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"Job Burnout Among Occupational Therapists Working in Palestine, Jordan, Qatar, and Saudi Arabia: A cross-sectional study"

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Thesis Approval

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Declaration

I declare that the content of the thesis is the result of my effort and this thesis as a whole, or part of it, has not previously been submitted for a degree or research at any other educational or research institution.

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Abstract

Background: Addressing burnout among occupational therapists is crucial, given the demanding nature of their professions. However, research specifically examining job burnout among occupational therapists in Palestine, Jordan Qatar, and Saudi Arabia is limited, this knowledge gap underscores the need for a comprehensive investigation to understand the unique challenges faced by these professionals. Objectives: This study aimed to assess the presence of burnout among occupational therapists working in Palestine, Jordan Qatar, and Saudi Arabia. Additionally, it sought to identify factors associated with burnout in this population. Methods: A cross-sectional study was conducted, involving a convenience sample of occupational therapists from the aforementioned countries. The Maslach Burnout Inventory Human Service Survey for Medical Personnel MBI-HSS (MP) was used as a primary outcome measure, as well as the Brief resilience scale (BRS) and a patient health questionnaire (PHQ) as additional scales. Data were analyzed using SPSS version 26. Results: The findings revealed that a significant proportion of occupational therapists experienced varying levels of burnout exhibiting moderate and high levels, which shows that there is a large number of OT professionals suffering from burnout, especially in the dimension of emotional exhaustion (25 % moderate and 25% high) and personal accomplishment showed that (35.75%) have high levels. In comparison (22%) scored moderate burnout levels. BRS and PHQ scales confirmed that Qatar OT professionals experienced high resilience with acceptable mental health status. In contrast, Saudi Arabia, Jordan, and Palestine professionals showed low levels of resilience and fair mental health status. Conclusion: This study highlights the

presence of burnout among occupational therapists in Palestine Jordan Qatar and Saudi Arabia, Sociodemographic and organizational factors, along with coping strategies, play a significant role in the manifestation of burnout, Faster attention is needed to implement interventions aimed at addressing burnout and promoting well-being among Occupational Therapists in these countries, These findings have implications for healthcare systems globally, emphasizing the importance of supporting health professionals to prevent burnout and ensure optimal patient care.

Keywords: Burnout, Job Burnout, Occupational Therapists, job stress, mental health, work-related stress.

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List of Abbreviations

Full name	Abbreviation
Occupational Therapy	OT
Brief Resilience Scale	BRS
Patient Health Questionnaire	PHQ
Maslach Burnout Inventory humans service survey for medical personnel	MBI HSS- MP
Maslach Burnout Inventory- Emotional Exhaustion	MBI-EE
Maslach Burnout Inventory- Depersonalization	MBI-D
Maslach Burnout Inventory- Personal Accomplishment	MBI-PA

Chapter 1 Introduction and Background

1.1 Chapter overview

This chapter provides background and rationale for the study of job burnout among occupational therapists. It identifies the research problem and existing gaps in the literature, outlines the research objectives, and discusses the significance of addressing burnout to enhance practitioner well-being and improve patient care outcomes.

1.2 Background and rationale

Burnout is a serious work hazard characterized by emotional depletion, depersonalization, and a lack of personal success or achievements (Shanafelt & Noseworthy, 2017). It results from chronic exposure to job stresses, especially in high-work-stress contexts such as the healthcare fields (Maslach & Jackson, 1981). Burnout influences healthcare personnel' emotional and physical well-being, as well as the quality of care they deliver to patients. Moreover, burnout has been linked to greater rates of absenteeism, job dissatisfaction, and turnover (West et al., 2016). This, in turn, jeopardizes the efficiency and sustainability of healthcare systems worldwide. Burnout is a serious problem among healthcare personnel, who are accustomed to being subjected to high levels of stress as a result of the high physical demands, psychological stress, and even emotional needs of patient care. Health care professionals, including physicians, nurses, and therapists. Typically work long hours, deal with emotionally difficult circumstances, and are under continual pressure to deliver high-quality treatment, often with few resources. This may result in lower work satisfaction,

lower turnover, and more absenteeism, all of which have a detrimental influence on patient outcomes and the overall value of healthcare systems (West et al., 2016). Furthermore, untreated burnout may lead to major health problems including despair, anxiety, and persistent physical challenges, which impair their capacity to perform efficiently. Occupational therapists, in particular, are subject to burnout because of the nature of their profession, which involves providing tailored rehabilitation services to people with increasingly complicated health problems and persistent physical, mental, and emotional requirements. The ongoing pressures of developing trailered therapies, monitoring patient progress, and dealing with emotionally charged situations, such as patients with severe disabilities or chronic health concerns, may lead to significant emotional tiredness (Scanlan & Still, 2013). Burnout among occupational therapists not only threatens their own mental and physical well-being but also diminishes the quality of care they provide, potentially undermining therapeutic outcomes for patients and leading to broader systemic inefficiencies (Poulsen et al., 2014).

Previous studies on burnout among occupational therapists found that a large proportion experienced emotional weariness, depersonalization, and a decreased sense of personal accomplishment (Maslach & Jackson, 1981). Burnout can be caused by a variety of circumstances, including large caseloads, emotional pressures, and a lack of support systems. However, existing literature frequently lacks thorough regional insights, especially in Middle Eastern nations where socio-political and economic constraints might increase burnout (Elbarazi et al., 2017). Furthermore, many studies have limitations, such as a small sample size, a focus on specific geographic regions, or insufficient consideration for long-

term results. These gaps emphasize the need for additional research that not only quantifies burnout levels among occupational therapists in various contexts but also investigates strategies to address this growing concern. In the Middle East, occupational therapists encounter particular problems, such as political instability, economic hardship, and inadequate resources, which might raise the risk of burnout (Chemali et al., 2019). In Palestine, for example, healthcare professionals must adapt to constant changes in working conditions while coping with the psychological strain of serving individuals affected by conflict and social inequality (Jaradat et al., 2017). These regional stressors necessitate targeted research to develop appropriate burnout prevention strategies for occupational therapists who work in such environments. Despite rising awareness of burnout in the medical industry, little study has focused on occupational therapists in the Middle East. This study intends to fill this vacuum by analyzing the burnout levels and risk variables related to burnout among occupational therapists in the four nations being studied, offering significant information for developing tailored therapies. Addressing these gaps is critical for stressing the well-being of the profession and preserving the type and quality of service given.

1.3 Research problem

In the Middle East context, the burnout phenomenon among occupational therapists may exacerbated by regional factors, including economic, cultural, and even healthcare system stressors, the distinct characteristics of healthcare in Middle east countries' healthcare environments, such as varying levels of resources, deferent cultural expectation, and

economic pressures, may contribute to an increased risk of burnout among OT professionals, practicing in these countries, (Hamdan & Hamra, 2017). The research problem mainly focuses on examining the different levels that contribute to burnout and the consequences of burnout among these professionals. In the four countries selected. Based on their diverse healthcare environments, and varying economic levels, as well as the distinct challenges posed by different healthcare infrastructures, in addition to that, each country has its cultural aspects, and socioeconomic conditions that could impact OT professionals working conditions, and vulnerability to burnout. Moreover, the four countries selected for the study sample reflect a mix of different limitations in the resources and facing political instability which may intensify the risk of burnout.

Evaluating burnout levels in these contexts is crucial, as many previous researches have often been limited by focusing on 'Western healthcare systems, and that indicated a lack of comprehensive data about burnout among this population in these countries. Hence the previous studies tried to emphasize general healthcare professionals, with limited studies among occupational therapists' professionals, as a distinct group. By addressing these gaps, this study aims to develop targeted strategies to decrease the possibility of burnout and enhance well-being of the OT professionals. Also, to ultimately improve the quality of rehabilitation service provided, addressing these problems effectively needs a comprehensive evaluation of the factors impacting burnout among this specific population in these countries. Therefore, the research problem can be framed in two main questions:

1) What are the current levels of burnout among occupational therapists in the four countries being studied?
2) What are the key contributing factors to burnout among occupational therapists in these countries?

1.4 Research objectives

1) Determine the burnout levels among occupational therapists in the four countries: - Palestine, Jordan Qatar, and Saudi Arabia.
2) Explore the factors associated with burnout among occupational therapy professionals in these countries.

1.5 Research significance

The significance of this study is related to its thorough investigation of burnout among OT professionals, and since it stresses the critical need for improving the mental health of this population and better working conditions. This study indicates the serious consequences of burnout among occupational therapists and highlights the importance of adequate psychological and emotional support to improve their performance and overall well-being. Studying levels of burnout can mitigate burnout, and explore the influencing factors, in addition to enhancing the quality of care provided, hence increasing patients' outcomes. Furthermore, the study provides relevant and current data for decision-makers to create informed policies and procedures, focusing the future research effort on explaining the causes of the unit and developing feasible interventions, it also makes the development of specific training and educational programs easier, which could increase the awareness about

how OT professionals deal with psychological stress at work, and increasing their professional competency. Furthermore, the findings of this study raise awareness among community and hospital officials's important role of occupational therapists and the need for management support, this study ultimately enables occupational therapists to balance their work and personal lives, improving their overall quality of life and improving the healthcare system and the quality of care provided.

1.6 Theoretical framework of the study

This research is based on the Maslach Burnout Inventory (MBI), the version of medical personnel, which explores and explains burnout as a multidimensional construct with its three domains: emotional exhaustion, depersonalization, and reduced personal achievements. The Maslach burnout inventory has been recognized as a well-known instrument for assessing burnout among different populations (Maslach & Jackson, 1981). This study also utilized the Brief Resilience Scale (BRS) combined with the Maslach Burnout Inventory to assess resilience, which is defined as the capacity to recover from work stress. The Brief Resilience Scale, known as a strong tool for evaluating the capacity of healthcare professionals to recover from stress at work, provides insight into the significance of resilience in reducing burnout (Smith et al., 2008). Moreover, the Patient Health Questionnaire (PHQ) is used to evaluate mental health problems, such as depression and anxiety, that usually accompany burnout and resilience. This study aims to elucidate the interconnections between burnout resilience and the status of mental health among occupational therapists by combining these methods. This conception calls for a detailed

examination of the interaction of these components and their combined influence on the feelings of burnout in this profession. Moreover, this model emphasizes the need to address burnout as early as possible among healthcare providers such as occupational therapists, to improve recruitment, retention, and overall work environment well-being (Maslach & Leiter, (2016).

Chapter 2 Literature Review

2.1 Chapter Overview

This chapter contains a comprehensive literature review focused on the burnout phenomenon among occupational therapists, with emphasis on the Arab countries. It examines the definition and patterns of burnout within this profession. This literature review also provides a solid conception for the relational of the present study by outlaying existing literature gaps through a compressive review of the literature searched.

