Carver, 1997). Coping, which encompasses the cognitive and behavioral actions individuals undertake in response to perceived stressors or demands (Lazarus & Folkman, 1987), can vary in effectiveness for managing burnout symptoms. (Jenaro *et al.*, 2007) proposed that engaging in professional help-seeking, generating problem-solving ideas, and taking proactive steps to address the issue are task-oriented coping strategies that can aid in symptom management. On the other hand, emotion-focused coping involves self-directed emotional reactions aimed at reducing negative emotional responses (Acee *et al.*, 2003).

emphasis on emotion -focused coping rather than task-oriented coping has been associated with elevated levels of burnout (Chwalisz *et al.*, 1992). Task-Oriented coping, also referred to as problem-focused coping, encompasses purposeful strategies that may be influenced by burnout. Examples of such strategies include seeking professional assistance, exploring problem-solving approaches, and taking proactive measures to alleviate the stressor or resolve the issue at hand (Acee *et al.*, 2003). Task-oriented coping entails seeking support from the organization, family, and friends, as well as adopting a proactive stance to mitigate the impact of burnout on the individual. Conversely, another coping style is avoidance, which involves behavioral and cognitive efforts aimed at evading stress (Endler & Parker, 1994). Engaging in avoidance coping has also been linked to higher levels of burnout.

2.3.1. Categories of Coping Mechanisms:

According to (Carver, 1997) the coping strategies categorize into three domains:

2.3.1.1. Problem-Focused Coping:

Problem-focused coping refers to a type of coping strategy that aims to tackle the root cause of a stressful situation rather than merely address the emotional response to it. This approach involves identifying the problem, analyzing it, and taking specific steps to solve it. It may involve seeking information, planning, acting, and evaluating the results. Problem-focused coping is often used when an individual feels a sense of control over the situation or has resources available to deal with it. This type of coping strategy is often seen as more effective in situations where the problem is controllable and can be solved (Song *et al.*, 2018).

2.3.1.2. Emotion-Focused Coping:

Emotion-focused coping is a type of coping strategy used to manage stress by regulating emotions in response to a stressful situation rather than addressing the problem itself. This coping style involves identifying and processing emotions related to a stressor, such as sadness, anger, or anxiety, to reduce their negative impact on mental and physical health. Examples of emotion-focused coping strategies include seeking emotional support from friends or family, engaging in relaxation techniques such as meditation or yoga, and using distraction techniques to take the mind off the stressor. This coping style is often used when the stressor is uncontrollable or cannot be changed. However, it may not always be effective in the long term as it does not directly address the root cause of the stressor (Hasan *et al.*, 2018).

2.3.1.3. Avoidant Coping:

Avoidant coping is a type of coping mechanism used to manage stress or negative emotions that involves avoiding the stressor or emotion rather than confronting it directly. People who use avoidant coping tend to deny the problem or the stressor and often rely on distraction or escape to avoid facing it. They may also use substances or engage in other behaviors, such as excessive

socializing or overeating, to avoid confronting the issue. While avoidant coping may provide temporary relief, it can ultimately lead to negative consequences, such as increased stress levels, decreased self-esteem, and a lack of resolution of the underlying issue (Haastrup, 2018).

2.3.2. Coping styles and affect:

Coping strategies are not only seen in individuals who are experiencing psychological distress, but they can also be utilized in daily life to promote good health and prevent burnout. The transactional model of stress and coping, as proposed by (Lazarus & Folkman, 1987), is in line with this perspective. Five hundred and twenty-eight (234 Arabic and 294 Jewish) university students from Northern Israel were surveyed to examine their evaluations, coping processes, and reactions to stress. As stated in the abstract, three coping techniques, namely problem-focused coping, emotion-support coping, and avoidance coping, were examined. Actively resolving stresses is an example of problem-focused coping; seeking emotional support is an example of emotion-support coping; and avoiding the problem and the circumstances is an example of avoidance coping.

The study's results by (Zeidner & Ben-Zur, 2014) showed that individuals' coping methods varied with their level of perceived stress. Emotion-focused coping, including emotion-support coping and avoidance coping, was positively correlated with negative affect at times of heightened stress perception. Arab students reported higher stress perception, which was associated with the utilization of all three coping strategies, greater negative affect, and engagement in risky behaviors. Overall, the research highlights the significance of having reliable coping mechanisms to deal with stressful events and keep one's head on straight.

2.3.3. Measuring coping strategies:

Coping strategies were classified into two primary dimensions: problem-focused coping and emotion-focused coping. Problem-focused coping encompasses active coping, directive coping, engagement, and planning. Emotion-focused coping includes subcategories such as acceptance, avoidance,

denial, disengagement, reappraisal, seeking social support, turning to religion, and venting. Several major coping inventories were utilized in this study, including the Coping Orientation of Problem Experience Inventory (COPE) (Carver, 1997), the Ways of Coping Checklist (Folkman & Lazarus, 1980), the Ways of Coping Questionnaire (WCQ) (Folkman & Lazarus, 1988), the Coping Strategies Inventory (Tobin *et al.*, 1989), and the Coping Inventory for Stressful Situations (Endler & Parker, 1994).

2.4. The link between coping strategies and burnout syndrome:

Coping skills have been recognized as crucial protective factors in determining health outcomes (McPherson *et al.*, 2003). Researchers have extensively investigated the association between coping strategies and burnout symptoms, although the results have been mixed (de Jonge, 1998; McCarthy *et al.*, 2006; Parker *et al.*, 2012).

The concept of coping strategies has received significant attention in the literature, with researchers suggesting that it plays a vital role in predicting an individual's level of burnout (González-Morales *et al.*, 2010; Jenaro *et al.*, 2007). Empirical studies have highlighted that an individual's coping strategy can either increase or decrease psychological burnout (Anshel, 2000).

Two prominent coping strategies explored in the literature are emotion-focused coping and reappraisal coping. Emotion-focused coping involves utilizing various emotional processes and understanding to deal with stress, including wishful thinking, distancing, self-blame, tension reduction, self-isolation, seeking emotional support, reinterpretation, acceptance, denial, and turning to religion (Carver *et al.*, 1989; Lazarus & Folkman, 1987).

On the other hand, reappraisal coping is a strategy that revolves around the reinterpretation or reevaluation of a stressful situation to alter one's emotional response to it. Carver and Scheier describe reappraisal coping as a form of problem-focused coping, focusing on cognitive processes aimed at changing the perception of a situation to reduce its impact. Conversely, Lazarus

and Folkman emphasize reappraisal as an emotion-focused coping strategy, with a focus on cognitive assessment and the subsequent reinterpretation of the emotional significance of the event to manage emotional reactions (Paniora *et al.*, 2017).

Despite the differences in perspectives, both problem-focused coping by Carver and Scheier and emotion-focused coping by Lazarus and Folkman recognize the significance of reappraisal as a coping mechanism. Reappraisal coping can be valuable in managing stress and adapting to challenging situations, enabling individuals to modify their emotional experiences or seek alternative solutions to the stressors they encounter.

Studies have shown that burnout dimensions vary, with reduced personal accomplishment developing independently from emotional exhaustion and depersonalization (Leiter, 1991). Emotional exhaustion and depersonalization are considered core factors of burnout, while reduced personal accomplishment is less frequently observed and is more associated with personality traits (Brenninkmeijer & VanYperen, 2003; Büssing & Glaser, 2000; Cordes & Dougherty, 1993; Maslach & Schaufeli, 2018).

Furthermore, the relationship between coping and burnout appears to be particularly strong among nursing professionals due to the demanding and stressful nature of their profession (Coffey & Coleman, 2001; H. Shin *et al.*, 2014).

Recent interventions have been designed to enhance coping skills and address burnout both at the individual and organizational levels. Person-directed interventions focus on improving job competence, personal coping skills, and social support, as well as incorporating relaxation exercises (Awajeh *et al.*, 2018).

The work by (Shin *et al.*, 2014) used a meta-analysis to analyze how demographic and occupational factors influence the relationship between coping strategies and burnout dimensions. Stress levels and the risk of burnout can be affected positively or negatively by the nature of a job, especially those

involving caregiving. With many studies examining burnout in the helping professions, a meta-analysis of 36 studies indicated that emotion-focused coping was positively connected with all three characteristics of burnout, while problem-focused coping was negatively correlated.

In their study, the researchers discovered that emotion-focused coping was more strongly associated with emotional exhaustion and depersonalization, while problem-focused coping was more strongly linked to reduced personal accomplishment. According to Shin *et al.*, occupational factors play a role in the connection between coping methods and burnout signs and symptoms. In contrast to those who solely focus on emotion regulation in the face of a stressful event, problem-focused people actively seek ways to alter their own behavior or the surrounding environment to ease their distress. The Findings (Devereux *et al.*, 2009; H. Shin *et al.*, 2014) contribute to our knowledge of the association between coping methods and burnout symptoms, highlighting the importance of work type and the role of coping in lowering burnout risk. These findings may be applicable to the present investigation of the experiences of those caring for adjudicated adolescents.

acknowledging that coping mechanisms can differ depending on the circumstances or may change over time even in comparable situations (Stoeber & Janssen, 2011) used a two-week diary study to look at the connection between two characteristics of perfectionism and coping mechanisms. A total of 149 students (116 female and 33 male) from the University of Kent in the UK took part in the study by answering questions on their daily stressors, coping strategies, and how they felt at the end of the day. According to the findings, perfectionism-related negative emotions are predicted by emotion-focused coping, avoidant coping, and social support methods, while perfection-related positive emotions are predicted by positive reframing, humor, and acceptance. The authors argued that an adaptable approach to coping was crucial to happiness. Although these results do not apply directly to the main caregivers of

adjudicated adolescents, they do offer additional coping skills that may improve health and well-being and lessen the likelihood of burnout.

Reduce burnout by (Isaksson Ro *et al.*, 2010) examined how a counseling intervention affected physicians' occupational stress and coping mechanisms in Norway. The study included 184 participants: 101 females and 83 males. After the session, participants reported much less emotional exhaustion, job stress, and emotion-focused coping compared to their baseline; there was no change from these initial values during the three-year follow-up. Further, the study found that a decrease in job stress and emotion-focused coping preceded a decrease in emotional fatigue, suggesting that interventions aimed at reducing job stress and increasing coping strategies may lessen the likelihood of burnout.

People who have been diagnosed with burnout and recommended for help, (Hätinen *et al.*, 2013) The research investigated the potential role of coping mechanisms in the recovery process from a person-centered perspective. The group included 85 people from Laukaa, Finland, with 75.3% being female because their employers nominated them. Clients were urged to build coping mechanisms to deal with the job pressures that had contributed to their burnout, as this is seen as an essential part of burnout rehabilitation. The findings showed that decreasing emotion-focused coping was linked to overcoming burnout and lowering depersonalization, but increasing avoidance-focused coping was not. Managing stressful negative emotions was also highlighted as crucial to overcoming burnout in the study.

In conclusion, coping strategies play a vital role in understanding and managing burnout symptoms. Emotion-focused coping and reappraisal coping are two significant strategies with varying perspectives, but both recognize the importance of reappraisal as a valuable tool for managing stress and adapting to challenging situations. The association between coping and burnout is complex, with burnout dimensions varying across different professions, such as nursing. Interventions aimed at enhancing coping skills and addressing burnout can be valuable in promoting individual well-being and organizational health.

2.5. Previous Studies:

Numerous studies have investigated burnout and coping strategies among psychiatric nurses, recognizing the unique challenges they face in their demanding and emotionally taxing work environment. This section provides a summary of key findings from notable studies in this area.

In a systematic review of quantitative studies conducted by (Labrague, 2021), It was revealed that the use of adaptive coping skills was associated with reduced levels of stress, stigma, and emotional strain. Maladaptive coping skills, on the other hand, were found to be connected to increased emotional stress. Similarly, a study conducted by (Simpson *et al.*, 2019) examined burnout levels, maladaptive schemas, and coping modes among clinical and counseling psychologists, and the findings indicated that coping modes do play a role in predicting burnout.

Several studies have examined the prevalence of burnout syndrome in nurses, and the findings indicate that around 30% exhibit severe symptoms of burnout syndrome and up to 86% test positively for at least one of the burnout subscales outlined by Maslach, which include emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment. The prevalence of burnout is not significantly higher depending on the nurse's work environment. However, nurses who work in high-stress areas such as critical care, the bone marrow transplant unit, the high-risk obstetrics unit, the post-operative anesthesia unit (PACU), the operating room, and the emergency department have a higher likelihood of experiencing burnout syndrome and concurrent PTSD diagnoses or symptoms (Embriaco *et al.*, 2007; Mealer *et al.*, 2012).

Previous research has highlighted the influence of burnout and diminishing performance among psychiatric professionals on clinical productivity and excellence, calling attention to the value of preventative actions improving self-awareness and self-care to forestall burnout, stress, and job

performance decline (Posluns & Gall, 2020). Self-stigma and the perception of risks and rewards associated with disclosure of painful emotions have been shown in studies to be significant barriers to seeking professional care among health professionals (Aulsbrook, 2021). These findings provided support for the idea that an individual's coping strategies play a role in whether they experience burnout.

The phenomenon of burnout, which is a psychological strain resulting from chronic work stress, has garnered significant attention in research, particularly within the field of human services providers. Extensive studies have examined burnout as both a symptom and an outcome, with a specific focus on psychiatric professionals experiencing emotional exhaustion, depersonalization of clients, and a diminished sense of personal accomplishment (Maslach & Jackson, 1981).

Researchers have used the Maslach Burnout Inventory (MBI) to determine how widespread burnout is among healthcare workers and the factors that contribute to it (Bazmi *et al.*, 2019). According to the findings, healthcare workers, including psychiatric professionals, showed high degrees of burnout across emotional exhaustion, depersonalization, and low personal accomplishment. Age, years of experience, and education were also found to play a role, with employees under the age of 30, women with advanced degrees, and those with more than 20 years of service showing greater rates of burnout.

Psychiatrists working in non-academic settings, especially inpatient facilities, and community mental health, were found to be at a greater risk for burnout in another study (Summers *et al.*, 2020). This highlights the importance of context in determining burnout and shows that certain work conditions may make mental health professionals more vulnerable to burnout.

Various studies have reported different levels of burnout among psychiatric nurses. Some studies, such as those by (Bohlender, 2022) and (Hamaideh, 2011), reported high levels of burnout in the depersonalization and emotional exhaustion domains among psychiatric nurses. However, the findings

of studies conducted by (Breen & Sweeney, 2013; Christodoulou-Fella *et al.*, 2017; McTiernan & McDonald, 2015; Sherring & Knight, 2009) showed contrasting results, with lower rates of emotional weariness and depersonalization, and higher rates of personal success among mental health nurses in Ireland and Greece. (Abdalrahim, 2013) found that psychiatric nurses predominantly utilize problem-focused coping strategies, suggesting that they may prioritize other coping mechanisms rather than directly addressing the underlying issues contributing to their stress.

In terms of coping strategies, psychiatric nurses were found to predominantly engage in positive reappraisal, problem-focused coping, and emotion-focused coping strategies. These coping strategies reflect their adaptive approach to managing work-related stress. Emotion-focused coping strategies were prevalent, indicating the nurses' recognition of the importance of emotional well-being in their profession and their efforts to cope with it.

The concept of burnout, initially introduced by Maslach (1976), has been instrumental in understanding the detrimental effects of chronic workplace stressors on individuals' physical and psychological health, as well as their personal and social functioning. Maslach's pioneering study highlighted the three dimensions of burnout: exhaustion, cynicism, and professional inefficacy. By identifying these dimensions, Maslach laid the foundation for further research on burnout and its implications.

The comprehensive theoretical review conducted by (Dall'Ora *et al.*, 2020) focused specifically on burnout in nursing. The study identified numerous factors associated with burnout in this profession, including a high workload, low control over the job, poor social support, and inadequate staffing levels. The consequences of burnout in nursing were found to include compromised patient safety, reduced job performance, and intentions to leave the profession. These findings emphasize the urgent need to address these factors and implement interventions that prevent and alleviate burnout among nurses.

(Gillespie & Melby, 2003) conducted a comparative study to examine burnout levels among nurses in accident and emergency (A&E) departments and acute medicine units. The study revealed higher levels of emotional exhaustion and depersonalization among nurses in A&E departments, indicating the demanding nature of work in these high-stress environments. The findings highlight the importance of implementing targeted interventions and support systems to address burnout and promote well-being among nurses working in A&E settings.

(Tawfik *et al.*, 2019) investigated the relationship between physician burnout, well-being, work unit safety grades, and self-reported medical errors. The study found that higher levels of physician burnout were associated with increased reporting of medical errors. Furthermore, better work unit safety grades were linked to lower rates of burnout and medical errors. These findings underscore the significance of addressing burnout and fostering a supportive and safe work environment, which can enhance patient safety and improve the quality of care provided by physicians.