2.2 History and definition of the concept of burnout

Burnout is a complex psychological condition resulting from a prolonged response to persistent workplace stressors, particularly prevalent among healthcare providers and professionals, who are facing interpersonal demands, (Maslach & Jackson, 1981). This notion of burnout, first being studied and recognized by the known psychologist Herbert Freudenberg in the early 1970s, indicated the significant emotional exhaustion experienced by healthcare professionals, in high-stress environments, such as hospitals, clinics, and rehabilitation institutions, (Freudenberg., 1974). Expanding upon Freudengerbers' seminal research, Maslach and her colleagues created the Maslach Burnout Inventory (MBI), which underscored the ramifications of burnout for both healthcare professionals and the quality of care provided (Maslach & Jackson, 1981; Maslach et al.,2001). People recognize burnout as a dynamic and developing phenomenon largely defined by emotional exhaustion, which occurs when people experience emotional depletion and an inability to fulfill job obligations (Maslach & Leiter. 2016). The depletion of emotional resources is fundamental to the

burnout phenomenon and illustrates the significant effect of stressful workplace environments on healthcare delivery. Further burnout is characterized by two additional dimensions: Depersonalization, which entails a distant and cynical attitude towards work and coworkers, undermining professional relationships, and diminishing job satisfaction (Maslach & Goldberg, 1998). The last factor decreased personal accomplishment, leads to a decrease in feelings of efficacy and success, often cultivating a sense of inadequacy and subsequent disengagement from professional duties. Maslach et al., 2001). Maslach et al. (2001) delineate burnout as a complexity and highlight the need for treatments to improve healthcare for professionals and the quality of care they provide (Carmona-Barrientos et al., 2020)

2.3 Impact of burnout on healthcare professionals, and occupational therapists

Burnout is a significant risk among healthcare providers due to the demands required by the work roles and professional responsibilities, which involve high emotional, physical, and cognitive demands. Healthcare professionals, including physiatrists, nurses, and therapists, face challenging duties such as high workloads, decreased power, and emotional fatigue for the services they offer to their patients, which increase their exposure to developing burnout (Maslach et al., 2001). The literature consistently shows that burnout among healthcare professionals could lead to decreased job satisfaction, poorer patient improvement and outcome, and high rates of turnover (Poulsen et al., 2014). Burnout can consistently harm healthcare professionals. Their ability to perform the assigned duties could lead to a decline in the quality of care they provide, and emotional exhaustion can lead to reduced empathy, impairing their ability to form meaningful relationships in their communities. However,

depersonalization, or a cynical attitude toward their patients and colleagues, has risky consequences, further harming teamwork and the service provided to their patients (Maslach & Leiter, 2013). Hence, the reduced sense of personal achievements can contribute to dissatisfaction with their job and higher rates of turnover, in addition to higher levels of absenteeism (Scalan & Still, 2013).

Among these healthcare professionals, occupational therapists are particularly vulnerable to burnout, due to the nature of their role in facilitating recovery and improving daily life skills, the combination of emotional and physical demands makes OTs prone to experiencing burnout, studies indicated that a significant percentage of OT professionals experiencing burnout, which has been linked to decreased job satisfaction, a reduction in the quality of care provided and increased turnover rates (Poulsen et al., 2014).

Moreover, the consequences of burnout on healthcare professionals, including occupational therapists, who work in different healthcare settings, encounter unique challenges that can lead to burnout. For instance, those who work in psychiatric institutions frequently deal with intense emotional strain due to work responsibilities, which involve treating psychologically distressed patients. Burnout has a significant impact on OT professionals, including their ability to fulfil their duties and maintain a high standard of care. Nonetheless, elevated workloads and physical demands are prevalent for occupational therapists engaged in physical rehabilitation. The aforementioned demands elevate the likelihood of burnout, particularly among therapists operating in resource-constrained settings, due to insufficient

support and resources, which exacerbate stress and feelings of inadequacy (Li Calzi et al., 2006).

Several articles have explored the effects of burnout on the well-being and quality of life of occupational therapists, as indicated by Chung, in his study titled: "Occupational Therapists Professional Quality of Life'' who revealed that, high levels of compassion satisfaction, companied with low levels of burnout, (Chung, 2020). Pignatielio and his colleagues (2015), revealed that occupational therapists who work in environments with limited resources developed feelings of emotional exhaustion and anxiety, which are main features of burnout, due to heightened stressors and inadequate management support. This aligns with the assertions of academics Maslach and Leiter (2016), who contended that burnout can result in emotional depletion, a fundamental aspect of burnout, which directly impacts occupational therapists' accessibility to their clients.

Burnout can affect cognitive functioning, as noted by Edward & Dirette (2010), who identified that cognitive deficits, such as diminished concentration, attention, and decision-making, are significant consequences of burnout. Moreover, for occupational therapists, this can have severe repercussions, especially in the treatment planning and rehabilitation process, where sharp decision-making- is essential for patients. Pignatillo et al (2015) again mentioned that heavy caseloads in the scope of physical rehab settings contribute to burnout.

Physical health is another issue that could be impacted by burnout, Gomez et al. (2013) highlight those physical symptoms, such as long-term fatigue and muscle pain, are common

in healthcare professionals suffering from burnout. These are relevant for occupational therapists as they often perform physically demanding tasks and roles.

Moreover, burnout can lead to a decline in job satisfaction and increased turnover rates. Hoff et al. (2019), argued that burnout is a major predicting symptom of turnover intention in healthcare providers, Occupational therapists experiencing burnout symptoms are more likely to leave their jobs, which can impact workforce shortage. This corresponds to Maslach et al. (2016), in a study that underlines the feelings of inadequacy and inefficacy that come with burnout, making healthcare providers suffer from decreased competency in their roles, which could influence their skilled performance. Finally, the literature collectively reveals that burnout can affect occupational therapists by leading to emotionally exhausting cognitive and physical issues and reduced job satisfaction, and this not only diminishes the well-being of OT professionals but also compromises the quality of their performance and quality of care provided.

2.4 Burnout variability among occupational therapists

Burnout can defer among various occupational therapy groups, for example, therapists in physical rehabilitation institutions may deal with high caseloads and high physical demands, while the OTs working in mental health hospitals or clinics encounter a deeper emotional difficulty. Furthermore, occupational therapy professionals who work in settings with limited resources run the risk of experiencing a decline in support, which can increase work pressure and feelings of inadequacy (Pignatiello et al., 2015). Moreover, the studies designed specifically for effective treatments of management of stress among occupational

therapists are limited, particularly in high-stress work environments, Upon Maslach and Leiter (2016) indicated that managing burnout is crucial for therapist well-being as well as for preserving the caliber of service they provide (Maslach & Leiter, 2016). Furthermore, occupational therapy professionals play a critical role in supporting individuals at mental health institutions through a variety of strategies and interventions that focus on enhancing daily functions and improving the quality of life, and that was supported by Edward and Dinette (2010), who emphasized that occupational therapist has a major role in these settings such as:

1) Evaluating social and psychological needs through a thorough evaluation to ascertain the degree of social and psychological challenges that patients face, as well as executing individual planning through the creation of treatment plans and interventions (Derakhshanrad et al., 2019).

Developing everyday living skills through life skills training in areas including time management, self-care, and social interaction; while striving to increase patients' independence in carrying out daily tasks. (Çapri, 2013).

3. Stress and anxiety management: Using coping mechanisms by assisting farmers in creating efficient ways to handle psychological stress, as well as using relaxation techniques like deep breathing and meditation to lower levels of worry and stress (Maslach et al., 2016).

4. Improving community participation through group activities: To assist the injured in reintegrating into society and their professional activities, occupational therapists must plan group activities that foster social interaction and a sense of belonging. These responsibilities expose them to daily pressures that can result in job burnout. (Pashniak & Brown, 2018).

2.5 Recognizing and assessing burnout

Hogan et al. (2023) found that burnout develops gradually, with minor symptoms at the outset that worsen as stress levels rise without intervention. In a study titled "Understanding the Burnout Experience; Recent Research and its Implications for Psychiatry," Kim et al. (2016) discussed how Maslach and Leiter conceptualized the stages of burnout may begin. After delving into the phases of burnout development, they found that it begins with symptom stimulation, progresses via tension emergence and chronic tension development, and finally culminates in persistent pressure. Additionally, a complete understanding of the signs and symptoms displayed by the individual is necessary for detecting burnout symptoms. Worldwide, healthcare providers employ a variety of psychological tools to assess the likelihood of experiencing burnout symptoms on the job. These tools include questionnaires and outcome assessments. Furthermore, research shows that many companies and healthcare facilities use diverse approaches to identify burnout, such as: Performing medical exams: to detect any bodily signs that might be associated with long-term stress, including sleeplessness, migraines, and gastrointestinal issues. While keeping an eye out for changes in the specialist's mood, level of social isolation, and performance on the job (e.g., more mistakes and lower productivity). (Del Castillo et al., 2013). Medical evaluations: Moreover, studies indicated that numerous corporations and healthcare institutions employ diverse methods for detecting burnout, including:

1) Physical evaluation: Conduct medical examinations to identify any physical symptoms likely linked to chronic stress, such as insomnia, headaches, and gastrointestinal problems. Assessing changes in the specialist's professional performance, characterized by more errors

and diminished productivity, alongside signs of social withdrawal, isolation, and emotional instability. Gomez-Gascon et al. (2013).

2) Clinical interviews: To evaluate the professional and personal history through discussions with the specialist, to understand the work background and possible personal factors contributing to psychological burnout, and to assess the severity by identifying symptoms associated with psychological burnout, such as emotional exhaustion, reduced professional efficacy, and feelings of detachment from work (Carmona-Barrientos et al., 2020).

Studies about detecting levels of burnout have employed many different outcome measures internationally, with MBI being the widest tool being utilized, due to its strong psychometrics properties and across different cultures, in addition to that it was cross-culturally adapted to many languages to evaluate burnout levels among multiple workforces. In addition to MBI, there were several assessment tools frequently utilized to prove a comprehensive understanding of burnout, particularly among health care providers, these tools not only addressed burn0out but also explored the related psychological and organizational factors, The following are the most frequently utilized outcome measure internationally used for detecting burnout:

1) Burnout Questionnaire for Healthcare Professionals: This outcome measure is designed to assess different stress levels and influencing factors that contribute to burnout in healthcare settings, the focus of tools at the organizational and personal stressors, enabling the identification of burnout influencing sources beyond individual characteristics. (Showman et al., 2021)

2) Patient Health Questionnaire (PHQ): This tool evaluates mental health status and concerns, including depression, and anxiety, usually it's a company using burnout outcome measures. Understanding the psychological state of healthcare providers may yield significant insights into the impact of burnout on mental health and work performance. (Maslach et al., 2016).

3) The General Health Questionnaire (GHQ): this outcome measure assesses overall mental health and well-being. Focusing on the psychological distress and detects individuals at risk for mental health issues due to burnout. This assessment tool may aid in the development of treatments and interventions for treating burnout. (Goldenberg & Williams, 1988).

4) Conner-Davidson Resilience Scales (CD-RISC): resilience is an essential factor in stress management among healthcare workers, and it can help in setting prevention of burnout, the DC-RISC assesses resilience levels and provides an insight into the healthcare professionals' capacity to navigate the challenges intrinsic to their professions (Conner and Davison, 2003).

5) Quality of Life (QoL) Measure: Assessing the quality of healthcare providers may offer a thorough framework for understanding the impacts of burnout. Instruments such as the WHO Quality of Life-BREF (WHOQOL-BREF) evaluate many life domains, including physical health, psychological well-being, and social connections. World Health Organization, 1998.

6) Turnover Intention Scale: this tool evaluates the phenomenon of turnover intentions, offering organizational insights into prospective staffing difficulties and the necessity for impotent initiatives that target retaining critical employees. (Hoff et al., 2019).

7) Burnout Assessment Tool (BAT): The BAT is used mainly for detecting burnout levels By combining a deductive and inductive approach, allowing for integrated insight into the burnout reason, the questionnaire was formulated after carefully structuring items from existing burnout instruments, (Schaufeli et al., 2020)

2.6 Burnout prevention and managing strategies

Furthermore, numerous studies have highlighted effective strategies for preventing and managing burnout, focusing on both organizational and individual interventions. These strategies emphasize the importance of fostering a supportive work environment, providing resources for stress management, and promoting a healthy work-life balance the approaches suggested in the literature, the following table presents the detailed strategies used in the articles reviewed:

Table 2- 1 suggested strategies and management for resolving burnout

Article	Healthcare Providers being studied	Possible treatment/management suggestion
Poulsen et al., 2014		Improving the work environment by reducing the workload, distributing work in a balanced manner, reducing administrative burdens and institutional support, while providing support by management and enhancing the culture of appreciation and cooperation
(Pigni, 2014)		Training on stress management through training programs, along with providing training programs on stress management techniques and coping with stress, in addition to raising awareness about mental health,

	enhancing awareness of its importance, and providing the necessary resources for support.
Maslach et al., (2016)	Promoting work-life balance by using flexible working hours by providing flexible work schedules that help achieve a balance between professional and personal life and using regular breaks that reduce stress.
(Maslach & Leiter, (2016).	Professional development and autonomy: Encouraging continuous professional development and giving employees more autonomy in decision-making can empower and engage professionals in their roles, reducing feelings of burnout
Bakker & Demerouti, (2017).	Job redesign and role clarity: Providing role definition and setting well-defined expectations can significantly reduce job ambiguity and role conflict. Both of these are major contributors to burnout, ensuring employees have a thorough understanding of their responsibilities helps to lower stress and enhance job satisfaction.
Shanafelt at al., (2015)	Peer support and mentorship programs: establishing formal peer support and mentorship programs can create a sense of belonging and shared purpose among employees, providing emotional support and reducing feelings of isolation

2.7 Levels and contributing factors of burnout among occupational therapists

For reviewing previous literature, a comprehensive systematic search was conducted through MIDLINE, PubMed, and Google Scholar databases, using the keywords “burnout, job burnout, occupational therapists, job stress, mental health, and work-related stress." The

relevant MESH terms were also used. The search was limited to articles published in English between 1970 and 2023, as the concept of burnout began to have tension in the early 1970s. More details of the searched literature are attached to the Prisma chart Appendix A.

Table 2-1 presents a detailed analysis of articles based on the factors influencing burnout, which discussed burnout as a significant and widespread concern among occupational therapists, indicating that it severely impacts these professionals, mental health, physical well-being, and patient care standards. Scanlan and his colleagues 2019, in their study titled, "Relationships between job satisfaction, burnout, professional identity, and meaningfulness of work activities for occupational therapists working in mental health" among 118 Australian OTs, revealed that greater meaningfulness in work activities correlated with increased job satisfaction; hence, reduced burnout and stronger professional identity, with the personal value being the most significant factors (Scanlan & Hazelton, 2019). Organizational shortcomings, including lack of managerial support, insufficient resources, and substandard working circumstances, increase the risk of burnout (Scanlan & Still, 2013) and additional stressors, such as high (Leiter & Harvie, 1996) (Megnist et al., 2021). Reis and her colleagues, who studied burnout in 2018 among 374 occupational therapists in Portugal, indicated that management encumbrances, such as unnecessary documentation and bureaucratic burdens, reduce the time allocated for direct patient treatment, hence heightening irritation and fatigue. Also indicated that insufficient acknowledgment further exacerbates discontent and reduced motivation among professionals. Reis et al., 2018). Furthermore, the researchers Brown and Pashniak (2018) studied the factors impacting burnout among numerous occupational therapy participants in Canada, using MBI as the

main outcome measure, identifying that higher depersonalization and lower emotional exhaustion among the OT sample being studied related to work addiction, and high scores in dedication and personal accomplishment can be protective factors against burnout. Brown & Pashniak, 2018). On the other hand, Painter and his colleagues (2003) studied burnout among a large sample of occupational therapists (3000 participants) in the United States of America, revealing that the contributing factors for burnout were divided between institutional and personal factors, such as high caseloads, lack of control and limited autonomy, inadequate social support, and policies and procedures that can restrict decision-making, and they highlighted the personal factors, such as coping skills, age, and experience in the home environment, in addition to gender, that could play a crucial role in developing burnout (Painter et al., 2003). Moreover, in a study of burnout and distress among allied healthcare providers, including occupational therapists, (2019), a sample of 52 participants in healthcare providers, including OTs, in Canada, indicated high rates of burnout; almost 73% of the participants and 69% reported high emotional problems due to unfair treatment and insufficient staffing. (Rubin et al., 2021). These results correspond to Derakhshanrad study 2019, "The Relationships between Problem-Solving, Creativity, and Job Burnout in Iranian Occupational Therapists," which highlighted the sample of 50 occupational therapy Iranian participants, indicating that high job demands, including physical and cognitive resources such as problem-solving and creativity skills, could be inversely related to burnout levels, highlighting that increased number of years of experience could contribute to lower burnout levels, and poor job-person fit, which is characterized by mismatches between job demands and cognitive resources along with emotional detachment from work, can increase

burnout levels. Moreover, Edward and his colleagues (2010) investigated the relationship between professional identity and burnout among 126 occupational therapists, revealing that job-related stress stems from role conflict and ambiguity, with high demands and insufficient recognition, and a poor work environment lacking support and clarity regarding the therapist's role. They add that their inability to define their professional identity may confuse, placing occupational therapists at high risk of burnout (Edwards & Dirette, 2010). A scoping review published in the Scandinavian Journal of Occupational Therapy of 29 studies about "occupational therapy and stress-related exhaustion" (Hogan et al., 2023) revealed that most of the studies indicated that the key factors include workplace stress, establishing routine, skills of time management, and adapting environments. Rubin Juy and his colleagues (2023) (Escudero-Escudero et al., 2020) in their study about the prevalence of burnout characterized the associated psychosocial factors and the relationship with health in a sample of 127 Spanish occupational therapists. By using MBI as an outcome measure, along with 3 more outcome measures, their findings support many other studies that the main contributing factors are: Neuroticism, role conflict, unfavorable work-family relationships, and open emotional expression strongly predicted elevated emotional exhaustion (EE), and they added that the primary predictors of cynicism were male gender, role conflict, and organizational engagement; job conflict, job ambiguity, and the pursuit of social support were significant predictors of decreased professional efficiency (Juy et al., 2023).

Recent research by Kim et al. (2020), which examined burnout levels and job stress among occupational therapists and physical therapists in Korean hospitals among a sample of 325

professionals, utilized MBI as a main outcome measure, indicating that hospital size, along with gender and age, were the main contributing factors impacting at least two dimensions of the MBI questionnaire, emphasizing that the more vulnerable groups consist of female therapists and in their 20s at small or medium hospital sizes, with low scores of quality of life (Kim et al., 2020). A 2019 meta-analysis indicated concerning burnout rates among occupational therapists, with around 29% experiencing emotional weariness, 25% reporting depersonalization, and 16% exhibiting a diminished sense of personal success. These findings align with extensive research on healthcare personnel that identifies burnout as a prevalent issue influenced by factors such as excessive workloads, inadequate managerial support, and insufficient resources (Scanlan & Still, 2013).

Another cross-sectional study included a large sample of occupational therapists: (951 OTs), in the United Kingdome, (2014), indicated that the main contributing factors for developing burnout are minimal psychological separation from work during non-working hours, inadequate financial satisfaction, felt job overload, difficulties in declining requests, less than 10 years of experience, the infrequent occurrence of experiencing a hearty chuckle and being childless, elevated degrees of work involvement were regarded by therapists as having minimal psychological detachment from employment, elevated income contentment, advanced degrees, over 40 hours of labor every week, frequent occurrence of hearty daughter and parenthood. Poulsen et al., 2014). Another recent study of burnout and resilience among 31 occupational therapists and 94 physiotherapists in the USA (2023) during the coronavirus-19 period. Utilizing MBI as the main outcome measure and investigating the experiences of burnout during COVID-19 pandemic-related distress

revealed that burnout among OT and PT professionals is significantly associated with factors such as COVID-19-related stress, resilience at work, sleep disturbances, and financial issues, in addition to gender, with resilience acting as a key protective factor against burnout (Roundy et al., 2023). While Charlie & Reyes (2018) investigated burnout among Filipino occupational therapists, emphasizing a lack of therapists in the Philippines. Using a mixed-methods approach, the findings revealed that burnout was impacted by age 24-29, unmarried status, early in practice, and working long hours. The therapists were under pressure from personal and social expectations, which led to burnout and decreased creativity in practice(Charlie & Reyes, 2018). These results were also confirmed by Anvari and his colleagues (2011), revealing that the burnout phenomenon results in the convergence of professional and personal variables, indicating the key factors encompass large caseloads, rigid deadlines, and substantial workloads, all of which cultivate chronic work stress. (Anvari et al., 2011).

2.8 Summary

In conclusion, this chapter has provided a detailed examination of the existing literature on burnout, with a specific focus on occupational therapists in Middle Eastern countries. Particularly Palestine, Jordan Qatar, and Saudi Arabia. Burnout is recognized as a significant issue in healthcare, marked by emotional exhaustion, depersonalization, and reduced sense of personal accomplishment. The review underscores the historical evolution of burnout research and the crucial role of the Maslach Burnout inventory model in understanding this complex phenomenon. The chapter has identified key factors contributing to burnout among occupational therapists, including high job demands, lack of

organizational support, and personal characteristics. The consequences of burnout are profound, affecting not only the well-being of therapists but also the quality of care provided, in addition to strategies that can be used to prevent burnout.