The systematic review conducted by (Adriaenssens *et al.*, 2015) focused on the determinants and prevalence of burnout in emergency nurses. The review identified various factors contributing to burnout, including a high workload, a lack of control, interpersonal conflicts, and organizational factors. The prevalence of burnout varied across studies, highlighting the need for targeted interventions and organizational support to mitigate burnout and promote well-being among emergency nurses.

In conclusion, the reviewed studies have significantly contributed to our understanding of burnout in healthcare settings, particularly among nurses and physicians. Also, research indicates that coping strategies and organizational factors have a substantial impact on the prevalence of burnout among psychiatric professionals, including nurses and psychiatrists. Adaptive coping strategies, such as positive reappraisal and problem-focused coping, are

associated with lower levels of burnout, while maladaptive coping mechanisms can contribute to increased emotional strain and stress.

Addressing organizational factors, such as workload and support systems, is crucial to creating a supportive work environment that promotes well-being and mitigates burnout among psychiatric professionals. These studies highlight the importance of addressing factors such as workload, control over the job, social support, and organizational practices to prevent and alleviate burnout. Creating supportive work environments and implementing targeted interventions are crucial for promoting the well-being of healthcare professionals and improving patient outcomes. Future research should continue to explore effective strategies to prevent and manage burnout syndrome.

2.6. Theoretical Framework:

The foundation of any academic research lies in its theoretical underpinnings. A theoretical framework acts as the backbone of a research study, offering a lens through which a problem is examined and understood. It integrates and links key theories, concepts, and ideas that guide the research, providing context and direction. In the realm of understanding burnout levels and coping strategies among nurses in psychiatric hospitals, the chosen theoretical framework serves as a beacon, shedding light on intricate relationships and dynamics inherent in this environment. This section will delve into the central theories that inform our understanding of burnout and coping, particularly focusing on the works of (Maslach *et al.*, 2012). These foundational theories will be explored in depth, elucidating their relevance and application to the current study on nurses in psychiatric hospitals in Iraq.

2.6.1. Burnout Based on Maslach's Conceptualization

Burnout is a profound psychological phenomenon that predominantly emerges in individuals engrossed in challenging interpersonal engagements intrinsic to their occupational settings. This framework seeks to delve into the

intricate dimensions and causes of burnout, particularly drawing from Christina Maslach's seminal work on the topic.

2.6.1.1. Contextual Understanding of Burnout:

Epidemic Nature: As pointed out by (Maslach & Leiter, 1997), burnout has escalated to concerning levels among workers, notably in the North American context.

Root Causes: Burnout germinates from enduring emotional tensions that stem primarily from consistent interactions, especially with those grappling with grave issues. It represents a specialized form of occupational stress, inherently tied to the relational dynamics between caregivers or service providers and recipients.

2.6.1.2. Maslach's Triadic Conceptualization of Burnout:

Emotional Exhaustion: This represents the pinnacle of emotional drain experienced by workers. It encapsulates the heightened emotional demands imposed on professionals, pushing them to the brink of exhaustion.

Depersonalization: Within this dimension, professionals begin to perceive their clients or patients not as individuals but as mere objects. Such a dehumanized perspective leads to a detached or insensate demeanor, commonly termed as 'detached concern'.

Reduced Personal Accomplishment: This component encapsulates the dwindling sense of efficacy among professionals. It manifests when individuals feel their endeavors fail to yield fruitful outcomes or bring about positive change.

2.6.1.3. Interplay of Factors:

It is essential to understand that burnout is a composite outcome of the interplay between persistent emotional strain and the relational dynamics between providers and recipients of care. The strain, coupled with the

expectations and demands of interpersonal interactions, accelerates the path towards burnout.

This framework, founded on Maslach's profound insights, provides a comprehensive lens to interpret, analyze, and address the phenomenon of burnout, particularly within professions requiring intense interpersonal interactions.

2.6.2. Coping based on Lazarus and Folkman's Conceptualization

Coping, as an intrinsic mechanism, is paramount for individuals navigating the complexities of contemporary healthcare environments. This framework elaborates on the multifaceted nature of coping, drawing from established theoretical insights.

2.6.2.1. Determinants of Coping Choices:

Intrinsic & Extrinsic Influences: Coping strategies are not arbitrarily chosen but are influenced by a mélange of internal (e.g., beliefs, values, past experiences) and external factors (e.g., available resources like financial or social support).

2.6.2.2. Classification of Coping Behaviors:

Problem-Oriented vs. Affective-Oriented Strategies: General coping behaviors bifurcate into problem-oriented and affective-oriented methods. While the former, as its name suggests, directly confronts the stress-inducing issues, the latter addresses the emotional aspects tethered to the stress. Drawing upon (Keller, 1990), problem-oriented strategies are touted as constructive approaches to stress mitigation.

Temporal Dimensions of Coping: Within these broad classifications, coping can further be dissected temporally. Short-term methods, encompassing acts like eating or sleeping, prefer immediate relief but sidestep the root cause of stress. In contrast, strategies rooted in past experiences or discussions with peers exemplify long-term coping, targeting sustained stress alleviation.

This theoretical framework, grounded in the scholarship of Lazarus and Folkman (1984), Lazarus (1998), and Keller (1990), presents a comprehensive understanding of coping, especially in high-stress environments like healthcare.

Chapter three:

Methodology

Chapter Three: Methodology

3.1. Design of the Study:

The nature of this research was quantitative, and a descriptive correlational study design was employed in current study, within the psychiatric nursing field. This quantitative study was conducted through the period of September 19th, 2022, and June 1st, 2023. According to (Kesmodel, 2018) Cross-sectional studies were excellent for assessing the level of a condition or characteristic in a population at a specific time, which aligned with the first objective of measuring the levels of burnout and second objective to identify coping strategies among the nurses in psychiatric hospitals.

3.2. Administrative Permissions:

The Research Ethics Committee at the College of Nursing, University of Babylon, provided the essential permissions required to undertake the subsequent stages of the research, as outlined in Appendix (A). Additionally, the study necessitated authorization from the Health Department in Baghdad, which operates under Iraq's Health Ministry, to collect sample from nurses located within the psychiatric hospital departments.

3.3. Setting of the Study:

The study was conducted in Ibn-Rushed and Al-Rashad psychiatric hospitals, situated in Baghdad province. The research population was obtained through a single method, which involved disseminating survey papers format to identified departments within the hospitals in which nurses were employed based on inclusion criteria.

3.4. Population and sampling plan:

The research aimed to target nurses who were working in psychiatric hospitals, with the intention of ensuring comprehensive coverage of the relevant population. To achieve objectives of the present study, two hospitals were selected to collect a (n = 150) eligible nurses by non- probability purposive sampling method over a period of 30 days, from April 1st, 2023, to April 30th,

2023. The sample selection criteria were Both male and female nurses who work in psychiatric settings, The nurses had no prior history of physical and mental health problems and the nurses who had direct care responsibilities toward patients.

3.5. Ethical Considerations:

After providing an overview of the objectives, potential hazards, and advantages of the research, the individuals were requested to voluntarily decide whether to join or not. Once they agreed, they were provided with an anonymous survey instrument to ensure the privacy of their information. In addition, they were reassured that their data would only be used for research purposes.

3.6. Instrument of the Study:

An appropriate questionnaire consisting of four parts was adapted for this study through a comprehensive examination of pertinent literature and research. The questionnaire was utilized to assess the coping strategies and levels of burnout among nurses working at psychiatric hospitals (see Appendix B). The questionnaire is divided into the following parts:

3.6.1. Part one of the socio-demographic characteristics questionnaire:

The first part includes seven items of the socio-demographic variables for the nurses, including age, gender, educational level, residency, marital status, having children and monthly income.

3.6.2. Part two of the Occupational Characteristics Questionnaire:

The second part includes six items for occupational characteristics for nurses, including years of experience in a psychiatric hospital, workplace, additional administrative tasks inside the hospital, extra career outside the hospital, working shift, and number of working hours.

3.6.3. Part three of the Maslach Burnout Inventory (MBI):

The utilization of the "MBI-HSS" (Maslach Burnout Inventory: Human Services Survey), which has been widely adopted as an assessment tool for

evaluating burnout. The MBI-HSS, developed by Maslach *et al.* (1996), adopts a tripartite framework that enables the investigation of burnout levels among psychiatric nurses. The survey consists of 22 items aimed at addressing the research objectives pertaining to burnout levels among nurses working in psychiatric hospitals, while also evaluating burnout possibilities across three distinct domains: exhaustion, depersonalization, and personal accomplishment. It is important to note that, although the findings may appear promising, this instrument should not replace a comprehensive scientific diagnosis. Its purpose is solely to foster awareness regarding the susceptibility of individuals to burnout (Kim *et al.*, 2018).

The scale employed in this study is a self-reported instrument that is assessed and rated on a seven-point Likert scale. During the survey administration, participants were requested to indicate the frequency of specific behaviors or experiences using a scale ranging from 0 to 6. The response options encompassed a spectrum from "never" (score of 0) to "every day" (score of 6). This scale was implemented to assess the frequency of these behaviors or experiences, thereby facilitating a deeper understanding of the patterns and prevalence of these phenomena among the surveyed individuals. Subsequently, the obtained scores were subjected to analysis and interpretation, thereby yielding insights into the frequency of these behaviors or experiences among the survey respondents.

3.6.3.1. Domains, Scoring and Interpretation Information of the (MBI)

Domains of the Maslach Burnout Inventory (MBI) encompass the following aspects:

1. **Exhaustion Domain:**

Exhaustion Domain is characterized by feelings of extreme fatigue even at the mere contemplation of work, difficulty maintaining uninterrupted sleep, and the occurrence of other physical ailments. Exhaustion serves as a fundamental element of the syndrome, as emphasized by the MBI and numerous

scholarly sources. Notably, these issues tend to dissipate outside the work environment, unlike feelings of sadness.

The scoring criteria for the Exhaustion Domain are as follows:

- ❖ A total score of 16 or below indicates a low level of burnout.
- ❖ A score between 17 and 26 suggests moderate burnout.
- ❖ Scores above 27 indicate higher levels of burnout.

2. Depersonalization Domain:

Instead of referring to the dehumanization of social interactions, the concept of depersonalization (or loss of empathy) is used in this domain. Excessive detachment can lead to cynicism, hostility towards patients or colleagues, feelings of guilt, isolation, and a decline in social connections. The affected individual may find it challenging to exhibit compassion towards clients and/or coworkers.

The scoring criteria for the Depersonalization Domain are as follows:

- ❖ A total score of 6 or below indicates a low level of burnout.
- ❖ A score between 7 and 12 suggests moderate burnout.
- ❖ A score of 13 or higher indicates high levels of burnout.

3. Personal Accomplishment (Scores Reversed):

Personal accomplishment is characterized by a diminished sense of achievement, wherein individuals evaluate themselves negatively and conclude that they lack the ability to improve their circumstances. This aspect reflects the discouraging effects of a persistent and challenging situation that consistently leads to failure, regardless of considerable effort. The affected individual begins to question their ability to attain their goals. The first two domains contribute to the development of this aspect. If an individual demonstrates positive scores in the first two domains but exhibits a low score in the third domain, it may indicate the presence of burnout. For ease of interpretation, scores in this domain are reversed and aligned with the direction of the first two domains.

The scoring criteria for the Personal Accomplishment Domain are:

- ❖ A score of 31 or below indicates a low level of burnout.

- ❖ A score between 32 and 38 suggests moderate burnout.
- ❖ A score of 39 or above indicates high levels of burnout.

3.6.4. Part Four of the Brief COPE Scale:

The study assessed the coping strategies of the independent variable using the Brief COPE (Carver, 1997), which divides coping styles into three groups: "emotional, problem-focused, and dysfunctional or avoidant coping." This tool was originally developed to examine coping techniques such as emotion-focused coping, problem-focused coping, and avoidant coping in health research. It was derived from a longer inventory that had been previously used in research. According to Carver (1997), adaptive techniques such as "emotion-focused and problem-focused coping" have been linked to positive outcomes, while dysfunctional coping has been linked to negative outcomes. This scale is designed to be self-reported and measured on a 4-level rating scale, with the following ratings:

1= I haven’t been doing this at all

2= I’ve been doing this a little bit

3= I’ve been doing this a medium amount

4= I’ve been doing this a lot

Within each level, there are four possible responses to indicate how frequently the behavior or activity is performed. The responses range from 1, which means the behavior or activity has not been done at all, to 4, which indicates that the behavior or activity has been done a lot. By using this scale, researchers can assess the frequency of various behaviors or activities with more precision.

3.6.4.1. Domains, Scoring and Interpretation Information of brief cope:

Scores are presented for three overarching coping styles as average scores (sum of item scores divided by number of items), indicating the degree to which the respondent has been engaging in that coping style. According to (Carver, 1997) During interpretation it is most helpful to look at the pattern of responding across the three subscales. Consistently low scores on all subscales may indicate either:

(A) the respondent does not feel they have many stressors to cope with. For example, that life is stress free.

(B) a lack of reflective capacity or resistance to disclosing personal information.

(C) the respondent does not have many coping skills. The three overarching coping styles are outlined below.

1. **Problem-Focused Coping (Items 2, 7, 10, 12, 14, 17, 23, 25)**

Characterized by the facets of *active coping, use of informational support, planning, and positive reframing*. A high score indicates coping strategies that are aimed at changing stressful situations. High scores are indicative of psychological strength, grit, a practical approach to problem solving and is predictive of positive outcomes.

2. **Emotion-Focused Coping (Items 5, 9, 13, 15, 18, 20, 21, 22, 24, 26, 27, 28)**

Characterized by the facets of *venting, use of emotional support, humor, acceptance, self-blame, and religion*. A high score indicates coping strategies that are aiming to regulate emotions associated with stressful situations. High or low scores are not uniformly associated with psychological health or ill health but can be used to inform a wider formulation of the respondent's coping styles.

3. Avoidant Coping (Items 1, 3, 4, 6, 8, 11, 16, 19)

Characterized by the facets of *self-distraction*, *denial*, *substance use*, *and behavioral disengagement*. A high score indicates physical or cognitive efforts to disengage from the stressor. Low scores are typically indicative of adaptive coping. In addition to the three overarching subscales, scores are presented for the below 14 facets. Individual examination of the questions can pinpoint adaptive or maladaptive styles of coping and be useful for eliciting a discussion with the respondent.

- **Scores are also presented for each of the following facets:**
  - **Problem-Focused**

1. Active coping, items 2 & 7 (Problem-Focused)
2. Use of informational support, items 10 & 23 (Problem-Focused)
3. Positive reframing, items 12 & 17 (Problem-Focused)
4. Planning, items 14 & 25 (Problem-Focused)

  - **Emotion-Focused**

1. Emotional support, items 5 & 15 (Emotion-Focused)
2. Venting, items 9 & 21 (Emotion-Focused)
3. Humor, items 18 & 28 (Emotion-Focused)
4. Acceptance, items 20 & 24 (Emotion-Focused)
5. Religion, items 22 & 27 (Emotion-Focused)
6. Self-blame, items 13 & 26 (Emotion-Focused)

❖ **Avoidant**

1. Self-distraction, items 1 & 19 (Avoidant)

2. Denial, items 3 & 8 (Avoidant)

3. Substance use, items 4 & 11 (Avoidant)

4. Behavioral disengagement, items 6 & 16 (Avoidant)

3.7. Validity of the Questionnaire:

The concept of validity refers to the extent to which the data gathered accurately reflects the intended scope of the test. Validity refers to whether the instrument measures what it claims to measure. These four types of validity are: (face, content, construct, and criterion) validity (Taherdoost, 2016).

Seven specialists representing a wide range of scientific disciplines worked together to refine the study protocol and instrument. These individuals all have extensive experience in their respective fields. The study's expert panel was asked to provide feedback on the study instrument's clarity, usefulness, appropriateness, and ease of use. Each specialist revised the instrument in terms of its scientific content, informational flow, and ability to carry out the sample-gathering task at hand. As a result, the advised adjustment was made to the apparatus. (As stated in Appendix C).

3.8. Pilot Study:

The primary aim of this pilot study was to assess the dependability and accuracy of the research tool, test its readability, and assess how long it should take to collect data from each participant based on estimates made during interviews, and spot any potential stumbling blocks.

3.9. Reliability of the Questionnaire:

A total of 15 nurses were recruited as study participants. The researcher introduced the study and invited the participants to share their views on burnout

and coping strategies. Participants provided self-reports individually, and the researcher explained the study's purpose and title. During the interview, participants were asked to complete the questionnaire to assess its ease of use, clarity, and estimated time to complete.

The data collected from the pilot study were analysed, and no changes were made. Consequently, the experimental study was not included in the original sample. The Cronbach's alpha value was found to be 0.70 or higher, which indicates a high level of reliability.