In the context of the Arab world, and specifically Palestine, burnout is exacerbated by unique challenges such as political instability, resource limitations, and exposure to trauma, this underscores the need for targeted interventions to address burnout in this population. Overall, the literature review highlights the importance of ongoing research and practical strategies to prevent and manage burnout, ensuring the well-being of occupational therapists and the effectiveness of their work.

Table 2-2 The Main Reviewed Studies.

Article	Country	Study Design	Participants	Outcome measures	Main results
Scanlan & Hazelton (2016)	Australia	Cross-sectional study	232 OT	MBI, PHQ, and general health Questionnaire (GHQ)	OT professionals exhibited high levels of emotional exhaustion and depersonalization particularly those working in high-stress environments like emergency care, high levels of depressive symptoms were noted about emotional exhaustion psychological distress was found to negatively correlate with job satisfaction, and organizational support was identified as a protective factor.
Derakhshanrad et al.,(2019).	Iran	a non-experimental, cross-sectional study	50- OT	Rend sip Creativity Questionnaire (RCQ). Social Problem-Solving Inventory-Revised Short-Form (SPSI-R) & MBI	Study of the relationship between burnout, a consequence of job demands, and cognitive resources of problem-solving and creativity. Results showed that cognitive resources were inversely associated with burnout.

Maslach & Leiter (2016)	Canada	Cross-sectional study	1200 health care providers.	MBI, Areas of work life survey	Identified workload control and rewards as the area's most strongly associated with burnout job resources such as support and recognition were essential for mitigating burnout
Scanlan et al, (2016)	Australia	Cross-sectional	277 OT	Oldenburg Burnout Inventory (OLBI)	have intricate the burnout phenomenon results in the convergence of professional and personal variables. Indicating the key factors encompass large caseloads, rigid deadlines, and substantial workloads.
(Leiter & Harvie, (1996)	International	review	NA	Mental health workers including OT	Evaluate research on exhaustion in mental health professionals and suggest potential areas for future research. It will compile the results about demographic variables, established norms, and potential antecedents.
Megnist et al, (2021)	Systematic review	Ethiopia	N/A	Healthcare workers including OT	Burnout and occupational stress respectively affected over half and one-third of health care workers in Ethiopia. Sociodemographic and occupation-related factors were significant. It is imperative to reinforce policies that enhance educational opportunities, career advancement, and employment satisfaction.
Reis et al, (2018).	Cross-sectional	Portugal	374 OT	The Copenhagen Burnout Inventory questionnaire (Portuguese version)	pilot study evaluated the burnout levels of 374 Portuguese occupational therapists, examining the correlation between burnout and factors such as practitioner age, gender, client age, years of professional activity, and field of practice. Results showed that 23%, 44%, and 45% of occupational therapists presented with client-related burnout, personal burnout (PB), and work-related burnout.
Brown & Pashniak, (2018).	Cross-sectional	Canada	139 OT	MBI & Utrecht work engagement scale (UWES-9)	This study found that Canadian occupational therapists showed higher depersonalization and lower emotional exhaustion compared to previous research. Burnout and work addiction risks varied across years of experience, while low scores in vigor contrasted with high dedication

					and personal accomplishment, which may help protect against burnout.
Painter et al, (2003).	Cross-sectional	USA	3000 OT	MBI	This research revealed that occupational therapists had significant emotional weariness, little depersonalization, and reduced personal achievement. Burnout levels varied across five healthcare professions, with occupational therapists in chronic care environments exhibiting more burnout than their counterparts in other settings. Aligning therapists' competencies, passions, and experiences with appropriate work settings may alleviate burnout.
.(Rubin et al., (2021)	Cross-sectional	Canada	45Allied health including OTs	MBI & Copenhagen Burnout Inventory, the Stanford Professional Fulfillment Index, the Well-Being Index (WBI), and the Patient Health Questionnaire (PHQ)	assessed burnout and distress levels among allied healthcare personnel at a cardiovascular facility in Canada. The results indicated that 73% of respondents encountered burnout, while 69% reported emotional issues in the preceding month. Perceived inequitable treatment in the workplace was associated with increased emotional issues and unhappiness. Furthermore, 56% had significant discomfort, indicated by a Well-Being Index (WBI), while 29% exhibited severe distress, with a WBI.
Edwards & D irette, (2010).	Cross-sectional	USA	OT 126	MBI, Professional Identity Questionnaire (PIQ)	This research investigates the link between burnout and the development of professional identity among occupational therapists, demonstrating how the profession's vast scope may impede the formation of a distinct professional identity. The findings imply that a lack of professional identity correlates to increased burnout, which has implications for developing a stronger and healthier occupational therapy workforce.
Hogan et al, (2023),	Scoping review	Finland	OT	29 papers	SR- examined occupational therapy's role in managing stress-related exhaustion, analyzing 29 papers from 2000 to 2022. Most studies focused on recovery-

					oriented group interventions, with limited descriptions of preventive measures. OT contributed to multi-professional efforts in stress reduction and return-to-work programs, using activities like craft, nature engagement, and gardening.
Juy et al., (2023).	Cross-sectional	Spain	127 OT	MBI, & Five-factor Reduced Personality Inventory (NEO-FFI), &Work-Home Interaction-Nijmegen Questionnaire (SWING),& The Role Ambiguity General Questionnaire, & Goldberg General Health Questionnaire (GHQ-12	The study sought to evaluate the frequency of burnout and associated psychosocial variables among Spanish occupational therapists. Among the 127 participants, 15.8% reported experiencing burnout, with emotional weariness being the most significantly impacted component at 38.7%. Neuroticism, role conflict, adverse work-family interaction, and emotional expressiveness were significant predictors of emotional tiredness. Cynicism was more prevalent among men and associated with role conflict and emotional expressiveness, while role conflict, ambiguity, and the pursuit of social support were predictors of diminished professional efficacy.
Kim et al., (2020)	Cross-sectional	Korea	325 OT	MBI, The Job Content Questionnaire (JCQ), Short form 36	This research looked at burnout and work stress among 325 physical and occupational therapists from different South Korean hospitals. Key results revealed that hospital size, gender, and age all had a substantial impact on burnout and work-related stress, with female therapists in their 20s in small- to medium-sized hospitals being particularly sensitive. This group had high levels of occupational stress and burnout. The research emphasizes the necessity for hospitals and society to develop supportive settings that meet the unique issues that therapists encounter to increase their well-being.
Scanlan & Still, (2013).	Cross-sectional	Australia	34 OT	Oldenburg Burnout Inventory	The study examined the characteristics that influence job satisfaction, turnover intention,

				(OLB), Job Satisfaction Questionnaire, Turnover Questionnaire	and burnout among occupational therapists working in mental health. Burnout was connected to poorer job satisfaction and increased turnover intention, while job satisfaction was positively associated with rewards and cognitively difficult work. Stress, weariness, and demanding recipient interaction were major contributors to worse well-being. Interventions to prevent burnout and increase retention are advised.
Poulsen et al.,(2014).	Cross-sectional	Australia	951 OT	Demographic and working situation questions, Questions on detachment, assertiveness, and workload, Utrecht Work Engagement Scale, Oldenburg Burnout Inventory	This research investigated the demographic and job-related psychosocial characteristics linked with burnout and work engagement in 951 occupational therapists. The study indicated poor psychological detachment from work, low-income satisfaction, job overload, difficulty saying 'no,' less than 10 years of experience, seldom laughing, and the absence of children. In contrast, strong job engagement was linked to higher income satisfaction, postgraduate credentials, working more than 40 hours per week, frequent laughing, and having children.
Roundy et al, (2023).	Cross-sectional	USA	31 OT 94 PT	MBI, & BRS & The Impact of Event Scale-Revised (IES-R)	This study examined burnout, COVID-19 pandemic–related distress, and resilience among physical and occupational therapists during the first year of the pandemic. Results showed that greater pandemic-related distress was linked to higher emotional exhaustion and depersonalization, while resilience at work was associated with lower burnout and greater personal accomplishment. A key factor, "finding one's calling," was particularly important in reducing burnout across all areas. These findings highlight the need for targeted interventions to mitigate burnout in therapists during and beyond the COVID-19 pandemic.

Charlie & Reyes, (2018)	Mixed method	Philippine	231 OT	MBI	This research investigated burnout among Filipino occupational therapists, emphasizing a lack of therapists in the Philippines. Using a mixed-methods approach, the findings revealed that burnout was impacted by characteristics such as age 24-29, unmarried status, early in practice, and working long hours. The therapists were under pressure from personal and social expectations, which led to burnout and decreased creativity in practice.
Chung. (2020)	Cross-sectional	Korea	200 OT	Quality of life scale	This study evaluated the quality of life and occupational stress among 200 occupational therapists (OTs), and elevated compassion fulfillment. Variables including gender, age, occupation, and economic stability affected the degrees of burnout and secondary traumatic stress. The study determined that enhancing the work environment and support for occupational therapists is crucial for mitigating compassion fatigue and augmenting job satisfaction.
Li Calzi, S.(2006)	Experimental study	Italy	124	OT & PT and other rehab professionals	This study examined burnout among 124 professionals in physical rehabilitation, comprising physicians, nurses, therapists, and technicians. The findings indicated a moderate-low overall degree of burnout, with emotional weariness being most prevalent among therapists and depersonalization more pronounced among physicians. Technicians exhibited mild melancholy, whereas anger was observed in all groups. The research indicates potential sources of psychological suffering and intervention opportunities.

Chapter 3 Methodology

3.1 Chapter overview

This chapter outlines the research methodology utilized, including the study design, setting, and population, as well as the sampling method and participant recruitment procedure, inclusion criteria, it also details the data collection instruments, specifically the Maslach Burnout Inventory (MBI), Brief Resilience Scale (BRS), and patient health questionnaire (PHQ). This chapter also discusses the data collection and analysis procedures, along with the ethical considerations maintained throughout the study.

3.2 Study design

This study used a cross-sectional research design, which is a type of observational study that collects data on a population at a specific point of time. This approach is well suited for assessing the levels and characteristics of variables of interest among study participants. Moreover, researchers benefit from using this kind of study which enables the generation of preliminary insight and hypotheses that inform the design of more valuable longitudinal investigations and interventions. (Chirico, n.d.)