3.9.1. Table of Reliability of the Studied Questionnaire (*n=15*)

Reliability Statistics			
Scales	**No. Of Items**	**Cronbach's Alpha**	**Ass.**
MBI	**22**	**.87**	**Acceptable**
Brief COPE	**28**	**.81**	**Acceptable**

This table was statistically created to display the study instrument's reliability coefficient. The calculated outcome demonstrates that the questionnaire is a valid tool for examining the phenomenon of psychiatric nurses' burnout and coping strategies in the same group at any point in the future.

3.10. Data Gathering:

The data collection process started on April 1st, 2023, and continued until April 15th, 2023, after obtaining all necessary approvals. To ensure adequate sample size within a limited time frame, only one type of data collection method was used, and the questionnaire was distributed in paper form to participants selected from general psychiatric hospital departments. All participants were informed of the study's purpose and asked to participate voluntarily. Participants with a history of mental health problems were not allowed to complete the questionnaire and were excluded if they responded yes to the question about a history of mental illness. The participants were supervised by the researcher throughout the completion of the self-report, which took approximately 20-25 minutes per form.

3.11. Statistical Data Analysis:

The researcher used SPSS-26 and Microsoft Excel (2022) to analyze the data collected from the study sample, process it statistically to find relationships between variables, and extract the results of the study through a set of statistical tests, all of which were instrumental in arriving at the final conclusions. Two approaches were used in the present study, as follows:

3.11.1. Descriptive Approach:

1. Statistical tables of Frequencies (No.) and Percent %.
2. Mean of scores M.S. and the overall average score M±.
3. Standard Deviation test ±SD.
4. Cronbach's alpha.

3.11.2. Inferential Approach:

1. **Analysis of variance (ANOVA):**

This test is utilized to determine the differences in dependent variables with regards to independent variables, such as differences in nurse burnout with different socio-demographic characteristics (only with more than two class variables). at (significant level sig.) 0.05 indicated the statistical differences.

2. **T-Test for independent Samples:**

Different levels of burnout among nurses, for example, were used as examples of dependent variables and their associations with independent variables, and so on (only with two class variables). at (significant level sig.) 0.05 indicated the statistical differences.

3. **Pearson's correlation coefficient (r):**

This test was used to correlate study variables such as nurses' burnout and coping strategies. in which (-r) means negative correlation and (+r) means positive correlation at significant levels of 0.01** and 0.05*.

4. **Simple Linear Regression:**

to examine which job variables can predict nurses' burnout. in which (-β) means negative prediction and (+β) positive predication.

3.12. Limitations of the Study:

1. The major limitation of the study is the small sample size (N = 150).
2. Causality cannot be determined by cross sectional study design since it measures the relationship between two variables at a limited point in time, which minimizes the chance of generalizing the recent findings to all psychiatric nurses.
3. In this study, the participants were not chosen randomly; therefore, this might also influence the generalizability of the research results.
4. The study utilized self-administered questionnaires to gauge nurses' perceptions of burnout and coping strategies. With self-report measures, there's a risk that participants might either understate or exaggerate their responses. One potential concern in the study could be the "social desirability bias," where participants might lean towards providing socially acceptable answers rather than expressing their genuine feelings or experiences. Such bias is commonly observed when individuals are questioned about sensitive topics like illegal activities, sexual matters, or opinions that might deviate from societal norms (Salzmann-Erikson, 2015).

Chapter Four:

Results Of the Study

Chapter Four: Results of The Study

4.1. Descriptive statistics of the study variables:

Table 4.1.1: Descriptive statistics of the nurses by their sociodemographic

Demographic variables	categories	No.	%
1. Age	From 18 to 23 years	25	16.7
	From 24 to 29 years	41	27.3
	From 30 to 35 years	40	26.7
	From 36 to 41 years	29	19.3
	More than 41 years old	15	10.0
	Total	150	100
2. gender	Male	91	60.7
	Female	59	39.3
	Total	150	100
3. Educational Level	Secondary vocational education	41	27.3
	Diploma	39	26.0
	Bachelor's degree	67	44.7
	Post Graduate degree	3	2.0
	Total	150	100
4. Residency	Urban	137	91.3
	Rural	13	8.7
	Total	150	100
5. Marital Status	Single	46	30.7
	Married	93	62.0
	Divorced	8	5.3
	Widower	3	2.0
	Total	150	100
6. Having Children	Yes	65	43.3
	No	85	56.7
	Total	150	100
7. Monthly Income	Not enough	54	36.0
	Somewhat enough	61	40.7
	Enough	35	23.3
	Total	150	100

No.= Number; %= Percentage

The study revealed information about the participants. The highest percentage, 27.3%, was found among the second age group (24–29) years, and 26.7% was found among the group (30–35) years. In terms of gender, males made up 60.7%, while females made up the remaining proportion. The most common level of education was a bachelor's degree (44.7%) compared to other levels of education. Most participants were from urban areas (91.3%). In terms of marital status, 62% were married, and the remaining participants fell into other categories. In terms of parental status or having children, 56.7% of the total sample of 150 participants did not have children, while the remaining participants did. Finally, a larger proportion of participants, 40.7%, reported having a somewhat adequate monthly income compared to the other categories. Monthly incomes were identified depending on the question directed to the sample.

Table 4.1.2: Descriptive Statistics of The Nurses by Their Occupational Characteristics

Occupational Variables	Categories	No.	%
1. years of nurses' experience in the psychiatric hospital	Less than 1 year	54	36.0
	From 1 to 2 years	36	24.0
	From 3 to 5 years	24	16.0
	More than 5 years	36	24.0
	Total	150	100
2. Workplace In the Hospital	Psychological counselling unit	11	7.3
	Patient care unit in the wards	117	78.0
	ECT treatment unit	7	4.7
	Mental health rehabilitation unit	6	4.0
	Emergency care unit	9	6.0
	Total	150	100
3. Additional administrative tasks in the hospital	No	112	74.7
	Yes	38	25.3
	Total	150	100
4. Additional career outside the hospital	No	97	64.7
	Yes	53	35.3
	Total	150	100
5. Working shift in the hospital	Morning	73	48.7
	Evening	77	51.3
	Total	150	100
6. Number of working hours per day in the hospital	7 hours	73	48.7
	18 hours	77	51.3
	Total	150	100

No.= Number; %= Percentage

The findings of the present investigation demonstrate that a considerable proportion of the nurses (36%) reported having less than one year of experience in the field of psychiatric nursing. Moreover, the majority (78%) of the nurses were employed in the patient care unit in the wards, while a significant number (74.7%) did not have any supplementary administrative responsibilities within the hospital. Additionally, a substantial proportion (64.7%) of the nurses did not hold any other employment outside the hospital setting. More than half of the

nurses (51.3%) worked during the evening shift and a similar proportion (51.3%) worked for (18) hours per shift.

Table 4.1.3: Descriptive Statistics of the Nurse's Burnout by Exhaustion

Exhaustion Items	0	1	2	3	4	5	6	M.s	Ass.
	No.	No.	No.	No.	No.	No.	No.		
1. I feel emotionally drained by my work.	15	9	5	10	17	56	38	4.17	High
2. Working with people all day long requires a great deal of effort.	6	5	4	8	9	24	94	5.05	High
3. I feel like my work is breaking me down.	28	47	9	6	5	14	41	2.79	Moderate
4. I feel frustrated by my work.	27	10	6	47	9	7	44	3.32	Moderate
5. I feel I work too hard at my job.	41	8	5	7	47	15	27	3.09	Moderate
6. It stresses me too much to work in direct contact with people.	26	9	5	12	9	50	39	3.83	Moderate
7. I feel like I am at the end of my rope.	73	21	12	10	6	7	21	1.73	Low

Level of Assessment (Low=0-2; Moderate=2.1-4; High=4.1-6)

[0= Never; 1=A Few Times Per Year; 2=Once A Month; 3=A Few Times Per Month; 4=Once A Week; 5=A Few Times Per Week; 6=Every Day]

The table provides statistical evidence that the nurses displayed a moderate level of burnout in relation to exhaustion across all the examined items, except for items 1 and 2, for which the responses indicated a high level of burnout. Conversely, for item 7, the responses revealed a low level of burnout.

Table 4.1.4: Descriptive Statistics of the Nurses' Burnout in Terms of Depersonalization

Depersonalization Items	0	1	2	3	4	5	6	M.s	Ass.
	No.	No.	No.	No.	No.	No.	No.		
1. I feel I look after certain patients/clients impersonally, as if they are objects.	103	10	11	7	0	10	9	1.05	Low
2. I feel tired when I get up in the morning and must face another day at work.	44	13	5	15	7	11	55	3.21	Moderate
3. I have the impression that my patients/clients make me responsible for some of their problems.	47	14	1	22	7	23	36	2.94	Moderate
4. I am at the end of my patience at the end of my workday.	43	15	7	14	11	14	46	3.07	Moderate
5. I really don’t care about what happens to some of my patients/clients.	94	9	12	6	5	11	13	1.36	Low
6. I have become more insensitive to people since I've been working.	68	9	17	5	14	6	31	2.2	Moderate
7. I'm afraid that this job is making me uncaring.	69	6	5	2	10	15	43	2.63	Moderate

Level of Assessment (Low=0-2; Moderate=2.1-4; High=4.1-6)

[0= Never; 1=A Few Times Per Year; 2=Once A Month; 3=A Few Times Per Month; 4=Once A Week; 5=A Few Times Per Week; 6=Every Day]

This table illustrates that the nurses reported a moderate level of burnout related to depersonalization across all the examined items, except for items (1) and (5), for which the responses indicated a low level of burnout.

Table 4.1.5: Descriptive Statistics of Nurses' Burnout in Terms of Personal Accomplishment (Reverse Scores)

Personal Accomplishment Items	0	1	2	3	4	5	6	M.s	Ass.
	No.	No.	No.	No.	No.	No.	No.		
1. I accomplish many worthwhile things in this job.	4	0	0	1	1	90	54	5.21	High
2. I feel full of energy.	5	0	24	1	2	97	21	4.47	High
3. I am easily able to understand what my patients/clients feel.	3	1	0	1	0	92	53	5.21	High
4. I look after my patients'/clients' problems very effectively.	4	0	0	1	1	96	48	5.17	High
5. In my work, I handle emotional problems very calmly.	1	0	0	4	2	97	46	5.21	High
6. Through my work, I feel that I have a positive influence on people.	3	0	0	1	9	90	47	5.14	High
7. I am easily able to create a relaxed atmosphere with my patients/clients.	3	0	0	2	3	90	52	5.20	High
8. I feel refreshed when I have been close to my patients/clients at work	5	1	0	8	4	88	44	4.97	High

Level of Assessment (Low=0-2; Moderate=2.1-4; High=4.1-6)

[0= Never; 1=A Few Times Per Year; 2=Once A Month; 3=A Few Times Per Month; 4=Once A Week; 5=A Few Times Per Week; 6=Every Day]

Concerning the mean score, this table indicated that the nurses reported a high level of burnout related to personal accomplishment across all the items on the scale that were examined.

Table 4.1.6: Distribution of Nurses Burnout by their Overall Domains

Scale	Min.	Max.	M.	SD.	Score	No.	%
Exhaustion (7Q)	**0**	**42**	**23.98**	**10.93**	**Low Burnout (0-16)**	**41**	**27.3**
					Moderate Burnout (17-26)	**59**	**39.3**
					High Burnout (27-42)	**50**	**33.3**
					Total	**150**	**100.0**
Depersonalization (7Q)	**0**	**42**	**16.46**	**11.72**	**Low Burnout (0-6)**	**26**	**17.3**
					Moderate Burnout (7-12)	**37**	**24.7**
					High Burnout (13-42)	**87**	**58.0**
					Total	**150**	**100.0**
Personal Accomplishment (8Q) (Scores Reversed)	**3**	**48**	**40.58**	**6.53**	**Low Burnout (0-31)**	**6**	**4.0**
					Moderate Burnout (32-38)	**6**	**4.0**
					High Burnout (39-48)	**138**	**92.0**
					Total	**150**	**100.0**

Min.: Minimum; Max.: Maximum, M: Mean for total score, SD=Standard Deviation for total score

This table presents an overview of the distribution of burnout among nurses across the various domains, with the following observations: Regarding exhaustion, 39.3% of nurses reported a moderate level of burnout (Mean=23.98; SD=10.93). Concerning depersonalization, 58% of nurses reported a high level of burnout (Mean=16.46; SD=11.72). In terms of personal achievement, most nurses (92%) reported a high level of burnout (Mean=40.58; SD=6.53).

Table 4.1.7: Descriptive Statistics for Coping Strategies in Terms of Problem - Focused Coping

Problem Focused Items	1	2	3	4	M.s	Ass.
	No.	No.	No.	No.		
1. I've been concentrating my efforts on doing something about the situation I'm in	77	34	13	26	1.92	Low
2. I've been taking action to try to make the situation better	79	18	22	31	2.03	Moderate
3. I've been getting help and advice from other people	111	21	11	7	1.43	Low
4. I've been trying to see it in a different light, to make it seem more positive	70	14	26	40	2.24	Moderate
5. I've been trying to come up with a strategy about what to do	63	29	26	32	2.18	Moderate
6. I've been looking for something good in what is happening	84	28	22	16	1.80	Low
7. I've been trying to get advice or help from other people about what to do	101	21	14	14	1.61	Low
8. I've been thinking hard about what steps to take	61	23	32	34	2.26	Moderate

Level of Assessment (Low=1-2; Moderate=2.1-3; High=3.1-4)

[1=I have not been doing this at all; 2=I have been doing this a little bit; 3=I have been doing this a medium amount; 4=I have been doing this a lot]

With respect to the average score, the above table demonstrated that the nurses reported a low level of response to problems related to items 1, 3, 6, and 7, while they reported a moderate level of response to problems related to items 2, 4, 5, and 8.

Table 4.1.8: Descriptive Statistics for Coping Strategies in Terms of Emotion - Focused Coping

Emotional Focused Items	1	2	3	4	M.s	Ass.
	No.	No.	No.	No.		
1. I've been getting emotional support from others	103	29	12	6	1.47	Low
2. I've been saying things to let my unpleasant feeling escape	73	24	13	40	2.13	Moderate
3. I've been criticizing myself	61	22	26	41	2.31	Moderate
4. I've been getting comfort and understanding from someone	84	21	14	31	1.95	Low
5. I've been making jokes about it	52	16	21	61	2.61	Moderate
6. I've been accepting the reality of the fact that it has happened.	55	18	18	59	2.54	Moderate
7. I've been expressing my negative feelings.	44	12	26	68	2.79	Moderate
8. I've been trying to find comfort	34	17	29	70	2.90	Moderate
9. I've been learning to live with it	35	29	28	58	2.73	Moderate
10. I've been blaming myself for things that happened.	40	23	21	66	2.75	Moderate
11. I've been praying or meditating.	38	16	30	66	2.83	Moderate
12. I've been making fun of the situation.	61	11	25	53	2.47	Moderate

Level of Assessment (Low=1-2; Moderate=2.1-3; High=3.1-4)

[1=I have not been doing this at all; 2=I have been doing this a little bit; 3=I have been doing this a medium amount; 4=I have been doing this a lot]

Regarding the average rating, according to this table, the nurses reported a moderate level of response to emotional focus across all the examined items, except for items 1 and 4, for which the responses indicated a low level of emotional focus.

Table 4.1.9: Descriptive Statistics for Coping Strategies in Terms of Avoidant Coping

Avoidant Coping Items	1	2	3	4	M.s	Ass.
	No.	No.	No.	No.		
1. I've been turning to work or other activities to take my mind off things	54	17	21	58	2.55	Moderate
2. I've been saying to myself "this isn't real".	89	12	8	41	2.01	Moderate
3. I've been using alcohol or other drugs to myself feel better.	147	1	1	1	1.04	Low
4. I've been giving up trying to deal with it.	65	28	12	45	2.25	Moderate
5. I've been refusing to believe that it has happened	146	2	1	1	1.05	Low
6. I've been using alcohol or other drugs to help me get	98	17	5	30	1.78	Low
7. I've been giving up the attempt to cope	85	18	4	43	2.03	Moderate
8. I've been doing something to think about it less, such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping	80	23	8	39	2.04	Moderate

Level of Assessment (Low=1-2; Moderate=2.1-3; High=3.1-4)

[1=I have not been doing this at all; 2=I have been doing this a little bit; 3=I have been doing this a medium amount; 4=I have been doing this a lot]

Considering the mean score, this table indicated that the nurses reported a moderate level of response to avoidant coping across all the items examined, except for items 3, 5, and 6, for which the responses indicated a low level of avoidant coping.