3.3 Study setting

The questionnaire was sent in September 2023, and data collection commenced at the end of that month, accompanied by a reminder for all participants on October 1st. The survey was conducted over a duration of 4 weeks, concluding with the collection of final results in mid-October 2023. The survey was sent to occupational therapists across four countries in

the Middle East. These communities were chosen due to their distinctive socioeconomic and cultural situations within the Middle East for the following reasons: Diverse healthcare systems exist, with each country possessing unique healthcare policies and frameworks that affect occupational therapy practices and may influence burnout levels. For example, Saudi Arabia has significantly invested in healthcare infrastructure (Almalki et al., 2011), whereas Palestine encounters challenges concerning resource availability (Giacaman et al., 2009). Comprehending these distinctions facilitates a thorough examination of the impact of systemic influences on occupational therapy practitioners. Variety: Socioeconomic variety, including therapists from both high-income nations (Qatar and Saudi Arabia) and lower-income countries (Jordan and Palestine), guarantees that the sample reflects a broad spectrum of economic situations and their influence on burnout (van de Vijver & Tanzer, 2004). Specifically, these economic discrepancies underscore variations in healthcare financing and occupational demands for occupational therapy specialists. Qatar's solid economy facilitates a more comprehensive healthcare system than that of Jordan and Palestine, where financing is constrained (Wankel, 2012). This disparity may influence workloads and job satisfaction. Cultural Variation: The cultural disparities across these nations help elucidate the impact of cultural context on burnout, enhancing the generalizability of the results throughout the Middle East (Maslach & Leiter, 2016). Furthermore, the chosen nations exemplify diverse cultural perspectives on labor and mental well-being. Research indicates that cultural norms might profoundly influence professional stress and burnout (Giacaman et al., 2009). Examining these disparities may provide insight into how cultural variables influence occupational therapy experiences. The availability of

data is increasing, with an expanding corpus of research on healthcare professionals in these nations, including studies on burnout (Alfuqaha & Alsharah, 2018). The current literature provides a robust basis for more research. 5) Regional Health Initiatives: Recent health efforts aimed at enhancing mental health services in these nations underscore the need for assessing burnout levels among occupational therapists, as shown by Qatar's implementation of national mental health programs that may influence the performance of OT practitioners. Qatar Ministry of Public Health, 2018 A Google Forms online survey tool was used, allowing researchers to gather data swiftly while maintaining a high degree of completeness. Participants were instructed to answer all questions since this approach minimizes the likelihood of incomplete data. The researchers selected a multi-country setting to get a comprehensive grasp of the experiences and attributes of occupational therapists within the Middle Eastern environment.

3.4 Study population

The study's target population consisted of occupational therapists working in four Middle Eastern countries (Jordan, Qatar, Palestine, and Saudi Arabia), who were contacted via an online survey. A total of 135 people answered, with 98 being female and 37 being male. This gender distribution suggests that the occupational therapy profession in the studied regions was dominated by females more than men at the time of the survey (Kesmodel., 2018). The study's goal was to document the perspectives and features of this unique group of occupational therapists working in Middle Eastern countries. By focusing on this

professional group, the researchers aimed to get insight into their experiences, attitudes, and practices within the regional environment. (Lunneborg 2007; Ikiugu et al. 2017; Gomez 2016).

3.5 Sampling method and participants recruitment

The study employed the convenience sampling technique, since the convenience sampling technique allows for comprehensive data collection, particularly if the target population is easily accessible, and when the time or resources are limited. This method is beneficial in studies that require rapid data collection from accessible participants, such as occupational therapists within a specific organization or network, although the convenience sample can provide practical advantages (Etikan, 2016), For the population of the survey, occupational therapy specialists working in the four countries being selected (Palestine, Jordan, Qatar and Saudi Arabia), the survey shared through WhatsApp groups (OT groups only). These countries were selected for cultural differences that can provide insight into how cultural context influences burnout, making the findings more generalizable across the Middle East (Maslach & Leiter, 2016). Moreover, the socioeconomic diversity of including therapists from both high-income (Qatar and Saudi Arabia) and lower-income (Jordan and Palestine) countries ensures that the sample captures a wide range of economic conditions and their impact on burnout (van de Vijver & Tanzer, 2004). The survey accessed therapists in Qatar and Saudi Arabia through established networks among prominent medical institutions, and the survey was distributed throughout Jordan and Palestine via the official OT representative body to guarantee a comprehensive representation of various services.

Representativeness and limitations: While the survey targeted abroad cross-section of occupational therapists, the actual number of OT population approached is unknown, as a result, the response rate was not specified, and this is acknowledged as a limitation of the study. Never, the total sample reached 135 occupational therapists among the four countries, which provided a robust representation.

Feasibility: Among the participants from the countries being studied, a total of 135 responses were distributed among the four countries as follow: 38 from Palestine, 36 from Jordan, 32 from Saudi Arabia, and 29 from Qatar. The dataset was found to have a high level of completeness as the use of Google Forms ensured mandatory responses., ensuring that the final data collected was large enough for reasonable analysis.

Regarding relevance: Filed-specific insights focusing on occupational therapists provided, profession specific for a better understanding of burnout, which can inform targeted interventions and policies in the healthcare field in these countries, and the sample size is consistent with previous studies, allowing for comparability of the study. (Polit & Beck, 2010). Detailed normality test results are provided in Appendixes B, C, D, And E.

3.6 Inclusion criteria

1) Profession: Must be a registered or licensed occupational therapist currently working or on the job.
2) Geographic location: must reside in one of the four specified counties (Palestine, Jordan Qatar, or Saudi Arabia)
3) Experience: must have at least one year of professional experience as an occupational therapist

.

3.7 Data collection instruments

Three instruments used the study which is used in researches, employed for data collection in this study, all administered through an online survey using Google Forms, including the Maslach Burnout Inventory (MBI) to measure burnout, The Brief Resilience Scale (BRS) to assess resilience, and the Patient Health Questionnaire (PHQ) to evaluate psychological distress. Additionally, s sociodemographic questionnaire was included to capture relevant participants' information attached to the appendix section.

3.7.1 The sociodemographic questionnaire

The sociodemographic questionnaire included information about participants' gender, age, and country of practice, as well as their professional role and years of experience. It also gathered details on educational background, income level, scope of service, daily working hours, and daily caseload. This comprehensive collection of data is essential for understanding the participants' profiles and contextualizing the study's findings, the main sociodemographic characteristics of the study sample are presented in Appendix H.

3.7.2 Maslach Burnout Inventory Human Service Survey for Medical Personnel (MBI-HSS MP)

The MBI-HSS MP is a well-established self-report measure designed to assess burnout specifically among medical personnel, including occupational therapists, developed by Christina Maslach, this version of the Maslach Burnout Inventory (MBI) Addresses the unique stressors faced in healthcare settings (Maslach & Leiter, 2016). The MBI is widely utilized to evaluate burnout, comprising three dimensions: Emotional Exhaustion

Depersonalization, and Reduced Personal Accomplishments (Lin et al., 2022). Participants respond using a Likert scale ranging from 0 (never) to 6 (every day). Copy of the purchase license attached to Appendix # I, which was purchased to use the MBI-HSS MP for 200 participants within the healthcare sector. This license is valid for 3 years since September 2023. The MBI is supported by strong psychometric properties, including high reliability and validity, making it a trusted tool for accurately assessing burnout among healthcare professionals. Its consistent performance across studies further justifies its use in evaluating burnout-related experience in healthcare settings with the following psychometric properties:

1) Reliability: The MBI-HSS MP demonstrated high internal constancy across its subscales. In a study by Lin et al., Cronbach's alpha coefficient was reported as 0.89 for emotional exhaustion and 0.87 for depersonalization, indicating strong reliability (Lin et al,.2022)
2) Validity: The MBI-HSS MP exhibits strong construct validity, accurately measuring burnout. Studies show significant correlations between MBI scores and other burnout measures, supporting its validity. Additionally, it has demonstrated concurrent validity through positive correlations with established burnout assessment tools (Lin et al., 2022)
3) Factor structure: Confirmatory factor analysis has constantly upheld the three-factor structure of the MBI, confirming emotional exhaustion, Depersonalization, and personal accomplishment. Factor loadings reported in Lin et al.'s study further

validate the instrument's ability to capture distinct burnout dimensions among medical personnel (Schaufeli et al., 2020).

1. Disrobement Validity: The MBI effectively distinguishes between burnout and related constructs such as job dissatisfaction or general distress, ensuring it accurately assesses burnout-specific experiences (Chao et al., 2011). Additionally, while sensitivity to change scores may vary, interventions aimed at reducing burnout have shown corresponding changes in MBI-HSS MP scores, highlighting its utility in evaluating interventions' effectiveness (Lin et al., 2022).

3.7.3 Brief Resilience Scale (BRS)

A brief resilience scale was created to evaluate how people recover from being stressed, it serves as a valid and reliable tool for measuring resilience, also it can provide insight into how individuals handle stressors. The BRS has six items, with positive indicators in items 1, 3, and 5, and negative indicators in items 2, 4, and 6. To calculate the BRS score, the mean of the six items is determined, reversing the scores for items 2, 4, and 6 (Bizri et al., 2022). A score of 3 indicates an average level of resilience (Smith et al., 2013). The BRS has sown Cronbach’s alpha of 0.836, 0.902m 0.877, 0.798, 0.754, and 0.702 (Smith et al., 20213). The BES tool has been cross-culturally adapted to many languages around the world. In its English version, the BRS was employed in four countries, as all participants were fluent in English (Smith et al., 2008).

3.7.4 The Patient Health Questionnaire (PHQ)

PHQ assesses symptoms of Anxiety, depression, and stress, consisting of 4 items rated on a Likert scale from 0 (Not at all) to 3 (nearly every day). The PHQ is a reliable, valid, and sensitive tool for assessing depressive symptoms in various populations. Its brevity, ease of administration, and strong psychometric properties make it a valuable instrument for both clinical practice and research endeavors, PHQ reliability Internal Consistency: The PHQ demonstrated high internal consistency, with Cronbach's alpha coefficients typically ranging from 0.80 to 0.90 across different populations. (Levis et al., 2020). PHQ has demonstrated strong validity when compared to established measures of depression, such as the Beck Depression Inventory (BDI) and the Hamilton Depression Rating Scale (HAM-D), High correlations with these measures indicate that the PHQ accurately captures depressive symptoms, In terms of criterion validity, the PHQ has demonstrated effectiveness in identifying individuals with major depressive disorders, particularly in comparison to diagnostic interviews conducted by mental health professionals (Manea et al., 2016).

3.8 Data collection procedure

Participants were recruited through a multi-step process. Initially, potential participants were identified by communicating with a representative in each country, including associations, and societies of occupational therapists, thin an invitation distributed via WhatsApp groups which included these therapists in each country, to participate, along with detailing the study’s purpose, procedures, and ethical consideration. The invitation included

a link to an online consent form, ensuring informed and voluntary participation. Only those who accept to participate are included which meet the inclusion criteria, and automatically the form moves the participant to the questionnaires, which are considered enrolled in the study.