Table 4.1.10: Distribution of Coping Strategies by Their Overall Domains

Scale	Min.	Max.	M	SD	Score	No.	%
Problem- Focused Coping (8 Q)	**8**	**29**	**15.47**	**6.01**	**Low (8-16)**	**138**	**92.0**
					Moderate (16.1-24)	**6**	**4.0**
					High (24.1-32)	**6**	**4.0**
					Total	**150**	**100.0**
Emotional- Focused Coping (12 Q)	**12**	**45**	**29.84**	**7.69**	**Low (12-24)**	**38**	**25.3**
					Moderate (24.1-36)	**80**	**53.3**
					High (36.1-48)	**32**	**21.3**
					Total	**150**	**100.0**
Avoidant- focused Coping (8 Q)	**12**	**26**	**14.75**	**5.99**	**Low (8-16)**	**107**	**71.3**
					Moderate (16.1-24)	**20**	**13.3**
					High (24.1-32)	**23**	**15.3**
					Total	**150**	**100.0**

Min.: Minimum; Max.: Maximum, M: Mean for total score, SD=Standard Deviation for total score

This table presents the distribution of nurses according to their coping strategies in general and reveals the following results: With respect to problem-focused coping, the majority (92%) reported a low level (mean = 15.47; SD = 6.01). In terms of emotional-focused coping, more than half (53.3%) reported a moderate level (mean = 29.84; SD = 7.69). As for avoidant coping, most nurses (71.3%) reported a low level (mean = 14.75; SD = 5.99).

4.2. Association Between Nurses' Burnout and Coping Strategies:

Table 4.2.1: Association Between Nurses' Burnout and Problem-Focused

Correlation Statistics	1	2	3	4	P. Value
1. Problem Focused	1				
2. Exhaustion	-.431-**	1			.000
3. Depersonalization	-.127-*	.093	1		.005
4. Personal Accomplishment	.307**	-.081-	-.168-*	1	.000

***. The correlation is significant at the 0.01 level.*

**. The correlation is significant at the 0.05 level.*

According to the results, problem-focused coping strategies were associated with lower levels of exhaustion (r= -.431; p= .000) and depersonalization (r= -.127; p= .005). On the other hand, there was a positive association between the use of problem-focused coping strategies and personal accomplishment (r= .307; p= .000).

Table 4.2.2: Association between Nurses' Burnout and Emotion-Focused

Correlation Statistics	1	2	3	4	P. Value
1. Emotional Focused	1				
2. Exhaustion	.269**	1			.000
3. Depersonalization	.222**	.093	1		.000
4. Personal Accomplishment	-.197-*	-.081-	-.168-*	1	.005

***. The Correlation is significant at the 0.01 level.*

**. The Correlation is significant at the 0.05 level.*

The findings show emotional focused coping was positively correlated with exhaustion (r=.269; p=.000) and depersonalization (r=.222; p=.000), but negatively correlated with personal accomplishment (r=-.197; p=.005).

Table 4.2.3: Association between Nurses' Burnout and Avoidant Coping

Correlation Statistics	1	2	3	4	P. Value
1. Avoidant Coping	1				
2. Exhaustion	-.069-	1			
3. Depersonalization	-.805-**	.093	1		.000
4. Personal Accomplishment	-.168-*	-.081-	-.168-*	1	.005

***. The correlation is significant at the 0.01 level.*

**. The correlation is significant at the 0.05 level.*

According to what we found, there was an inverse relationship between avoidant coping and depersonalization (r= -.805; p= .000). Additionally, there was a negative correlation between avoidant coping and personal achievement (r=- .168; p= .005).

4.3. Differences in Nurses' Burnout by Their Sociodemographic data:

Table 4.3.1: Statistical Differences in Burnout Based on of the Age

Age	Source of variance	Sum of Squares	D. F	Mean Square	F-statistic	Sig.
Burnout	Between Groups	22.070	4	5.518	6.429	.000
	Within Groups	124.443	145	.858		
	Total	146.513	149			

The examination of variance indicated that there were notable statistical distinctions in burnout among nurses concerning their age categories (F=6.429; p=.000).

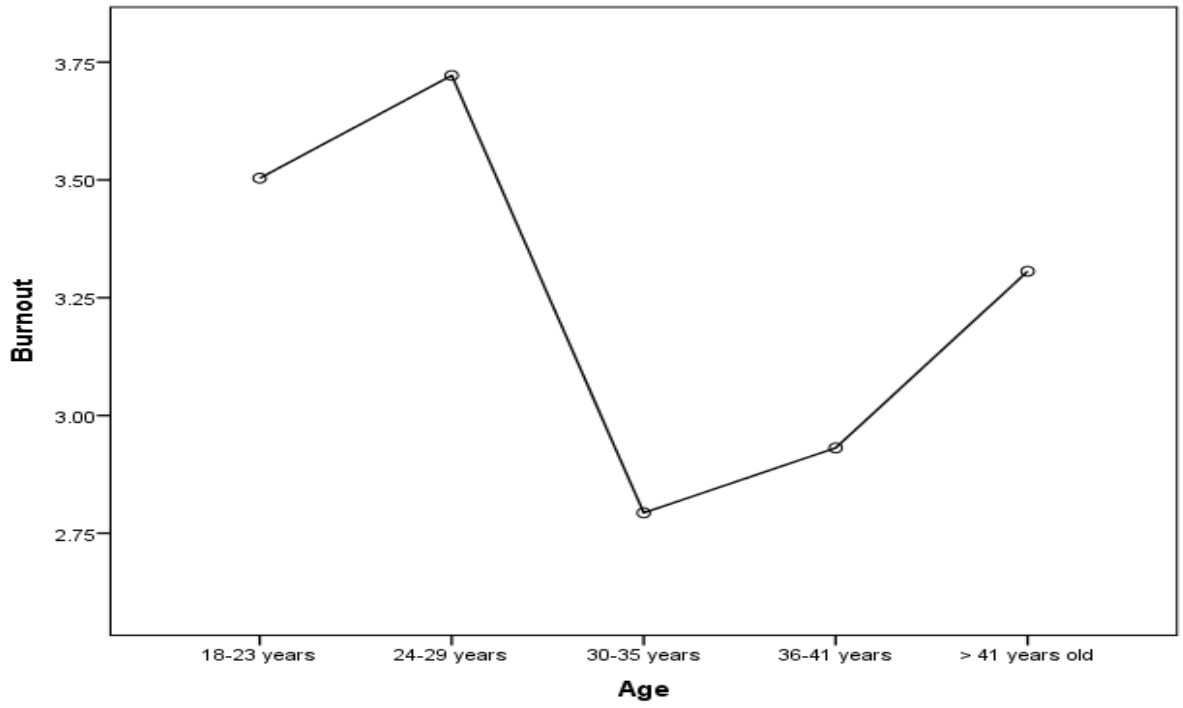

Fig. 1: Distribution of Burnout between Groups of Age

Table 4.3.2: Statistical Differences in Burnout Between the Groups of gender

Burnout	gender	Mean	SD	t-value	D. F	*Sig.*
	Male	**2.90**	**1.054**	**5.785**	**148**	**.000**
	Female	**3.77**	**.578**			

The results of the independent sample t-test revealed that there were significant statistical variations in burnout among nurses in relation to their gender (t=5.785; p=.000).

Table 4.3.3: Statistical Differences in Burnout based on of Education Level

Educational Level	Source of variance	Sum of Squares	D. F	Mean Square	*F-statistic*	*Sig.*
Burnout	**Between Groups**	**41.502**	**3**	**13.834**	**19.234**	**.000**
	Within Groups	**105.011**	**146**	**.719**		
	Total	**146.513**	**149**			

Based on means-variance analysis, the findings indicated statistically significant variations in burnout among nurses, considering their level of education (F=19.234; p=.000).

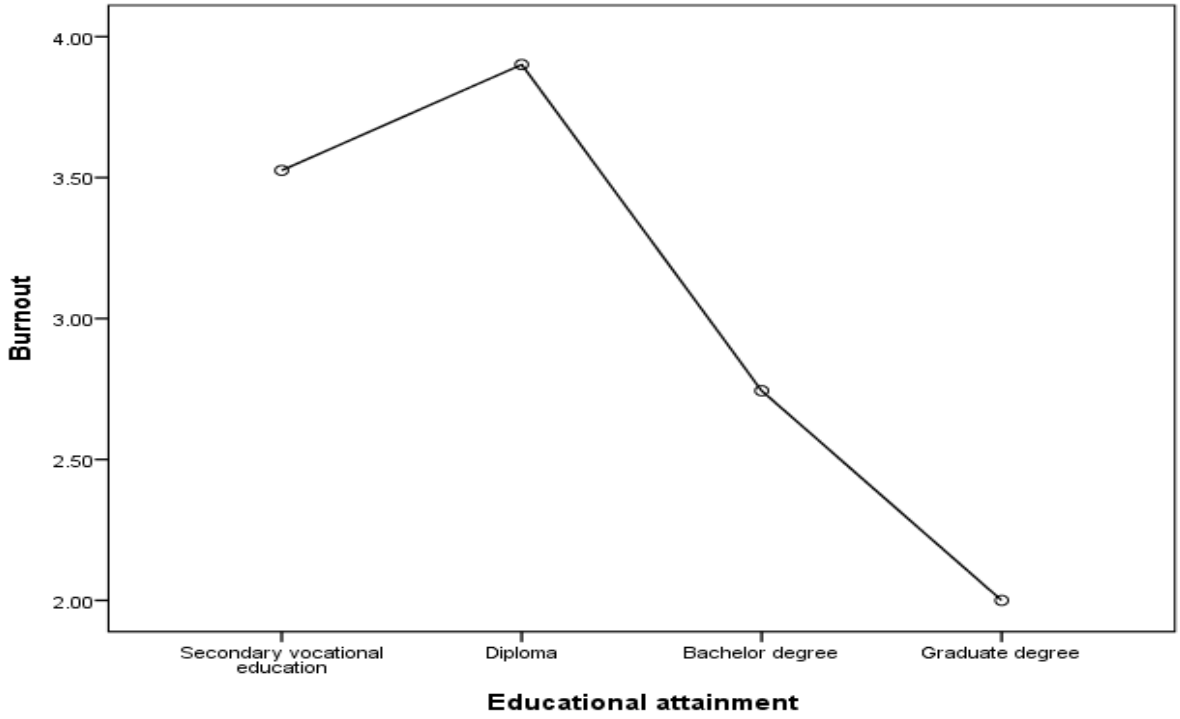

Fig. 2: Distribution of Burnout between Groups of Education Level

Table 4.3.4: Statistical Differences in Burnout Based on Residency Area

Burnout	**Residency**	**Mean**	**SD**	**T-Value**	**D.F**	***Sig.***
	Urban	**3.23**	**.991**	**.231**	**148**	**.818**
	Rural	**3.30**	**1.030**			

In terms of nurses' residency, the independent sample t-test showed no significant statistical variations in burnout (t =.231; p =.818).

Table 4.3.5: Statistical Differences in Burnout Based on Marital Status

Marital Status	Source of variance	Sum of Squares	D. F	Mean Square	F-statistic	*Sig.*
Burnout	**Between Groups**	**20.354**	**3**	**6.785**	**7.851**	**.000**
	Within Groups	**126.159**	**146**	**.864**		
	Total	**146.513**	**149**			

Statistically significant differences were found in the analysis of variance in burnout among nurses regarding their marital status (F=7.851; p=.000).

Fig. 3: Distribution of Burnout between Groups of Marital Status

Table 4.3.6: Statistical Differences in Burnout Based on Having Children

Burnout	Having Children	Mean	SD	T-Value	D. F	*Sig.*
	No	**3.23**	**.956**	**.128**	**148**	**.899**
	Yes	**3.25**	**1.023**			

Statistical analysis using an independent sample t-test revealed no discernible variation between levels of burnout experienced by nurses who have children and those who do not (*T=.128; P=.899*).

Table 4.3.7: Statistical Differences in Burnout Based on Monthly Income:

Monthly Income	**Source of variance**	**Sum of Squares**	**D. F**	**Mean Square**	***F-statistic***	***Sig.***
Burnout	**Between Groups**	**29.101**	**2**	**14.550**	**18.217**	**.000**
	Within Groups	**117.412**	**147**	**.799**		
	Total	**146.513**	**149**			

Based on means-variance analysis, it was discovered statistically significant variations in burnout between nurses in relation to their monthly income (F=18.217; p=.000).

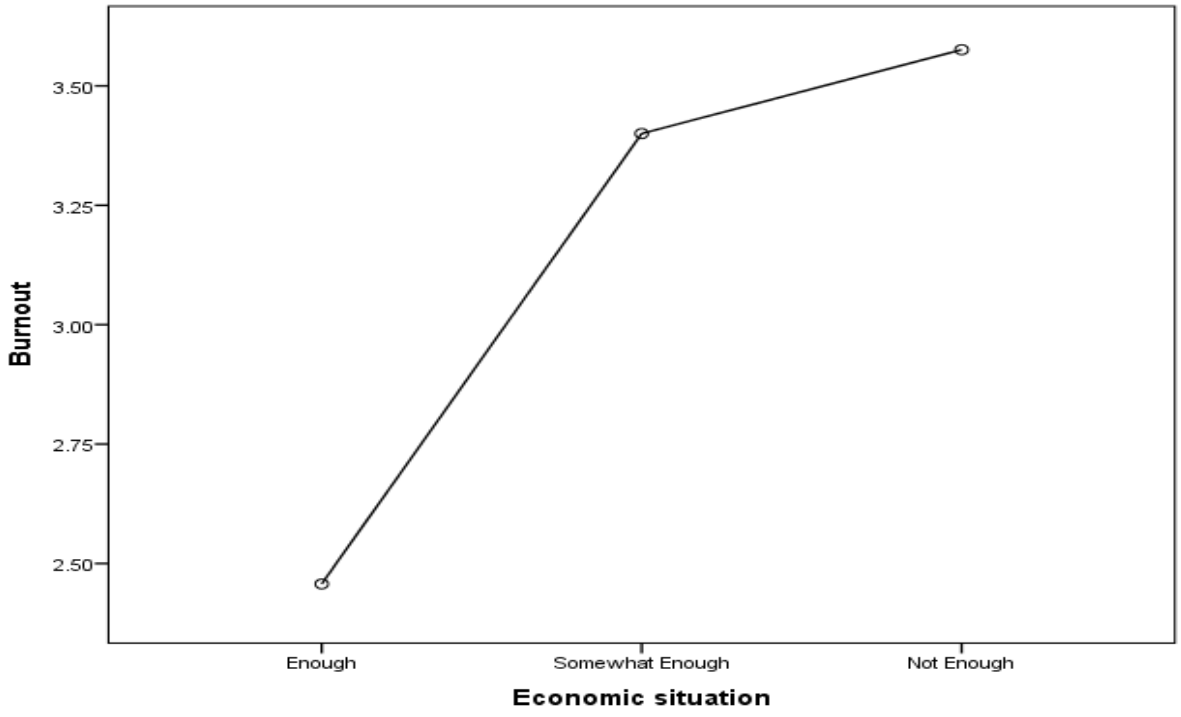

Fig. 4: Distribution of Burnout between Groups of Monthly Income

4.4. Predisposing Factors for Burnout among psychiatric nurses:

Table 4.4.1: Simple Linear Regression Analysis to Predict the Burnout Based on Job Characteristic

Variables	Unstandardized Coefficients		Standardized Coefficients	T	*Sig.*
	B	St. Error	Beta		
1. Years of Experience working in a psychiatric unit.	-.146-	.039	-.199-	-1.189-	.036
2. Workplace area.	.003	.054	.061	.918	.157
3. Extra responsibilities related to administrative duties.	.133	.111	.104	1.200	.032
4. Nurses Having Other employment opportunities beyond the hospital setting.	.188	.098	.176	1.898	.001
5. Working Time in The Hospital.	.026	.192	.013	.360	.271
6. Number Of Working Hours Per Day.	.126	.093	.113	1.360	.176

Dependent Variable: Nurses Burnout

The results of the simple linear regression analysis suggest that the number of years spent working in psychiatric units is negatively associated with burnout, meaning that as the years of experience increase, the level of burnout decreases significantly (β= -.199; p= .036). On the other hand, having additional administrative tasks in the hospital and an extra job outside the hospital are positively associated with burnout, indicating that these factors significantly contribute to nurse burnout (β= .104; p= .032) and (β= .176; p= .001), respectively.

Chapter Five:

Discussion of the results

Chapter Five: Discussion of The Results

5.1. Burnout Levels:

The present study's findings on burnout dimensions, including exhaustion, depersonalization, and personal accomplishment, are compared with the results of several previous studies.