Table 3-1Timetable for research steps, data collection, analysis, and writing a research paper

Task	2023-2024								
	June .23	July.24	Aug.23	Sep.23	Oct.23	Nov.23	Dec.23	Jan.24	Feb.24
Approvals									
Distribution the study									
Data collection									
Data analysis									
Write research paper									

3.9 Data analysis

The study utilized SPSS version 26 to perform the data analysis for this study, descriptive statics like frequencies, percentages, means, and standard deviation to characterize continuous data with a normal distribution. After assessing the normality of the data, a parametric statistical test, and independent t-test were used to compare the means of 2 groups and applied ANOVA to compare means across numerous groups.

The study followed the cross-sectional quantitative design, which facilitates a thorough assessment of the data and the derivation of reasonable inferences from the survey results, and the descriptive statistics utilized to capture the demographic attributes of the targeted population.

Kolmogorov-Smirnov test to examine the normality distribution of the data, this test is especially appropriate for small to medium sample sizes which often less than 2000 participants (Ikiugu et al., 2017), Skewness, Kurtosis and graphical representations such as histograms and Q-Q plots untallied, histogram figure attached to Appendix C, D, E, to assess them. Kolmogorov-Smirnov test is a well-known test to detect deviation from normality in the central region of the distribution (Ghasemi & Zahediasl, 2012).

3.10 Ethical considerations

Ethical approval from the instituting review board (IRB) at the Arab American University Palestine (AAUP), was obtained prior to commencing the study, an approval copy is attached to Appendix B. The researcher committed strict adherence to all IRB ethical guidelines. All the documents and materials of the survey/study were formulated in understandable language for the OT participants, which was clear and accessible to the participants from the selected countries. Participating in the survey was completely voluntary, with participants free to leave or cancel the participation at any time after completing the survey. Once the OT participants read the consent that formed on the first page of the survey, they were able to choose the option yes if they wanted to participate, which directly moves them to the second section of the survey where the questions start, or

they can choose no, which moves them directly to the decline page and leaving the survey. The survey consent form, attached to the appendix, included the study's purpose and the researcher's contact information. To protect participants' privacy, the form didn't ask for any identification of the participant. All data was stored on a password-protected computer accessible only to the researcher. Since the study involved a questionnaire to be competent for once without any changes, there were no harms of health-related. Another permission to use the MBI questionnaire was obtained from the owner of the MBI inventory for using the survey online, given that MBI is copy righted tool, it is essential to know the legal implications of utilizing it. A licensed copy of the MBI is attached to Appendix G.

Chapter 4 Results

4.1 Recruitment

The recruitment process of the Participants started at the end of September 2023, and a reminder was sent to all participants on the 1st of Oct 2023, thin the survey data collection finalized in the middle of October 2023, The Survey duration continued for 4 weeks. An online survey was distributed to 200 Occupational Therapists among the 4 included countries, (Palestine, Jordan, Qatar, and Saudi Arabia) and 135 responded, (98 Females and 37 males).

4.2 Data completeness and normality

There were no missing data while collecting the surveys since Google Forms was utilized to collect the data and the option of mandatory all answers was indicated to limit the missed question answers. Although the dataset contained some outliers, they were identified through visual assessments such as boxplots, and further statistical tests. Despite the presence of outliers, the overall distribution of the key variables remained approximately normal. Therefore, the decision was made to retain these outliers in the analysis, as they may offer important insights into the variability within the data (Aguinis et al., 2013). The retention of these outliers did not significantly violate the assumption required for parametric statistical analysis, thus allowing the use of these techniques to draw reliable conclusions. Therefore, the dataset exhibited a high level of completeness, with an overall response rate of (68%) across all surveyed variables, the comprehensive nature of the dataset allowed for thorough analysis without the necessity of extensive imputation procedures.

4.3 Sociodemographic characteristics

The sample consisted of 135 respondents from four countries (Palestine representing (28.1%) of the total sample, followed by Jordan (26.7%), Saudi Arabia (23.7%), and Qatar (21.5%). The majority of participants were female, with Jordan reporting the highest proportion at 78.9%. In terms of educational background, most of the participants (77.3%) held a bachelor's degree, while 18.54% had pursued advanced studies, such as a master's degree. Income distribution varied notably across regions, approximately 56.3% of the participants earned less than $20,000 annually. However, in Qatar, 34.5% of respondents reported earning more than $40,000.

Regarding marital status, 45.8% of the participants were single, with Jordan exhibiting the highest percentage of single individuals at 80.6%. Experience levels varied, with 45.9% of the participants having over five years of experience in the field, and Qatar standing out with 78.3% of its occupational therapists being highly experienced.

In terms of workload, most of the therapists (39.3%) managed between 6to8 patients daily, with 79.3% working between 6 to 8 hours per day. However, in Saudi Arabia, 43.8% of the participants reported working 9 to 11 hours daily. Employment sector distribution revealed that 45.2% of the respondents worked in the private sector. While Qatar displayed a strong reliance on public employment, with 86.2% of the therapists working in governmental institutions.

Finally, the scope of service provision was diverse, with 44.4% of the participants working in pediatric environments and 31.9% in multi-rehabilitation service, detailed scores for each variable are presented in Table 4 – 1

Table 4-1demographic data, values presented as numbers and percentage

Variable		Total population n (%)	Palestine. n (%)	Jordan. n (%)	Qatar n (%)	Saudi Arabia n (%)
Gender						
	Male	37(27.40)	08(21.10)	09(25.0)	09(25.00)	11(31.00)
	Female	98(72.60)	30(78.90)	27(75.0)	20(69.00)	21(65.60)
Level of Education						
	Diploma	03(10.00)	00(00.00)	0(0)	02(06.90)	01(03.00)
	BA	104(77.30)	27 (71.10)	33(91.7)	20(14.80)	24(75.00)
	MSc	25(18.40)	09(23.70)	02(05.6)	07(24.10)	07(21.90)
	PhD	01(00.70)	01(02.60)	00(00.00)	00(00.00)	00(00.00)
	OTD	02(01.50)	01(02.60)	01(02.80)	00(00.00)	00(00.00)
Annual income						
	Less than 20000 $	76(56.30)	28(73.70)	31(86.10)	06(20.70)	11(34.40)
	20000-30000$	23(17.00)	09(23.70)	02(05.60)	08(27.60)	04(12.50)
	30000-40000$	22(16.30)	01(02.60)	02(05.60)	05(17.20)	14(43.80)
	More than 40000$	14(10.40)	00(00.00)	01(02.80)	10(34.50)	03(09.40)

Marital status						
	Single	74(54.80)	20(52.60)	29(80.60)	05(17.20)	20(62.50)
	Married	54(40.00)	18(47.40)	06(16.70)	23(79.30)	07(21.90)
	Divorced	06(04.40)	00(00.00)	01(02.8)	00(00.00)	05(15.60)
	Separated	01(00.47)	00(00.00)	00(00.0)	01(03.40)	00(00.00)
Years of Experience						
	Less than 1 year	27(20.00)	11(28.90)	11(30.60)	01(03.40)	04(12.50)
	1 to 3 years	34(25.20)	10(26.30)	13(36.10)	00(00.00)	11(34.40)
	3 to 5 years	12(08.90)	01(02.60)	04(11.10)	05(17.20)	02(06.30)
	More than 5 years	62(45.90)	16(42.10)	08(22.20)	23(79.30)	15(46.90)
Daily Caseload						
	3 to 5 pts daily	18(13.30)	03(07.90)	07(19.40)	06(20.70)	02(06.30)
	6 to 8 pts daily	53(39.30)	14(36.80)	13(36.10)	13(44.80)	13(40.60)
	9 pts or more daily	35(25.90)	10(26.30)	11(30.60)	03(10.30)	11(34.40)
	Administrative with treatment responsibilities	16(11.90)	05(13.20)	01(02.80)	05(17.20)	05(15.06)
	Administrative role only.	05(03.70)	02(05.30)	01(02.80)	02(06.90)	00(00.00)
Daily working hours						

	Less than 5 hours a day	08(05.90)	04(10.50)	03(08.30)	00(00.00)	01(03.10)
	6 to 8 hours a day	107(79.30)	33(86.80)	29(80.60)	28(96.60)	17(53.10)
	9 to 11 hours per day	19(14.10)	00(00.00)	04(11.10)	01(03.40)	14(43.80)
	12 hours or more per day	01(00.70)	01(02.60)	00(00.00)	00(00.00)	00(00.00)
Working Agency						
	Governmental	59(43.70)	08(21.10)	06(16.70)	25(86.20)	20(62.50)
	NGO	05(03.70)	03(07.90)	01(02.80)	00(00.00)	01(03.10)
	Private sector	61(45.20)	23(60.50)	24(66.70)	04(13.80)	10(31.30)
	Own a Private Rehab Center	04(03.00)	02(05.30)	02(05.60)	00(00.00)	00(00.00)
	Other	06(04.40)	02(05.30)	03(08.30)	00(00.00)	01(03.10)
Scope of service/specialty						
	Pediatric	60(44.40)	16(42.10)	20(55.60)	11(37.90)	13(40.60)
	Physical	18(13.30)	08(21.10)	02(05.60)	05(17.20)	03(09.40)
	Psychiatric	05(03.70)	01(02.60)	02(05.60)	01(03.40)	01(03.10)
	Multi-Service Rehab	43(31.90)	12(31.60)	12(33.30)	05(17.20)	14(43.80)
	Other	09(06.70)	01(02.60)	00(00.00)	07(24.10)	01(03.10)

NGO: non-governmental organization. BA: Bachelor's degree, MSc Master's degree, Ph.D.: Doctor of Philosophy, OTD: Occupational Therapy Doctorate

4.4 Descriptive statistics for the outcome measures

Descriptive statistics for all Burnout outcome measures are presented in Table # (2-4) as follows:

4.4.1 Burnout among occupational therapists

The mean and standard deviation (SD) of the Maslach Burnout Inventory (MBI) dimensions: Emotional Exhaustion (EE), Depersonalization (D), and Personal Accomplishment (PA) are presented in Table # 4-2. The overall mean score for Emotional Exhaustion (MBI-EE) is 27.46 (SD = 14.43), indicating a significantly high level of burnout within the total population, as determined by established cutoff points (Williamson et al., 2018). In contrast, the scores for Depersonalization (MBI-D) and Personal Accomplishment (MBI-PA) reflect a lower prevalence of severe burnout among participants.