1. **Exhaustion domain:**

In terms of emotional exhaustion, the present study revealed that 39.3% of psychiatric nurses reported a moderate level of burnout. This finding is consistent with the study conducted by (Rashedi *et al.*, 2014), where moderate levels of emotional exhaustion were also reported among nurses. It suggests that a significant proportion of psychiatric nurses' experience moderate levels of emotional exhaustion as part of their work-related burnout.

However, the findings of the present study are inconsistent with several other studies such as a Studies conducted by (Åhlin, 2015; Bohlender, 2022; Konstantinou, 2014; Madathil, 2010; Mengesha, 2014) indicated higher levels of emotional exhaustion among participants. These studies suggest that emotional exhaustion may be more prevalent and severe in certain contexts or populations, possibly due to specific job demands, organizational factors, or individual differences.

2. **Depersonalization domain:**

In terms of depersonalization, the present study revealed that 58% of psychiatric nurses reported a high level of burnout. This finding aligns with previous studies conducted by (Åhlin, 2015; Bohlender, 2022; Madathil, 2010; Mengesha, 2014), where high levels of depersonalization were also observed among participants. It suggests that a significant proportion of psychiatric nurses experience a high degree of depersonalization as part of their work-related burnout.

However, the findings of the present study are inconsistent with the study conducted by (Konstantinou, 2014), which reported a moderate level of

depersonalization. This disparity highlights the variability in the experience of depersonalization among psychiatric nurses across different studies.

It is important to recognize that depersonalization is a significant aspect of burnout that can impact the quality of care provided by psychiatric nurses. High levels of depersonalization may lead to a sense of detachment from patients and result in a decline in empathetic and compassionate interactions.

Further research should aim to explore the factors contributing to the disparities in depersonalization levels among psychiatric nurses. Understanding the specific job-related stressors, organizational factors, and individual characteristics that influence depersonalization can inform the development of targeted interventions and strategies to address and prevent burnout in this population.

3. **personal accomplishment domain:**

In terms of personal accomplishment, the present study reported a high level of burnout among 92% of psychiatric nurses. This finding is consistent with previous studies conducted by (El-Azzab *et al.*, 2019; Febriana *et al.*, 2023; Łopatkiewicz *et al.*, 2022; Mengesha, 2014; Rashedi *et al.*, 2014; Tununu, 2018; Velimirović *et al.*, 2017), where low levels of personal accomplishment were reported among a significant proportion of nurses. These findings indicate that many psychiatric nurses experience a diminished sense of personal achievement in their work, which is a characteristic feature of burnout.

However, the findings of the present study are inconsistent with the study conducted by (Konstantinou, 2014), which reported moderate levels of personal accomplishment among participants. This discrepancy suggests that personal accomplishment levels may vary among psychiatric nurses across different studies and contexts.

It is important to recognize that personal accomplishment is a crucial aspect of professional well-being and job satisfaction. A diminished sense of personal accomplishment can impact nurses' motivation, engagement, and overall job performance.

Further research is warranted to explore the factors contributing to the disparities in personal accomplishment levels among psychiatric nurses. Understanding the specific organizational factors, job demands, and individual characteristics that influence personal accomplishment can inform the development of targeted interventions and strategies to promote nurses' sense of achievement and fulfillment in their work.

5.2. Coping Strategies:

The present study focuses on coping strategies among psychiatric nurses, specifically problem-focused coping, emotional-focused coping, and avoidant coping. The findings of this study are compared with the results of previous research to examine the consistency and inconsistency between them.

5.2.1. Problem-Focused Coping Strategies

In the current study, problem-focused coping strategies were assessed. Most nurses (92%) reported a low level of problem-focused coping. This suggests that nurses in the sample were less inclined to actively address the root causes of stress and burnout. This finding contrasts with the studies conducted by (Abdalrahim, 2013; Aulsbrook, 2021; Dix, 2017; Jose & Bhat, 2013; Makie, 2006; Tsaras *et al.*, 2018), These studies reported that problem-focused coping strategies, such as positive approach, problem-solving, and problem orientation, were commonly used by mental health professionals, including psychiatric nurses. The inconsistency in findings suggests variations in the use of problem-focused coping among psychiatric nurses across different studies.

5.2.2. Emotion-Focused Coping Strategies:

Regarding emotion-focused coping, over half of the nurses (53.3%) reported a moderate level of engagement in these strategies. Emotion-focused coping involves regulating and expressing emotions to manage stress. Studies conducted by (Jose & Bhat, 2013; Makie, 2006) support these findings, as they found that psychiatric nurses commonly employed strategies such as seeking social support to cope with job-related stress. These strategies highlight the

significance of emotional regulation and seeking support as effective coping mechanisms for psychiatric nurses.

5.2.3. Avoidant Coping Strategies:

Regarding avoidant coping, the present study reported that most nurses (71.2%) reported a low level of avoidant coping. This finding is inconsistent with the studies by (McTiernan & McDonald, 2015; Plana *et al.*, 2003), where avoidant coping strategies were favored and found to be commonly used among psychiatric nurses. These inconsistent findings suggest variations in the preference for avoidant coping strategies among psychiatric nurses in different settings or contexts.

The inconsistencies between the present study's findings and previous research could be attributed to various factors, including differences in sample characteristics, cultural contexts, measurement tools, and specific job demands or stressors experienced by psychiatric nurses. Coping strategies can be influenced by individual differences, organizational support, and the availability of resources.

Further research is needed to explore the reasons for these inconsistencies and to gain a more comprehensive understanding of coping strategies among psychiatric nurses. Understanding the factors that influence the selection of coping strategies can help in developing targeted interventions and support systems to enhance coping skills and well-being among psychiatric nurses, ultimately improving the quality of care provided to patients.

5.3. The Correlation Between Coping Strategies and Burnout symptoms:

5.3.1. Problem-Focused Coping and Burnout Symptoms:

The findings from the current research suggest that there is a significant relationship between problem-focused coping strategies and the presence of burnout symptoms. Specifically, individuals who leveraged problem-focused coping strategies manifested reduced symptoms of exhaustion and

depersonalization. This observation underscores the protective role of proactive problem-solving and pragmatic measures in confronting challenges, which appear to mitigate feelings of exhaustion and depersonalization.

Additionally, there was a discernible positive relationship between problem-focused coping strategies and personal accomplishment. This indicates that those adopting such strategies reported enhanced feelings of personal achievement.

This study's outcomes echo prior research emphasizing the merits of problem-focused coping in attenuating burnout symptoms and feelings of depersonalization. Notably, studies by (Javadi-Pashaki & Darvishpour, 2019; Mache *et al.*, 2016) have posited that task-oriented coping, a subset of problem-focused coping, serves as a buffer against burnout. Such findings reinforce the pertinence of incorporating coping skills training for professionals, allowing them to appraise and refine their coping strategies, ultimately staving off burnout.

Furthermore, the present study's findings resonate with (Aulsbrook, 2021) research, which established a positive link between feelings of workplace accomplishment and task-oriented coping, thereby underlining the advantageous relationship between problem-focused coping and personal accomplishment.

In alignment with (S. Shin *et al.*, 2018), this study identifies a negative correlation between problem-focused coping strategies and burnout symptoms. Such findings advocate for the adaptive nature of problem-focused coping, which has consistently been linked to reduced burnout across various studies (Lauzon, 1993; Leiter, 1991; Pines & Aronson, 1981; Rowe, 2000).

Moreover, the positive correlation between problem-focused coping and personal accomplishment corroborates prior research (Anderson, 2000; Ben-Zur & Michael, 2007; Leiter, 1991; Rowe, 2000). It is conceivable that the direct and effective confrontation of challenges through problem-focused coping may be instrumental in fostering greater professional fulfillment and, consequently, heightened personal accomplishment.

Intriguingly, the present study's findings diverge from those documented by (Keating, 2010; Wiese *et al.*, 2003). The latter studies found no observable link between problem-focused coping and emotional exhaustion or depersonalization, instead discerning a negative association exclusively with diminished personal accomplishment. Such discrepancies might be ascribed to variances in sample demographics, assessment instruments, or prevailing contextual nuances.

Moreover, (Jenaro *et al.*, 2007) discerned that certain strategies such as planning and active coping were inversely related to diminished personal accomplishment. This underscores the nuanced role of different coping modalities in influencing burnout among nursing professionals.

To sum up, the current investigation offers robust evidence highlighting the linkage between problem-focused coping mechanisms and burnout symptoms among psychiatric nurses. The identified relationships between such coping strategies, exhaustion, depersonalization, and personal accomplishment further accentuate the necessity of incorporating coping strategies within interventions designed to alleviate burnout. Nevertheless, the variability across studies necessitates continued exploration to intricately comprehend the multifaceted interplay between coping modalities and burnout in the nursing domain. Prospective research should contemplate adopting longitudinal frameworks and evaluating the efficacy of interventions homing in on specific coping techniques, aiming to fortify burnout prevention and mitigation endeavors in the nursing community.

5.3.2. Emotion-focused coping and burnout symptoms:

The current study’s findings underscore those individuals who predominantly employed emotion-focused coping strategies demonstrated a positive correlation with exhaustion and depersonalization. This infers those strategies anchored in emotional expression and seeking emotional support correlated with heightened feelings of exhaustion and depersonalization. Additionally, a notable negative correlation was identified between emotion-

focused coping strategies and personal accomplishment. This intimates that an overreliance on emotion-centric coping methods corresponded with diminished levels of personal achievement.

This research echoes the findings of Aulsbrook (2021), which similarly discerned a relationship between burnout levels, marked by emotional exhaustion and depersonalization, and the employment of emotion-oriented coping strategies, as gauged by the Coping Inventory for Stressful Situations (CISS).

Efficaciously, emotion-focused coping strategies have been touted as efficacious mechanisms for stress mitigation (Endler & Parker, 1994). However, Endler & Parker (1994) contend that while they can offer relief, these strategies may inadvertently exacerbate stress. Instances include individuals self-flagellating for excessive emotional reactions in stress-ridden scenarios, engaging in escapist daydreaming, or succumbing to introspective rumination, potentially intensifying stress levels.

Corroboratively, (Chwalisz *et al.*, 1992) determined that maladaptive coping strategies, encompassing certain emotionally driven mechanisms, correlated with escalated burnout levels. Such emotionally driven strategies have, on occasion, produced unintended adverse outcomes, as attested by Aulsbrook (2021) and (Endler & Parker, 1990).

In alignment with Shin *et al.* (2014), the present research identified a positive correlation between emotion-focused coping and the manifestations of burnout. This posits that nurses who leaned heavily on emotion-focused coping methods were more susceptible to feelings of exhaustion and depersonalization. Such findings are consistent with prior investigations that correlate specific emotion-focused coping techniques with maladaptive outcomes, such as depression, anxiety, and reduced life satisfaction (Heiligenstein *et al.*, 1996; Marine *et al.*, 2006; Patrick & Hayden, 1999).

Conversely, certain emotion-focused coping strategies have evinced a negative association with burnout symptoms. Strategies such as seeking

emotional support, positive reappraisal, acceptance, and religious coping have been documented to bear inverse relationships with burnout (Büssing & Glaser, 2000; Rohland, 2000; W. B. Schaufeli & Enzmann, 1999; Storm & Rothmann, 2003; Wiese *et al.*, 2003). Such findings imply that selecting emotion-focused coping modalities can be conducive to positive outcomes and serve as protective measures against burnout.

The relationship between emotion-focused coping and burnout indicators, however, remains intricate. Different facets of burnout, like emotional exhaustion, depersonalization, and diminished personal accomplishment, might manifest unique associations with emotion-focused coping strategies (der Colff & Rothmann, 2009).

In summation, the present study elucidates the nuanced relationship between emotion-focused coping strategies and burnout symptoms among psychiatric nurses. While some strategies might exacerbate burnout symptoms, others, as reflected in prior research, can serve as protective measures. Future inquiries should delve deeper into the dynamics at play and propose interventions championing adaptive coping methodologies, thereby catering to the well-being of psychiatric nursing professionals.

5.3.3. Avoidant-focused coping and burnout symptoms:

The current study delineates that individuals predominantly resorting to avoidant coping mechanisms manifest a negative correlation with depersonalization. This implies that those who distance themselves from the source of stress or adversity might experience diminished depersonalization. Concurrently, there was a negative association between this coping style and personal accomplishment, suggesting that the avoidant approach might act as an impediment to goal realization and achieving one's potential.

Intriguingly, this contrasts Aulsbrook's (2021) findings, which identified no notable correlations between the Maslach Burnout Inventory (MBI) subscales and avoidance coping. This deviation underscores the intricate dynamics of coping mechanisms and their interplay with burnout and personal

accomplishment. It hints that outcomes might vary contingent on specific research measures, sample distinctions, and other prevailing contextual variables.

Avoidance coping, while occasionally granting transient relief or a semblance of control, is widely recognized as a long-term maladaptive coping strategy. Such strategies typically revolve around suppressing or circumventing problems rather than proactively confronting them, potentially stymieing efforts to address and resolve stressors (Jenaro *et al.*, 2007; Simpson *et al.*, 2019).

Echoing the sentiment of prior research (Shin *et al.*, 2014), the current investigation discerned a positive relationship between avoidant-focused coping and burnout manifestations. This indicates that psychiatric nurses inclined towards avoidant strategies are likely to grapple with exacerbated burnout symptoms. This propensity to eschew or detach from stressors may inadvertently catalyze an intensification in depersonalization, potentially resulting in nurses fostering a detached or cynical demeanor towards their clientele or their profession.

Simultaneously, the study unveiled a negative linkage between avoidant coping and personal accomplishment, reinforcing the notion that a reliance on avoidance potentially curtails feelings of achievement and fulfillment in a clinical setting.

Historical research resonates with the present study's outcomes, accentuating the pivotal role of coping mechanisms in modulating and preempting burnout, especially amongst healthcare professionals. For instance, (Hasan *et al.*, 2018) postulated that psychiatric nurses equipped with efficient coping apparatuses fostered a more optimistic professional perspective, suggesting that advocating such mechanisms could amplify job contentment and holistic well-being.

Given that burnout can drastically impact productivity, engender increased absenteeism, and compromise patient care, organizational cognizance of the criticality of coping strategies becomes imperative. The repercussions of

burnout can precipitate diminished empathy amongst practitioners, culminating in impersonal interactions with patients or colleagues (Vredenburgh *et al.*, 1999; Wheeler *et al.*, 2011).

The Cognitive Appraisal Theory, premised on the notion that individuals' reactions to situations are rooted in their perceptions, can serve as a pivotal scaffold for human service providers (Lazarus & Folkman, 1987). Infusing this theoretical framework within professional training paradigms might empower such professionals to cultivate adept coping skills, fortifying their resilience against burnout.

In summation, the present investigation underscores the adverse implications of avoidant-focused coping strategies on burnout symptoms amongst psychiatric nurses. By channeling resources and bolstering support for effective stress management, healthcare institutions can potentially enhance the overall job satisfaction and immersion of psychiatric nurses, thereby elevating patient care standards. However, the imperative for more extensive research remains evident-particularly to decode the underlying reasons for nurses gravitating towards avoidant coping strategies and to pinpoint efficacious interventions. Future longitudinal research endeavors might offer invaluable perspectives on the causative relationships between avoidant coping and burnout and the prospective ramifications of interventions promoting adaptive coping strategies.

5.4. Differences In Burnout Among Nurses, According to Demographics Data:

5.4.1. Age:

This research investigated whether there were significant differences in nurses' burnout based on their age. The findings indicated that younger nurses experienced a rise in burnout. This confirms the correlation between seniority and burnout in the nursing profession found in prior research (Ahola & others, 2007; Lee & Ashforth, 1993; Sahraian *et al.*, 2008). These studies suggest that

younger nurses may be more vulnerable to burnout due to their lack of experience and training.

However, some studies have reported no significant correlation between age and burnout (Fischer *et al.*, 2020; White, 2006). This inconsistency may be due to variations in sample sizes, study designs, and instruments used to measure burnout. Nevertheless, by emphasizing the significance of age in psychiatric nurses' burnout, the current study contributes to the existing literature.

In conclusion, the present study found that age is an important factor in understanding burnout among psychiatric nurses. Younger nurses may be more vulnerable to burnout, and healthcare organizations should provide support and resources to mitigate this risk. The correlation between age and burnout is worth investigating further in this population, as is the impact of other factors such as gender, education, and work environment on burnout.

5.4.2. Gender:

Current research examines the association between sociodemographic characteristics and burnout severity among psychiatric nurses, specifically in terms of gender. Female nurses reported higher levels of burnout than their male counterparts, a finding supported by the study's statistical analyses. This result agrees with what we already know about burnout among healthcare workers, such as nurses. For example, studies by (Angermeyer *et al.*, 2006; Caccese & Mayerberg, 1984; Maslach & Jackson, 1985; Priebe *et al.*, 2005) have reported higher burnout levels among female healthcare workers compared to their male counterparts.

However, there have been inconsistencies in the literature regarding the association between gender and burnout. Some studies have found that male nurses experience higher levels of burnout than female nurses (Sahraian *et al.*, 2008). (Fischer *et al.*, 2020) also reported no significant association or correlation between burnout and gender in their sample. These inconsistencies

may be attributed to differences in the study population, measurement tools, or cultural factors.

The findings of this study highlight the need to account for gender as a sociodemographic component in evaluating burnout among psychiatric nurses. To improve nurses' psychological state and well-being, it is important to identify and address the underlying issues that contribute to gender variations in burnout. More study is required to determine the causes of the correlation between gender and burnout in the psychiatric nursing profession.

5.4.3. Educational Level:

This study examined whether higher levels of education were associated with lower levels of burnout among psychiatric nurses. The results indicated that nurses with lower levels of education (diploma and secondary education) felt more depersonalization and emotional exhaustion. This confirms what has been found in the past: that lower levels of education correlate positively with burnout (Becker *et al.*, 2006; W. B. Schaufeli & Enzmann, 1999). However, there have been inconsistencies in the literature regarding the relationship between education level and burnout symptoms.

Among mental health practitioners, for instance, higher education has been linked to greater emotional weariness in several research (Lim *et al.*, 2010). Additionally, some studies have found no significant relationship between education level and burnout (Bohlender, 2022; White, 2006). These inconsistencies may be due to differences in study populations, measurement tools, or other methodological factors.

It's worth noting that educational level is just one of many potential factors that may contribute to burnout. For example, work demands, work environment, and healthcare worker burnout have been connected to individual aspects such as personality and coping styles (Adriaenssens *et al.*, 2015). Therefore, it's important to consider the broader context in which burnout occurs.

In conclusion, this study adds to the existing literature by identifying an association between education level and burnout among psychiatric nurses. The nature of this connection, as well as any confounding factors that may lead to burnout among healthcare professionals, require additional study.

5.4.4. Place of residence:

The current study's findings indicate that there is no significant correlation between the place of residence of nurses and their burnout levels. This is a noteworthy observation that challenges certain presumptions about the influence of residential factors on burnout.

Conventionally, it is assumed that geographical or environmental influences related to residency can impact an individual's mental well-being, including their risk for experiencing burnout (Perry *et al.*, 2015). However, the present findings suggest that this may not be the case for the nursing population, at least not universally. There could be several explanations for this observation.

One plausible explanation could be that the inherent stressors related to the nursing profession, such as long work hours, high-stress environment, and the emotional burden associated with patient care, have a more profound impact on burnout levels (Reith, 2018). These occupational factors may, to some extent, homogenize burnout levels among nurses, regardless of their place of residence.

However, it's important not to take these findings out of context. The lack of a significant correlation does not necessarily mean that residency is irrelevant to nurse burnout. Other dimensions related to residency, such as commute times, the nature of the residential environment, access to supportive social structures, among other factors, might still have an impact on burnout levels but were not accounted for in this study.

In summary, while the study demonstrates no significant statistical relationship between nurses' residency and burnout levels, this should not discourage researchers from exploring this area further. More nuanced studies involving factors related to residency could provide further insights into this

complex phenomenon and contribute to the development of comprehensive strategies to prevent and manage burnout among nurses.

5.4.5. Marital Status:

The present study found significant differences in burnout among psychiatric nurses based on their marital status, with divorced and widowed nurses experiencing higher levels of burnout than single and married nurses. These findings are inconsistent with previous research that has suggested that unmarried individuals, especially men, are more prone to burnout compared to those who are married. The relationship between burnout and marital status may be related to social support. Being married can provide emotional support and a sense of belonging, which may help buffer the negative effects of work-related stress and prevent burnout. Conversely, being unmarried may lead to social isolation and a lack of emotional support, which may increase the risk of burnout (Maslach & Leiter, 1997; Yousefy & Ghassemi, 2006).

It is important to note that the present study cannot establish a causal relationship between marital status and burnout. Other factors, such as job demands and personal characteristics, may also contribute to fatigue and burnout. Future research could investigate the mechanisms underlying the relationship between marital status and burnout and explore potential interventions to mitigate the negative effects of burnout in unmarried individuals.

In sum, the current study adds to the growing body of literature on burnout among healthcare professionals by emphasizing the significance of education and marital status considerations in the assessment and prevention of burnout.

5.4.6. Having children:

The present study investigates the relationship between having children and burnout among psychiatric nurses. The findings suggest that there was no discernible variation in the levels of burnout experienced by nurses who have children compared to those who do not. However, it is important to consider

previous studies that have examined the association between having children and burnout among nurses.

(Ayala & Carnero, 2013) conducted a study that reported an association between having children and greater burnout. While their study did not specifically focus on psychiatric nurses, the findings suggest that having children may contribute to increased burnout levels. The additional responsibilities and potential family-work conflicts that arise from having children may increase stress levels and contribute to burnout among nurses.

Similarly, studies conducted on civilian nurses, such as the one by (Fujimoto *et al.*, 2008), have reported a positive association between having children and burnout. These studies suggest that the demands and responsibilities associated with parenting, in addition to the demands of nursing work, can contribute to higher burnout levels among nurses.

Contrary to these previous findings, the present study did not find a discernible variation in burnout levels between nurses who have children and those who do not. This difference in results may be influenced by various factors, including the specific sample characteristics, cultural context, and the support systems available to nurses.

The relationship between having children and burnout is complex and multifaceted. It is influenced by individual factors, work-family dynamics, and organizational support. Additional research is needed to further explore this relationship among psychiatric nurses specifically and to consider the unique challenges and support systems within psychiatric settings.

Understanding the impact of having children on burnout is crucial for healthcare organizations in developing strategies to support nurses who are balancing their professional and parental responsibilities. Initiatives that promote work-life balance, provide resources for childcare support, and offer flexible work arrangements may help mitigate the potential negative effects of parenting on burnout levels among psychiatric nurses.

Further research should explore the mechanisms through which having children may influence burnout among psychiatric nurses, considering factors such as work-family conflicts, social support networks, and coping strategies. By gaining a deeper understanding of these dynamics, healthcare organizations can implement targeted interventions to support nurses in managing their multiple roles effectively and reduce the risk of burnout.

5.4.7. Monthly Income:

The present study's findings add to the existing literature on burnout among psychiatric nurses, highlighting the importance of income as a sociodemographic factor that can affect burnout. The results are consistent with previous studies that have identified low pay as a significant contributor to nurse burnout (Konstantinou, 2014; Maslach *et al.*, 2001). However, some studies have found no significant relationship between income and burnout (Demerouti *et al.*, 2001).

It is worth noting that other factors, such as workload, job demands, and social support, can also contribute to nurse burnout. Therefore, interventions to prevent and reduce burnout should consider a broad range of factors, including workplace policies and practices, social support, and individual coping strategies (Dagget *et al.*, 2016).

The use of self-reported measures of income and exhaustion is one of the study's limitations, which can be subject to bias and error. Future research could use more objective measures of income, such as tax returns or payroll records, to increase the accuracy of the findings. Additionally, future studies could explore the potential moderating effects of other sociodemographic factors, such as marital status and years of experience, on the relationship between income and burnout.

In conclusion, the present study's findings suggest that income is an important sociodemographic factor that can affect nurse burnout. Employers should consider providing fair compensation and support to nurses to prevent and reduce burnout. Income, burnout, and other factors that contribute to nurses'

well-being are all interconnected in ways that require more study to fully understand.

5.5. Predisposing Factors for Burnout in Terms of occupational Data

5.5.1. Nurse years' Experience:

The present study examines the relationship between the period of experience in a psychiatric hospital and burnout among psychiatric nurses. The findings suggest that the number of years spent working in psychiatric units is negatively associated with burnout. This conclusion aligns with several previous studies investigating similar relationships.

One previous study conducted by (Rashedi *et al.*, 2014) identified a significant relationship between burnout and length of employment. Their findings indicated that as the length of employment increased, burnout levels decreased. This supports the present study's observation that experienced psychiatric nurses tend to experience lower levels of burnout.

(Łopatkiewicz *et al.*, 2022) also found evidence supporting the relationship between work experience and burnout. Their study revealed that depersonalization, one of the dimensions of burnout, decreased with increasing work experience. This further reinforces the notion that the more experienced nurses are, the less likely they are to experience burnout.

(Konstantinou, 2014) conducted a study that demonstrated how the more experienced nurses had lower levels of burnout. This finding aligns with the present study's results and provides additional support for the idea that a longer period of experience in psychiatric hospitals is associated with reduced burnout.

On the other hand, (Moreira & Lucca, 2020) identified a different perspective. Their study found that a shorter time in the psychiatric sector was associated with burnout. These contrasting results suggest that there may be other factors at play that influence the relationship between job experience and

burnout. Further research is needed to explore these potential factors and reconcile the conflicting findings.

(Trindade & Lautert, 2010) also observed that workers with less time in the institution or sector were more likely to develop burnout. They attributed this to difficulties in social integration, feelings of insecurity, job instability, and the need for acceptance. While their findings contrast with the present study, they highlight the importance of considering social and organizational factors that may influence burnout among nurses.

Finally, (Salmela-Aro & Upadyaya, 2018) found that workers at the beginning of their careers were more likely to experience burnout due to higher perceived interpersonal demands at work. This finding suggests that job characteristics beyond just experience may contribute to burnout among psychiatric nurses.

In summary, the present study's results align with previous research demonstrating a negative association between the period of experience in a psychiatric hospital and burnout among psychiatric nurses. However, some studies present conflicting findings, suggesting the presence of other influential factors. Future research should consider these factors to gain a comprehensive understanding of burnout among psychiatric nurses and inform effective interventions and support systems.

5.5.2. Workplace in the hospital:

The present study explores the relationship between workplace area in a psychiatric hospital and burnout among psychiatric nurses. The findings suggest that the workplace area is not associated with burnout. This observation diverges from the results of previous studies that have examined the impact of job characteristics on burnout among psychiatric nurses in different workplace areas.

One previous study conducted by (Schadenhofer *et al.*, 2018; Matos *et al.*, 2013) specifically focused on professionals from a psychiatric hospital in Australia. They found that burnout was associated with the sector of work that

involved direct contact with patients. This finding supports the notion that the workplace area, particularly those involving intensive patient contact, may have an impact on burnout among psychiatric nurses.

Contrary to these previous studies, the present study did not identify a significant association between workplace area and burnout among psychiatric nurses. This discrepancy may be attributed to differences in the study samples, settings, or methodologies employed. It is essential to consider the complexity of burnout and its multifaceted nature, which can be influenced by various individual, organizational, and contextual factors.

Future research should further explore the relationship between workplace area and burnout among psychiatric nurses, considering additional factors such as workload, patient acuity, organizational support, and the availability of resources. By investigating these factors, a more comprehensive understanding of the job characteristics that contribute to burnout in different workplace areas can be gained. This knowledge can inform targeted interventions and strategies to mitigate burnout and promote well-being among psychiatric nurses.

5.5.3. Additional Administrative Tasks in the hospital:

The present study explores the relationship between additional administrative tasks in a psychiatric hospital and burnout among psychiatric nurses. The findings indicate that having additional administrative tasks significantly contributes to nurse burnout. These findings align with previous studies that have examined the impact of job characteristics, specifically related to administrative tasks, on burnout among psychiatric nurses.

One previous study conducted by (Hill, 2020) investigated the relationship between job demands, job resources, job satisfaction, and burnout. The study found that participants who had lower job demands, more job resources, and higher job satisfaction were less likely to experience burnout. This suggests that excessive job demands, which may include additional administrative tasks, can contribute to burnout among psychiatric nurses.

(Fernández-Castro *et al.*, 2017) conducted research examining the associations between emotional exhaustion, work demand, job satisfaction, and burnout among healthcare professionals. They found that workers experiencing high levels of emotional exhaustion tended to perceive higher psychological demands and fatigue. Furthermore, they observed that even though there may be differences in the levels of work demands and burnout between the care and administrative sectors, the severity of these factors differed only minimally. This implies that both sectors, including those with additional administrative tasks, can be equally susceptible to burnout.

The present study's findings are consistent with these previous studies, indicating that additional administrative tasks in a psychiatric hospital contribute to nurse burnout. The demands and workload associated with administrative tasks can increase stress levels and lead to emotional exhaustion, ultimately contributing to burnout.

It is crucial for healthcare organizations to recognize the impact of administrative tasks on burnout among psychiatric nurses and take appropriate measures to address this issue. These measures may include workload management strategies, task delegation, providing sufficient resources and support, and offering opportunities for professional development and training to enhance job satisfaction and reduce burnout.

Further research should delve deeper into the specific aspects of administrative tasks that contribute to burnout among psychiatric nurses. This can help identify targeted interventions and organizational policies that aim to mitigate the negative effects of these tasks on nurses' well-being and ultimately enhance the quality of patient care.

5.5.4. Extra or Additional career outside the hospital:

The present study examines the relationship between additional careers outside the hospital and burnout among psychiatric nurses. The findings indicate that having extra or additional careers outside the hospital significantly contributes to nurse burnout. This observation aligns with a previous study

conducted by (Kowalczuk *et al.*, 2020) that investigated the impact of excessive workload on burnout symptoms.

(Kowalczuk *et al.*, 2020) found that excessive workload was associated with increased burnout symptoms among healthcare professionals. While their study did not specifically focus on additional careers outside the hospital, the concept of excessive workload is relevant to the present study's findings. Having an extra or additional career outside the hospital can lead to an increased workload and demands on nurses' time and energy, which can contribute to burnout.

Engaging in multiple careers or jobs can result in conflicting demands, time constraints, and increased stress levels for psychiatric nurses. Juggling responsibilities between the hospital and outside careers may lead to fatigue, emotional exhaustion, and decreased job satisfaction. These factors, in turn, can contribute to the development of burnout symptoms.

The present study's findings add to the existing literature by highlighting the detrimental impact of additional careers outside the hospital on burnout among psychiatric nurses. Healthcare organizations and policymakers should consider the potential risks associated with nurses holding multiple jobs and develop strategies to mitigate these risks. This may include ensuring reasonable workloads, providing adequate rest and recovery time, and promoting work-life balance initiatives.

Future research could explore the specific mechanisms through which additional careers outside the hospital contribute to burnout among psychiatric nurses. Understanding these mechanisms can inform the development of targeted interventions and support systems that address the unique challenges faced by nurses who balance multiple careers. By promoting the well-being of psychiatric nurses, healthcare organizations can enhance job satisfaction, retention rates, and ultimately, the quality of patient care.

5.5.5. working shift in the hospital:

The present study explores the relationship between working time or work shift in a psychiatric hospital and burnout among psychiatric nurses. The findings suggest that there was no association between the shift variable and subscale scores for burnout. These results differ from previous studies that have investigated the impact of work shift on burnout among psychiatric nurses.

(Konstantinou, 2014) conducted a study that indicated nurses who work night shifts may be more prone to burnout. This finding contrasts with the present study's results, which did not find an association between the shift variable and burnout subscale scores. It is important to consider the potential reasons for these discrepancies, such as differences in sample characteristics, methodologies, or other contextual factors.

Similarly, (Hooper *et al.*, 2010) conducted a study that found no significant differences in subscale scores for burnout related to the shift variable. Their findings align with the present study, which also did not observe a significant association between work shift and burnout among psychiatric nurses. These consistent results suggest that the specific work shift may not be a significant predisposing factor for burnout in this context.

In contrast, (Kivimäki *et al.*, 2001) found that working the night shift was associated with higher burnout scores. This conflicting finding implies that there may be differences in the impact of work shift on burnout depending on the specific study population, work environments, and other contextual factors. Additional research is necessary to further explore these discrepancies and gain a better understanding of the relationship between work shift and burnout among psychiatric nurses.

The present study's findings, combined with the previous research, suggest that the relationship between work shift and burnout among psychiatric nurses is complex and may be influenced by various factors. Other aspects of job characteristics, such as workload, work schedule flexibility, and organizational support, may interact with work shift and contribute to burnout.

Future studies should consider a comprehensive approach to examining the impact of work shift on burnout, considering various contextual and individual factors. This can help healthcare organizations identify effective strategies and interventions to prevent and manage burnout among psychiatric nurses, regardless of their work shift.

5.5.6. Numbers of working hours in the hospital:

The present study examines the relationship between the number of working hours per day in a psychiatric hospital and burnout among psychiatric nurses. The findings suggest that there was no association between the number of working hours per day and subscale scores for burnout. However, a previous study conducted by (Dall'Ora *et al.*, 2020) identified the number of work hours, particularly shifts of 12 hours or longer, as a predisposing factor for burnout.