Table 4-2Mean and (SD) of the total population and each country with each domain, measured by MBI

Variable	Total population	Palestine	Jordan	Qatar	Saudi Arabia
MBI-EE	27.46(14.43)	26.45(13.93)	29.89(14.67)	21.41(14.12)	32.09(15.01)
MBI-D	7.19(6.48)	6.42(5.90)	9.06(7.67)	3.83(3.85)	9.47(8.51)
MBI-PA	35.09(10.10)	34.74(10.45)	35.61(9.82)	36.93(10.30)	33.09(9.82)

Figure # (4-1) presents the varying experiences of burnout across the four countries, with notable deference in how OTs perceive their emotional exhaustion, depersonalization, and sense of personal accomplishment.

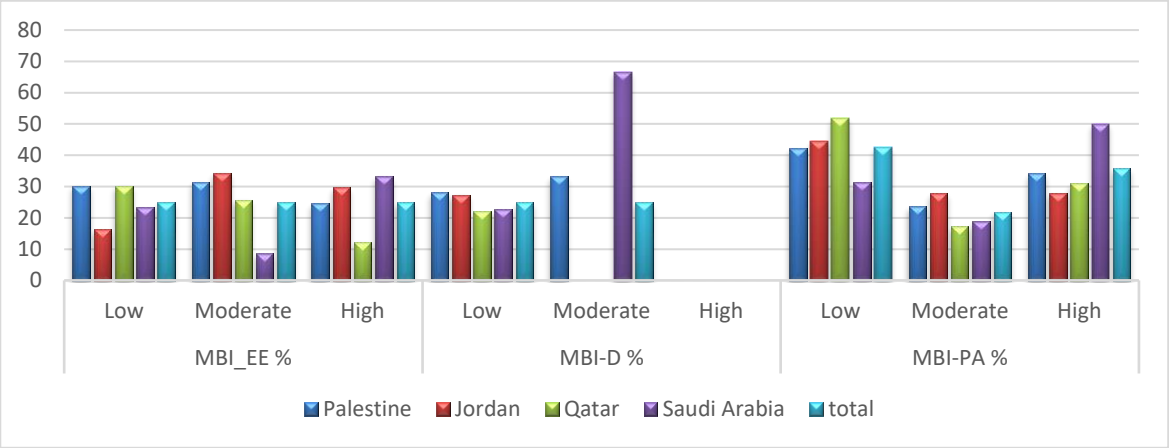

Figure 4-1 MBI all three domain percentages among OTs in the four countries

4.4.1.1 MBI- Emotional Exhaustion (MBI- EE questions, Q1 - Q9)

Table # (4-3) presents the total scores for the Maslach Burnout Inventory (MBI) Emotional Exhaustion dimension among occupational therapists (OTs) across the studied countries. Qatar exhibits the lowest mean score of 2.38 (SD = 1.75), indicating a lower level of emotional exhaustion among OTs in this country. In contrast, Jordan records the highest mean score of 3.56 (SD = 1.959), suggesting a higher level of emotional exhaustion. Palestine and Saudi Arabia have intermediate scores, with Palestine reporting a total score of 3.04 (SD = 2.146) and Saudi Arabia a score of 2.38 (SD = 2.025), both indicating a moderate level of emotional exhaustion among OTs.

Table 4-3MBI- EE questions Mean and (SD) score among the four countries with the total scores:

Question	Palestine	Jordan	Qatar	Saudi Arabia	Total
1-I feel emotionally drained from my work	3.08(2.005)	3.53(1.874)	2.69(1.966)	3.56(1.966)	3.21(1.952)

2-I am at the end of my patience at the end of my work day.	2.53(1.955)	3.25(1.903)	2(1.773)	3.44(3.44)	2.80(1.891)
3 I feel tired when I get up in the morning and have to face another day at work.	2.95(2.079)	3.44(2.021)	2.45(1.956)	4.16(1.834)	3.25(1.972)
4- Working with people all day long requires a great deal of effort.	3.82(1.784)	4.58(1.857)	3.48(2.198)	4.34(1.789)	4.05(1.907)
5- I feel like my work is breaking me down	2.82(2.025)	3.06(2.254)	1.79(1.953)	3.38(2.152)	2.76(2.096)
6- I feel frustrated by my work.	2.71(2.012)	3.06(2.069)	2.14(1.995)	3.25(2.11)	2.79(2.046)
7- I feel I work too hard at my job.	4.00(1.931)	4.17(1.828)	3.14(2.083)	4.09(1.855)	3.85(1.924)
8- It stresses me too much to work in direct contact with people.	2.16(1.824)	2.72(2.337)	1.97(1.861)	3.03(1.926)	2.47(1.987)
9- I feel like I'm at the end of my rope.	2.39(2.087)	2.08(2.089)	1.76(1.845)	2.84(2.245)	2.26(2.066)
Total of each country for all questions	3.32(1.966)	2.38(2.025)	3.56(1.959)	3.04(2.146)	2.86

Further insight into these trends in the MBI-EE question can be seen clearly in Figure # (4-2), which reveals that there is a significantly higher perception of effort when working with people in Jordan compared to Qatar, in question # 5, Jordan indicates a higher sense of work breaking down compared to Qatar, suggesting that OTs in Jordan may experience more challenges and stressors that impact their well-being.

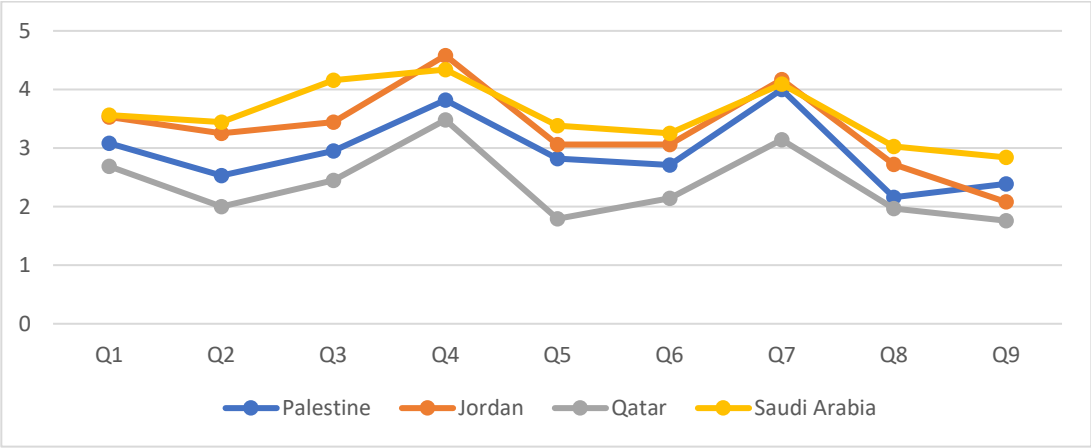

Figure 4-2 MBI-EE questions from 1-9 trends

Jordanian occupational therapists in question # 7 showed a stronger feeling of working too hard than Qatar, which may imply a higher perceived workload or intensity in job demands on OTs. Jordan consistently exhibits higher scores in questions 4, 5, and 7 reflecting potential challenges related to the effort required in working with people, in contrast, Qatar consistently shows lower scores, suggesting a comparatively less stressful work environment in these specific aspects. These results have been confirmed in MBI-EE percentages as shown in Figure # (3-4).

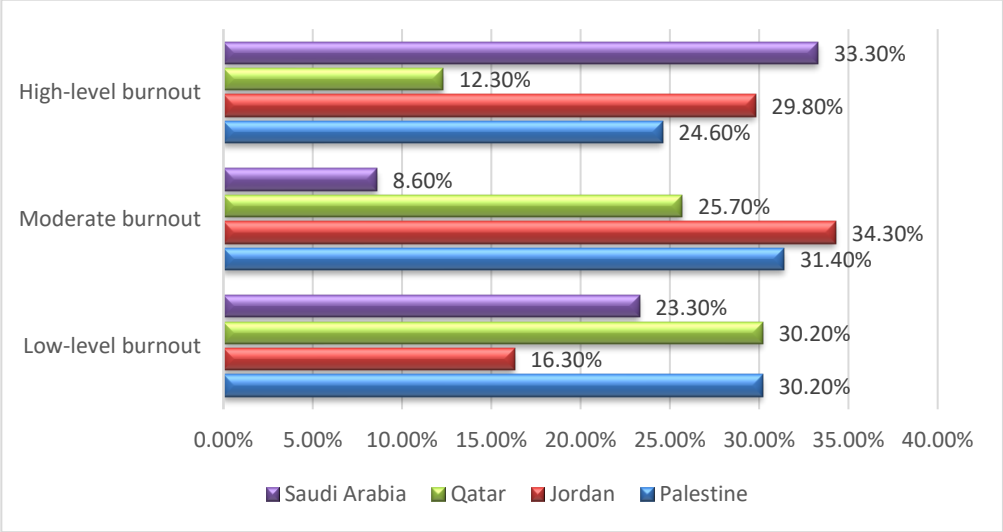

Figure 4-3 MBI EE percentages

Moreover, figure # (4-3) reveals that Jordan exhibits consistently higher MBI-EE scores on questions related to workload and personal well-being compared to Qatar, indicating a more intense work environment. In Palestine and Qatar, low levels of burnout are more common, (around 30.02%), while Jordan shows a higher proportion of moderate burnout (34.30%) and Saudi Arabia has a notable percentage of high-level burnout (33.30%).

4.4.1.2 MBI-Depersonalization (MBI-D) by questions

Table # (4-4) presents the total scores for the Maslach burnout inventory-depersonalization (MBI-D) among OTs in the four countries, Qatar consistently shows the lowest depersonalization levels at a mean score of 1.22 (SD=0.766), in Jordan exhibits the highest depersonalization scores, with a total mean of 1.812 (SD=1.971), indicating elevated levels of emotional detachment, and Saudi Arabia demonstrated notable emotional detachment with a total mean score of 1.89 (SD=2.060).

Table 4-4Mean scores and (SD) of MBI-Depersonalizations for each question

Question	Palestine	Jordan	Qatar	Saudi Arabia	Total
1-I feel I look after certain patients/clients impersonally as if they are objects.	1.11(1.467)	1.61(1.931)	0.90(1.676)	1.63(1.996)	1.312(1.767)
2- I have become more insensitive to people since I've been working.	1.71(1.707)	2.14(2.113)	0.76(1.154)	1.78(2.028)	1.60(1.750)
3- I'm afraid that this job is making me uncaring	1.45(1.751)	2.06(2.11)	0.55(0.827)	2.16(2.216)	1.55(1.726)
4- I don't care about what happens to some of my patients/clients.	0.45(1.201)	0.64(1.457)	0.38(0.728)	1.47(2.016)	0.73(1.350)
5- I have the impression that my patients/clients make me responsible for some of their problems	1.71(1.873)	2.61(2.246)	1.24(1.725)	2.44(2.047)	2.00(1.972)
Total	1.286(1.600)	1.812(1.971)	1.222(0.766)	1.89(2.060)	1.286(1.600)

Figure # 4-4 presents the trends in MBI-D scores. With Q2, Q3, and Q4, reflecting a challenging emotional environment. Jordan's highest scores at means cores in Q1 at 1.61, (SD=1.931) and Q5 at a mean score of 2.61 (SD=2.246) Further, suggesting a significant

depersonalization and stress. Palestine's mean score of 1.286 (SD=1.600) indicates an intermediate level of personalization among OTs'.