(Dall'Ora *et al.*, 2020) investigated the impact of various work-related factors on burnout among nurses. They found that working shifts of 12 hours or longer was associated with an increased risk of burnout. This finding contrasts with the present study's results, which did not find an association between the number of working hours per day and burnout subscale scores. These discrepancies may stem from differences in sample characteristics, study design, or other contextual factors.

It is important to note that the relationship between the number of working hours per day and burnout can be influenced by various factors beyond just the length of the shift. Other aspects such as workload intensity, job control, and rest and recovery periods between shifts may also contribute to the development of burnout.

The present study's findings, combined with the previous research, suggest that the relationship between the number of working hours per day and burnout among psychiatric nurses may not be straightforward. It is necessary to consider the multifaceted nature of burnout and examine the interplay between various job characteristics and individual factors.

Future studies should continue investigating the impact of working hours on burnout, considering additional factors that may influence this relationship. This could include exploring the influence of workload intensity, job demands, scheduling practices, and the availability of rest periods. By gaining a more comprehensive understanding of the factors contributing to burnout, healthcare organizations can develop targeted interventions and policies to promote nurses' well-being and prevent burnout in psychiatric settings.

Chapter six: Conclusion and Recommendations

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6.1. Conclusion:

The prevalence of stress in mental health nursing makes the study of burnout among these professionals highly significant. The growing need for better healthcare services and the current political crisis in Iraq highlight the urgency of addressing and managing burnout. The research aimed to assess the burnout levels and coping strategies used by nurses working at psychiatric hospitals, investigate the correlation between burnout and coping strategies, and identify the predisposing factors of burnout among psychiatric nurses working in psychiatric hospitals in Baghdad, Iraq. It therefore concluded the following:

1. Exhaustion was revealed to be an area where significant burnout was present in this research and Increased detachment and a decreased sense of fulfillment in life were noted.
2. Through correlational analysis, it was determined that burnout and coping styles are indeed correlated. The findings revealed that emotion-focused and avoidance-focused coping patterns were positively linked with "emotional exhaustion and depersonalization," while "problem-focused coping" strategies were negatively connected with these symptoms and positively linked with success on your own terms. These results suggest that coping strategies play a role in the severity of burnout experienced by nurses.
3. Also, other factors found in this study include younger, female, lower levels of education (diploma and secondary education), lower pay (monthly income), divorced and widowed nurses, lower years of experience, additional administrative tasks, and additional jobs outside the hospital. All these factors lead to an elevated severity of burnout syndrome among nurses working at psychiatric hospitals.

6.2. Recommendations:

1. Develop interventions targeting emotional exhaustion, depersonalization, and personal accomplishment. This can be done through training programs that enhance empathy and positive patient-provider relationships. Recognizing and rewarding nurses for their accomplishments can also improve job satisfaction.
2. Provide training on effective coping strategies. Nurses should be educated about different coping techniques and their impact on burnout. Emphasis should be placed on problem-focused coping strategies to effectively manage work-related stress.
3. Implement support programs for vulnerable groups. Certain factors, such as younger age, female gender, lower education levels, lower pay, and additional administrative tasks, contribute to higher burnout levels. Mentorship initiatives, career development opportunities, and financial support can help alleviate burnout among these groups.
4. Improve workload distribution and administrative tasks. Additional administrative tasks and multiple jobs outside the hospital contribute to burnout. Hospitals should review and optimize workload distribution, streamline administrative tasks, and provide adequate support in these areas.
5. Enhance workplace support and resources. Hospitals should invest in resources that support nurses' mental health, such as counseling services and mental health professionals. Creating a culture of open communication and establishing peer support programs can also reduce burnout.
6. Conduct further research. Future studies should explore additional factors contributing to burnout, such as organizational culture and leadership styles. Research can inform the development of evidence-based strategies to address burnout in psychiatric hospitals.

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Appendices

Appendices

8.1. Appendix A the instrument of Study:

جامعة بابل / كلية التمريض
قسم الدراسات العليا / الماجستير
فرع تمريض الصحة النفسية والعقلية

م / استبيان

تحية طيبة ...

يروم الباحث الى دراسة **(مستويات الاحتراق النفسي واستراتيجيات المواجهة بين الممرضين العاملين في المستشفيات النفسية)** من اجل الحصول على درجة الماجستير في تخصص تمريض الصحة النفسية والعقلية في جامعة بابل / كلية التمرض ، لذا قام الباحث بتصميم استبانة خاصة بهذا الموضوع، يرجى التكرم بتعبئة الاستمارة ، وما ستساهم به اجاباتكم من اثراء للمعرفة العلمية ولمعالجة المشاكل النفسية والاجتماعية، الرجاء قراءة المعلومات بدقة والاجابة على جميع فقرات الاستمارة، علما ان مشاركتكم في ملىء الاستمارة طوعية ويمكنكم الانسحاب من المشاركة في الدراسة في اي وقت.

ملاحظة: هذه الاستمارة الاستبيانية اعدت فقط لاغراض البحث العلمي ولا تحتوي على اسم المشارك للحفاظ على خصوصيته.

الباحث
علي حاجم شمخي

الجزء الاول: استبيان الخصائص الاجتماعية و الديمغرافية

شكرًا لك على المشاركة في استبياننا حول الخصائص الاجتماعية والديموغرافية للممرضين العاملين في مهنة تمريض الصحة النفسية والعقلية. سيساعدنا الاستبيان التالي في جمع معلومات حول جوانب مختلفة من خلفيتك. يرجى الإجابة على الأسئلة بأفضل ما لديك من القدرة:

1. **العمر:**

2. **الجنس:**
   - ذكر
   - انثى
3. **التحصيل الدراسي:**
   - اعدادية تمريض
   - دبلوم
   - بكالوريوس
   - دراسات عليا
4. **محل السكن:**
   - الحضر
   - الريف
5. **الحالة الزوجية:**
   - اعزب
   - متزوج
   - مطلق
   - ارمل
6. **هل لديك اطفال:**
   - نعم
   - لا
7. **الدخل الشهري**
   - لا يكفي
   - يكفي الى حد ما
   - يكفي

الجزء الثاني: استبيان الخصائص المهنية

شكرًا لك على المشاركة في استبياننا حول الخصائص المهنية في تمريض الصحة النفسية والعقلية.

سيساعدنا الاستبيان التالي في جمع معلومات حول جوانب مختلفة من وظيفتك. يرجى الإجابة على الأسئلة بأفضل ما لديك من القدرة:

1. **فترة العمل في مستشفى الأمراض النفسية:**
   - أقل من ١ سنة ☐
   - من ١ إلى ٢ سنة ☐
   - من ٣ إلى ٥ سنوات ☐
   - أكثر من ٥ سنوات ☐
2. **مكان العمل:**
   - وحدة الاستشارات النفسية ☐
   - وحدة رعاية المرضى الراقدين في الردهات ☐
   - وحدة علاج **ECT** ☐
   - وحدة إعادة تأهيل الصحة العقلية ☐
   - وحدة حالات الطوارىء ☐
3. **المهام الادارية الاضافية في المستشفى:**
   - نعم ☐
   - لا ☐
4. **الوظائف الاضافية خارج المستشفى:**
   - نعم ☐
   - لا ☐
5. **وقت العمل في المستشفى:**
   - صباحي ☐
   - مسائي ☐
6. **عدد ساعات العمل في المستشفى:**
   - **٧ ساعات** ☐
   - **١٨ ساعة** ☐
   - **٢٤ ساعة** ☐

الجزء الثالث: مقياس ماسلاش للاحتراق النفسي

تسأل الأسئلة التالية عن ماهو شعورك تجاه عملك في مهنة تمريض الصحة النفسية والعقلية اثناء مسيرتك المهنية. اقرأ العبارات بدقة وحدد مقدار شعورك او معاناتك على كل عبارة بوضع علامة (√) امام الاجابة الخاصة بك علما انه لاتوجد اجابة خاطئة او صحيحة بل اجابتك تدل على وجهة نظرك وتجربتك الشخصية.

العبارات	لا اعاني مطلقا	مرات قليلة بالسنة	مرة بالشهر	مرات قليلة بالشهر	مرة في كل اسبوع	مرات قليلة بالاسبوع	كل يوم
	٠	١	٢	٣	٤	٥	٦
1. أشعر بالاستنزاف العاطفي بسبب عملي.							
2. يتطلب العمل مع الناس طوال اليوم قدرا كبيرا من الجهد.							
3. أشعر أن عملي يحطمني.							
4. أشعر بالإحباط من عملي.							
5. اشعر اني اواجه صعوبة في انجاز عملي.							
6. إنه يجهدني كثيرا العمل في اتصال مباشر مع الناس.							
7. أشعر وكأنني في نهاية عمري.							
8. أشعر انني اتعامل مع بعض المرضى وكأنهم اشياء لا بشر.							
9. أشعر بالتعب عندما أستيقظ في الصباح وأضطر إلى مواجهة يوم آخر في العمل.							
10. لدي انطباع بأن مرضاي يجعلونني مسؤولا عن بعض مشاكلهم..							
11. عند انتهاء يوم عملي اشعر بنفاذ صبري.							
12. اصبحت لا اهتم بما يحدث لبعض مرضاي.							
13. لقد اصبحت اكثر حساسية تجاه الناس منذ ان عملت في الردهات النفسية.							
14. أخشى أن هذه الوظيفة تجعلني غير مهتم بالاخرين.							
15. لقد أنجزت العديد من الأشياء الجديرة بالاهتمام خلال مسيرتي المهنية.							
16. أشعر أنني مليء بالطاقة.							
17. أنا قادر بسهولة على فهم ما يشعر به مرضاي.							
18. أنا أعتني بمشاكل مرضاي بشكل فعال للغاية.							
19. في عملي، أتعامل مع المشاكل العاطفية بهدوء شديد.							

20. من خلال عملي، أشعر أن لدي تأثيرًا إيجابيًا على الناس.							
21. أنا قادر بسهولة على خلق جو مريح مع مرضاي.							
22. أشعر بالانتعاش عندما أكون قريبًا من مرضاي في العمل.							

الجزء الرابع: استبيان المواجهة الموجز لقياس استراتيجيات المواجهة

تسأل الأسئلة التالية كيف سعيت للتعامل مع (ضغوطات العمل في مهنة تمريض الصحة النفسية والعقلية) اثناء مسيرتك المهنية. اقرأ العبارات وحدد مقدار استخدامك لكل أسلوب مواجهة بوضع علامة (√) امام الاجابة الخاصة بك علما انه لاتوجد اجابة خاطئة او صحيحة بل اجابتك تدل على وجهة نظرك الشخصية.

العبارات	لا تنطبق عليَّ اطلاقاً	تنطبق عليَّ بصورة قليلةٍ	تنطبق عليَّ بصورة متوسطةٍ	تنطبق عليَّ بصورة كبيرة
	١	٢	٣	٤
1. احاول الانشغال في العمل او الانشطة الاخرى لابعاد ذهني عن التفكير في مشاكل مرضاي.				
2. كنت أركز جهودي على القيام بشيء حيال ضغط العمل في مهنة التمريض.				
3. كنت اوهم نفسي بان مايحدث ليس حقيقيا.				
4. كنت استخدم بعض الادوية الممنوعة لاشعر بتحسن.				
5. كنت احصل على دعم عاطفي من الاخرين.				
6. تخليت عن محاولة التعامل مع ضغوط العمل في مهنة التمريض.				
7. اتخذت إجراءات لمحاولة تحسين الوضع الذي انا فيه.				
8. كنت أرفض تصديق أن مهنة التمريض شاقة ومتعبة لي.				
9. كنت أقول أشياء للسماح لشعوري غير السار بالهروب.				
10. كنت اتلقى المساعدة والمشورة من اشخاص آخرين.				
11. كنت ادخن السجائر أو أتعاطى الكحول لمساعدتي في تجاوزها.				
12. كنت أحاول رؤية مهنة التمريض من زاوية مختلفة، لجعلها تبدو أكثر إيجابية.				
13. كنت أنتقد نفسي.				
14. كنت أحاول التوصل إلى استراتيجية حول ما يجب القيام به.				

15. كنت أحصل على الراحة والتفهم من شخص ما.				
16. تخليت عن محاولة التأقلم.				
17. كنت أبحث عن شيء جيد في ما يحدث لي.				
18. كنت ألقي النكات حول هذا الموضوع.				
19. كنت أفعل شيئا للتفكير في الأمر بشكل أقل ، مثل الذهاب إلى السينما أو مشاهدة التلفزيون أو القراءة أو أحلام اليقظة أو النوم أو التسوق.				
20. كنت أقبل حقيقة انني ممرض ومهنتي تتطلب جهدا اكبر.				
21. كنت أعبر عن مشاعري السلبية مثل كتابة مشاعري السلبية او الحديث مع شخص قريب مني.				
22. كنت أحاول أن أجد الراحة في ديني أو معتقداتي الروحية.				
23. كنت أحاول الحصول على المشورة أو المساعدة من أشخاص آخرين حول ما يجب القيام به.				
24. كنت أتعلم التعايش مع الضغوط.				
25. كنت أفكر مليا في الخطوات التي يجب اتخاذها.				
26. كنت ألوم نفسي على الأشياء التي حدثت.				
27. كنت أصلي أو أتأمل للتخلص من الضغوط.				
28. كنت أسخر من الوضع كي لا اتأثر به.				

Part 1: Socio-demographic characteristics:

1. Age:

2. Sex:

Male ☐

Female ☐

3. Educational attainment:

Secondary vocational education ☐

Diploma ☐

Bachelor’s degree ☐

Graduate degree ☐

4. Place of residence:

Urban ☐

Rura**l** ☐

5. Marital status:

Single ☐

Married ☐

Divorced ☐

Widower ☐

6. Do you have children?

Yes ☐

No ☐

7. Economic situation:

Not Enough ☐

Somewhat Enough ☐

Enough ☐

Part 2: Occupational Characteristics:

1. Period of employment in psychiatric hospital:

Less than 1 year ☐

From 1 year to 2 years ☐

From 3 years to 5 years ☐

More than 5 years ☐

2. Workplace:

Psychological counseling unit ☐

Patient care unit in the wards ☐

ECT treatment unit ☐

Mental health rehabilitation unit ☐

Emergency care unit ☐

3.additional administrative tasks in the hospital:

Yes ☐

No ☐

4. Additional jobs outside the hospital:

Yes ☐

No ☐

5. Working time in the hospital:

Morning ☐

☐

Evening

6. Number of working hours per day:

7 hours ☐

18 hours ☐

24 hours ☐

Part 3: Maslach Burnout Inventory (MBI)

Items	Never	A Few Times Per Year	Once A Month	A Few Times Per	Once A Week	A Few Times Per Week	Every Day
Section- A (exhaustion)	**0**	**1**	**2**	**3**	**4**	**5**	**6**
1. **I feel emotionally drained by my work.**							
2. **Working with people all day long requires a great deal of effort.**							
3. **I feel like my work is breaking me down.**							
4. **I feel frustrated by my work.**							
5. **I feel I work too hard at my job.**							
6. **It stresses me too much to work in direct contact with people.** **7. I feel like I am at the end of my rope.**							
Total score - SECTION A							

Items	Never	A Few Times Per Year	Once A Month	A Few Times Per Month	Once A Week	A Few Times Per Week	Every Day
Section- B (Depersonalization or loss of empathy)	**0**	**1**	**2**	**3**	**4**	**5**	**6**
1. **I feel I look after certain patients/clients impersonally, as if they are objects.**							
2. I feel tired when I get up in the morning and have to face another day at work.							
3. **I have the impression that my patients/clients make me responsible for some of their problems.**							
4. **I am at the end of my patience at the end of my workday.**							
5. **I really don't care about what happens to some of my patients/clients.**							
6. **I have become more insensitive to people since I've been working.**							
7. **I'm afraid that this job is making me uncaring.**							
Total score — SECTION B							

Items	Never	A Few Times Per	Once A Month	A Few Times Per	Once A Week	A Few Times Per Week	Every Day
Section- C (Personal Achievement)	**0**	**1**	**2**	**3**	**4**	**5**	**6**
1. **I accomplish many worthwhile things in this job.**							
2. **I feel full of energy.**							
3. **I am easily able to understand what my patients/clients feel.**							
4. **I look after my patients'/clients' problems very effectively.**							
5. **In my work, I handle emotional problems very calmly.**							
6. **Through my work, I feel that I have a positive influence on people.**							
7. **I am easily able to create a relaxed atmosphere with my patients/clients.**							
8. **I feel refreshed when I have been close to my patients/clients at work.**							
Total score — SECTION C							

Part 4: Brief COPE Questionnaire

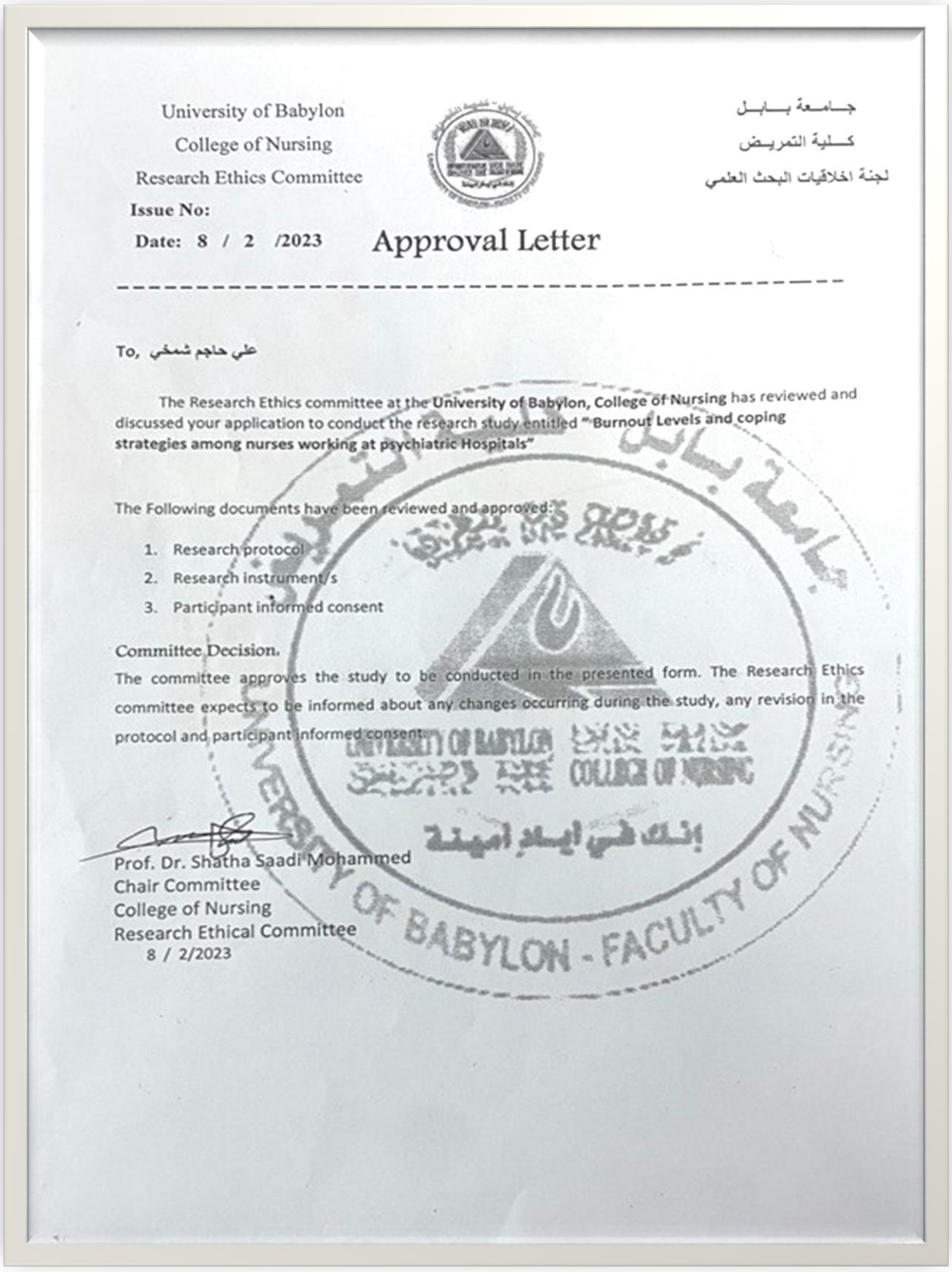
Instructions:

The following questions ask how you have sought to cope with a hardship in your life. Read the statements and indicate how much you have been using each coping style.

	I have not been doing this at all	I have been doing this a little bit	I have been doing this a medium amount	I have been doing this a lot
Items	**1**	**2**	**3**	**4**
1. I've been turning to work or other activities to take my mind off things.				
2. I've been concentrating my efforts on doing something about the situation I'm in.				
3. I've been saying to myself "this isn't real".				
4. I've been using alcohol or other drugs to myself feel better.				
5. I've been getting emotional support from others.				
6. I've been giving up trying to deal with it.				
7. I've been taking action to try to make the situation better.				
8. I've been refusing to believe that it has happened.				
9. I've been saying things to let my unpleasant feeling escape.				
10. I've been getting help and advice from other people.				
11. I've been using alcohol or other drugs to help me get through it.				
12. I've been trying to see it in a different light, to make it seem more positive.				
13. I've been criticizing myself.				
14. I've been trying to come up with a strategy about what to do.				
15. I've been getting comfort and understanding from someone.				
16. I've been giving up the attempt to cope.				

17.I've been looking for something good in what is happening.				
18.I've been making jokes about it.				
19.I've been doing something to think about it less, such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping.				
20.I've been accepting the reality of the fact that it has happened.				
21.I've been expressing my negative feelings.				
22.I've been trying to find comfort in my religion or spiritual beliefs.				
23.I've been trying to get advice or help from other people about what to do.				
24.I've been learning to live with it.				
25.I've been thinking hard about what steps to take.				
26.I've been blaming myself for things that happened.				
27.I've been praying or meditating.				
28.I've been making fun of the situation.				

8.2. Appendix B the Approval of Research Ethics Committee:



University of Babylon
College of Nursing
Research Ethics Committee

جـامـعة بـابـل
كـلية التمريـض
لجنة اخلاقيات البحث العلمي

Issue No:

Date: 8 / 2 /2023

Approval Letter

To, علي حاجم شمخي

The Research Ethics committee at the **University of Babylon, College of Nursing** has reviewed and discussed your application to conduct the research study entitled **"Burnout Levels and coping strategies among nurses working at psychiatric Hospitals"**

The Following documents have been reviewed and approved:

1. Research protocol
2. Research instrument/s
3. Participant informed consent

Committee Decision.

The committee approves the study to be conducted in the presented form. The Research Ethics committee expects to be informed about any changes occurring during the study, any revision in the protocol and participant informed consent.

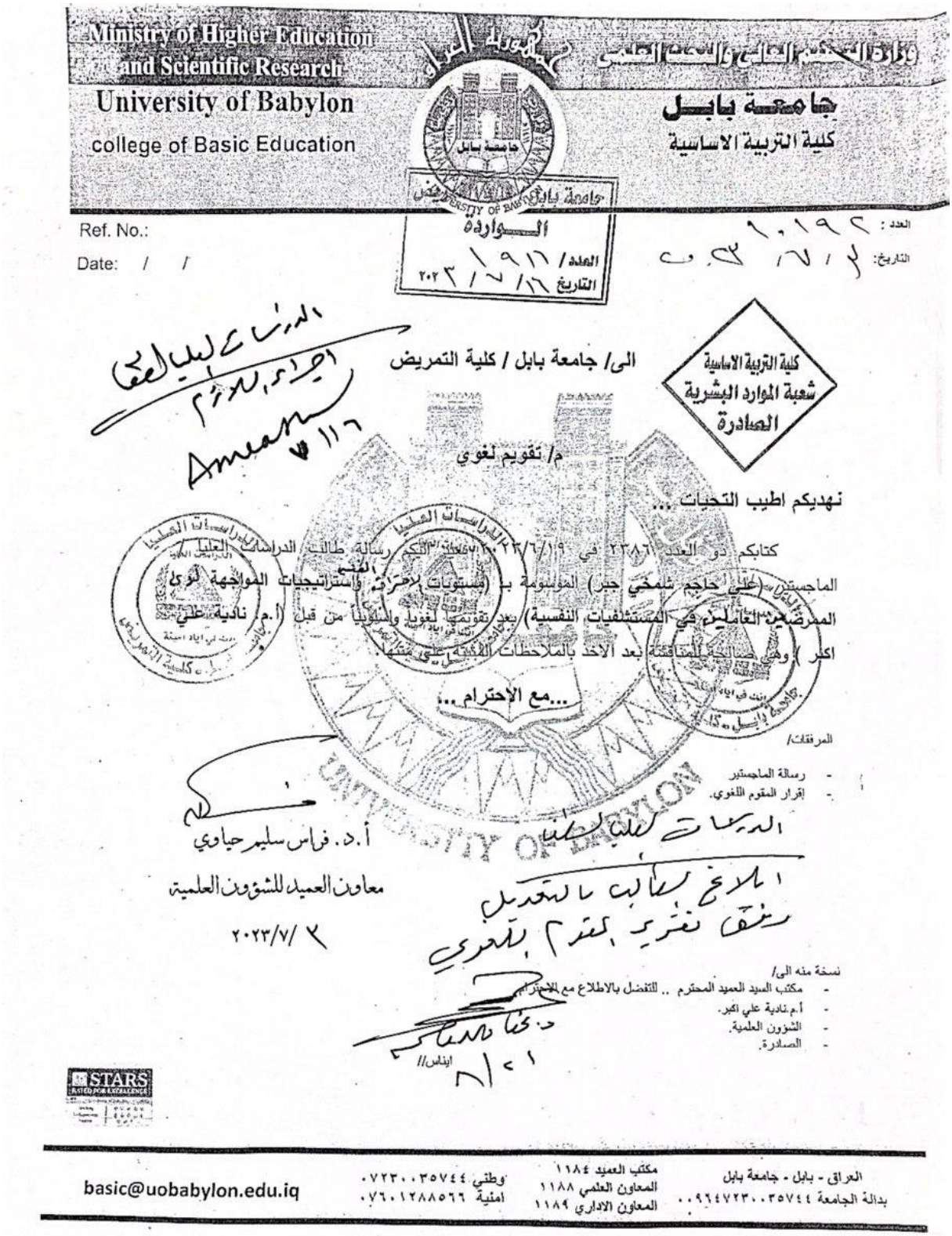
Prof. Dr. Shatha Saadi Mohammed
Chair Committee
College of Nursing
Research Ethical Committee
8 / 2/2023

UNIVERSITY OF BABYLON - FACULTY OF NURSING

8.3. Appendix C The Content of Experts:

ت	الاسم	الدرجة العلمية	سنوات الخدمة	مكان العمل	الاختصاص الدقيق
١	د. عبد المهدي عبد الرضا حسن	استاذ دكتور	٤٤ سنة	جامعة بابل/ كلية التمريض	تمريض الصحة النفسية والعقلية
٢	د. سجاء هاشم محمد	استاذ متمرس	٤١ سنة	جامعة بابل/ كلية التمريض	تمريض الصحة النفسية والعقلية
٣	د. مهدي حمزة منذور	استاذ مساعد	٢٠ سنة	معهد الصحة العالي/ ميسان	تمريض الصحة النفسية والعقلية
٤	د. مزهر خليف حسوني	استاذ مساعد	١٩ سنة	معهد الصحة العالي/ ميسان	تمريض الصحة النفسية والعقلية
٥	د. كوثر سلمان داوود	استاذ مساعد	١٧ سنة	المعهد الطبي التقني/ بغداد	تمريض الصحة النفسية والعقلية
٦	د. حيدر حمزة علي	استاذ مساعد	١٤ سنة	جامعة الكوفة/ كلية التمريض	تمريض الصحة النفسية والعقلية
٧	د. امير صلاح الدين عبد الرزاق	مدرس	٩ سنوات	جامعة بابل/ كلية التمريض	تمريض الصحة النفسية والعقلية

8.4. Appendix D The Linguistic Certification:



Ministry of Higher Education and Scientific Research
University of Babylon
college of Basic Education

وزارة التعليم العالي والبحث العلمي
جامعة بابل
كلية التربية الاساسية

Ref. No.:
Date: / /

الواردة
العدد / ١٩١٦
التاريخ ١٦ / ٧ / ٢٠٢٣

العدد : ٢٠١٩٢
التاريخ: ٢ / ٧ / ٢٠٢٣

كلية التربية الاساسية
شعبة الموارد البشرية
الصادرة

الى/ جامعة بابل / كلية التمريض

م/ تقويم لغوي

نهديكم اطيب التحيات ...

كتابكم ذو العدد ٢٣٨٦ في ٢٠٢٣/٦/١٩ بخصوص رسالة طالب الدراسات العليا الماجستير (علي حاجم شمخي جبر) الموسومة بـ (مستويات إحراج واستراتيجيات المواجهة لدى الممرضين العاملين في المستشفيات النفسية) بعد تقويمها لغوياً وانويباً من قبل (أ.م نادية علي اكبر) وهي صالحة للمناقشة بعد الاخذ بالملاحظات المدونة على متنها.

...مع الاحترام...

المرفقات/
- رسالة الماجستير
- إقرار المقوم اللغوي.

أ.د. فراس سليم حياوي
معاون العميد للشؤون العلمية
٢٠٢٣/٧/ ٢

نسخة منه الى/
- مكتب السيد العميد المحترم .. للتفضل بالاطلاع مع الاحترام.
- أ.م.نادية علي اكبر.
- الشؤون العلمية.
- الصادرة.

ايناس//

STARS

basic@uobabylon.edu.iq
وطني ٠٧٢٣٠٠٣٥٧٤٤ امنية ٠٧٦٠١٢٨٨٥٦٦
مكتب العميد ١١٨٤
المعاون العلمي ١١٨٨
المعاون الاداري ١١٨٩
العراق - بابل - جامعة بابل
بدالة الجامعة ٠٠٩٦٤٧٢٣٠٠٣٥٧٤٤

المستخلص:

الخلفية: إن الاحتراق النفسي، وهو حالة شديدة من التوتر تسبب الإرهاق العاطفي والعقلي وأحيانًا الجسدي في مكان العمل، هو مشكلة كبيرة بالنسبة للمهنيين في مجال الرعاية الصحية. تعتبر استراتيجيات االمواجهة، والتي تشمل الجهود المعرفية والسلوكية التي يبذلها الفرد للتخفيف من الاعباء الخارجية والداخلية.

الأهداف: تقييم مستويات الاحتراق النفسي واستراتيجيات المواجهة بين الممرضين النفسيين وتحديد العلاقة بينهما.

المنهجية: تم استخدام نهج كمي وصفي ترابطي واستخدام استبيانات ذاتية التقرير، وهما مقياس ماسلاش للاحتراق النفسي ومقياس المواجهة الموجز. تضمنت جمع البيانات طريقة عينة استدلالية غير احتمالية واستهدفت ١٥٠ ممرض بعملون في مستشفيات ابن رشد والرشاد للطب النفسي في بغداد، العراق. تم إجراء الدراسة بين ١٩ سبتمبر ٢٠٢٢ و١ يونيو ٢٠٢٣.

نتائج الدراسة: أظهرت الدراسة أن ٣٩٠٣٪ من الممرضات يعانين من إرهاق متوسط، و٥٨٪ يعانين من تبدد الشخصية، و٩٢٪ يعانين من الإنجاز الشخصي المنخفض. أظهرت استراتيجيات التكيف التي تهدف إلى إدارة العواطف وتجنب مصادر الضغط زيادة في الإرهاق والانفصال، بينما تقلصت هذه الاستراتيجيات الموجهة نحو حل المشكلات هذه الآثار وزادت من الإنجاز الشخصي. علاوة على ذلك، اختلفت مستويات الاحتراق النفسي بشكل كبير بناءً على العمر والجنس ومستوى التعليم والحالة الزوجية والدخل. من حيث البيانات المهنية، أدى الاستمرار في الوحدات النفسية إلى تقليل الاحتراق النفسي، في حين أدت المهام الإدارية الإضافية والوظائف الخارجية إلى تفاقمه، دون تأثير من مكان العمل أو الورديات أو ساعات العمل اليومية.

الاستنتاجات والتوصيات: إن الاحتراق النفسي موجود بشكل كبير بين الممرضين النفسيين في بغداد، ويتأثر بشكل رئيسي باستراتيجيات التكيف الخاصة بهم. تعتبر النهج الموجهة نحو حل المشكلات الأكثر فائدة. يجب على المستشفيات النفسية أن تقدم تدريبًا حول هذه الطرق التكيفية، وتقدم خدمات الاستشارة، وإعادة تقييم المهام الإدارية للممرضات. يمكن اعتماد استراتيجيات مثل تناوب الموظفين والتدخلات المصممة خصيصًا للممرضين الاقل سنا أو ذوات الدخل المحدود.

جمهورية العراق
وزارة التعليم العالي والبحث العلمي
جامعة بابل/ كلية التمريض

مستويات الاحتراق النفسي واستراتيجيات المواجهة بين الممرضين العاملين في المستشفيات النفسية

من قبل
الباحث علي حاجم شمخي

بأشراف
أ.د. قحطان هادي حسين

رسالة مقدمة
الى مجلس كلية التمريض في جامعة بابل
كجزء من متطلبات نيل درجة الماجستير في علوم التمريض

ايار ٢٠٢٣ م ذو القعدة ١٤٤٤هـ