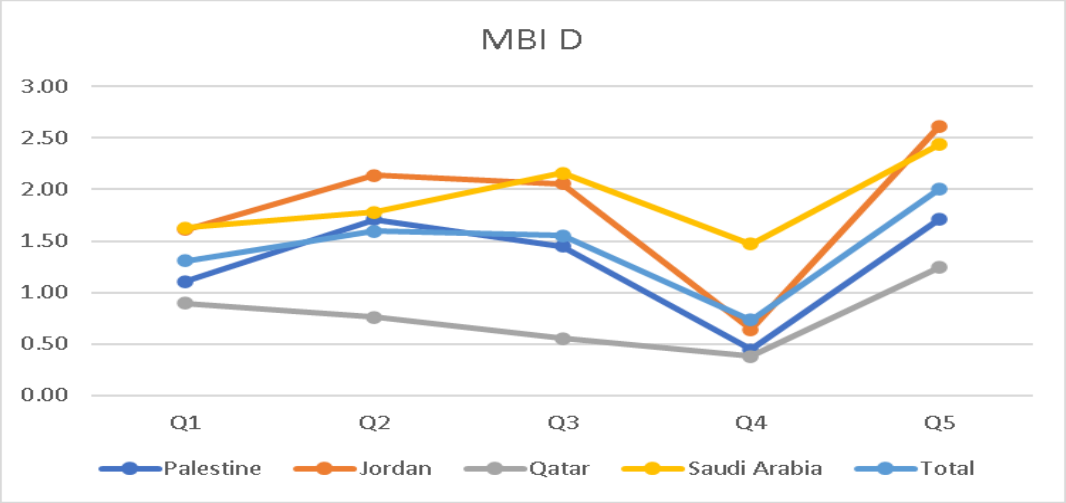

Figure 4-4 Trends of MBI-D questions

Figure # (4-5) revealed a notable trend in burnout among OTs in Palestine and Jordan burnout levels were 33.30% and 27.30% respectively, while Qatar shows a majority in the low-level burnout category which indicated less feeling of depersonalization, Saudi Arabia, however, has a significant 66.70% in the moderate category suggesting emotional detachment in patients' interactions, these findings align with the mean scores in table # (4-4), suggesting higher emotional detachment in patient interactions.

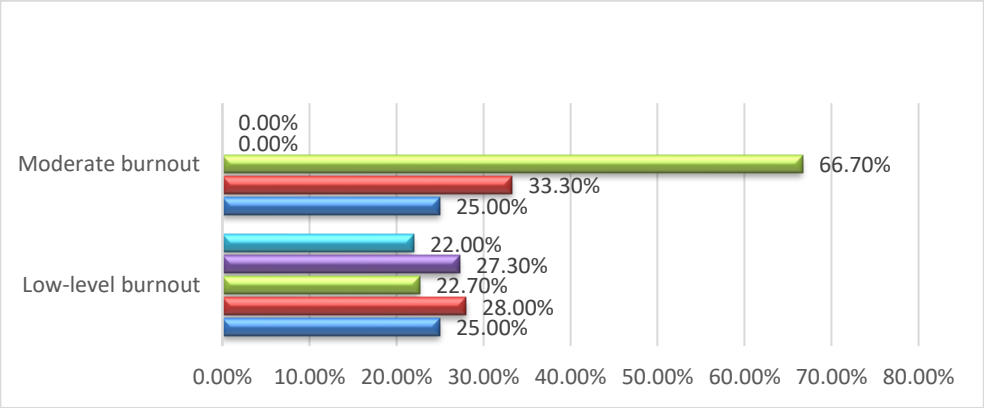

Figure 4-5 Percentages of MBI-D

4.4.1.3 MBI-Personal Accomplishment (MBI-PA questions 15 to 22)

Table # (4-5) presents the trends in personal accomplishment among OTs across Palestine, Qatar, Jordan, and Saudi Arabia, with Qatar generally demonstrating the highest scores in multiple areas with a total mean score of 4.61(SD=1.742), And Palestine also scores high in empathy with a total mean score of 4.34 (SD=1.722), while Jordan total mean score of 4.86 (SD=1.334), and Saudi Arabia OT's exhibits the lowest mean score of 4.14(SD =1.739)

Table 4-5mean and (SD) of MBI-Personal Accomplishments with each question score

Question	Palestine	Jordan	Qatar	Saudi Arabia
1- I am easily able to understand what my patients/clients feel.	5.24(1.364)	4.97(1.362)	4.90(1.988)	4.88(1.431)
2- I look after my patients'/clients' problems very effectively.	5.00(1.470)	5.17(1.231)	5.34(1.495)	4.91(1.467)
3- through my work, I feel that I have a positive influence on people.	4.71)1.393)	4.86(1.676)	4.86(1.642)	4.22(1.845)
4- I feel full of energy.	3.89(1.813)	3.56(1.858)	3.76(1.864)	3.38(1.755)

5- I am easily able to create a relaxed atmosphere with my patients/clients.	4.37 (1.683)	4.86(1.334)	4.45 (1.804)	4.19(1.768)
6- I feel refreshed when I have been close to my patients/ clients at work.	3.87(2.016)	4.17(1.781)	4.45(1.723)	3.63(2.044)
7- I accomplish many worthwhile things in this job.	3.92(2.045)	3.78(1.869)	4.62(1.635)	3.75 (1.884)
8- in my work, I handle emotional problems very calmly	3.74 (1.996)	4.25(1.948)	4.55(1.785)	4.16 (1.725)
TOTAL	4.34 (1.722)	4.25(1.632)	4.61(1.742)	4.14(1.739)

Figure # (4-6) highlights the overall proficiency of OTs across all countries in understanding patient needs, particularly in empathetic care as shown in (Q # 1), and maintaining composure when handling emotional challenges as clear in (Q # 8), reflecting strength in these areas, However, opportunities for improvement are noted in handling patients' problems (Q # 2), maintaining energy (Q # 4), and creating a relaxed atmosphere (Q # 5).

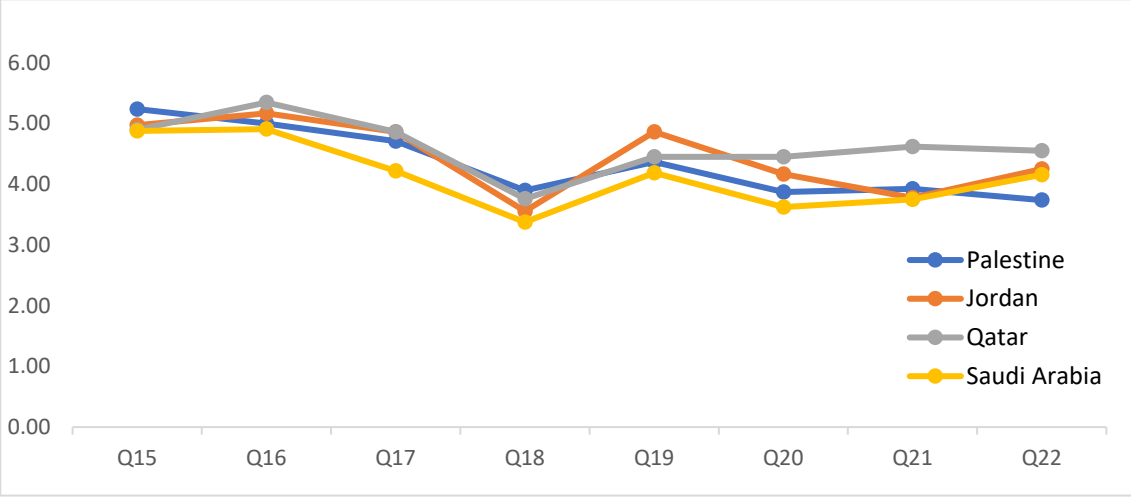

Figure 4-6 Trends of MBI-PA questions

The MBI-PA results reveal variation in perceived personal accomplishment, with Palestine and Jordan showing substantial percentages of moderate to high burnout, indicating

challenges in professional achievement. Qatar exhibits lower burnout levels, suggesting a more positive perception of accomplishment, while Saudi Arabia shows a higher percentage of high burnout, highlighting significant challenges in this domain.

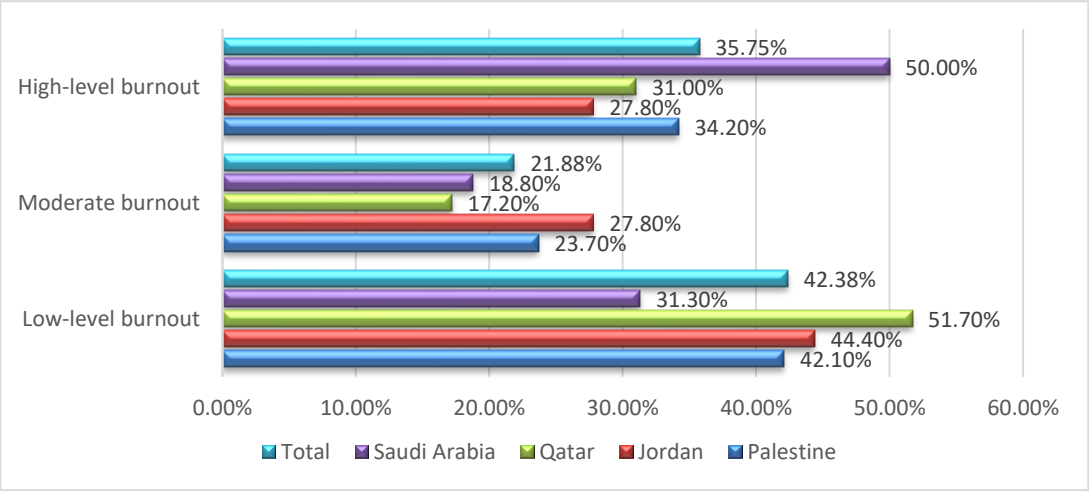

Figure 4-7 Percentages of MBI -PA

Figure # (4-7) highlights the variation in MBI-PA levels across the four countries. Jordan shows higher percentages of moderate and low–levels of burnout, aligning with elevated mean scores in Table # (6-4), indicating challenges in personal accomplishment. Palestine presents a balanced distribution, with moderate burnout levels suggesting middle-ground professional achievement. Qatar's lower burnout percentages form a healthier work environment, with a significant portion reporting low burnout reflecting a positive sense of accomplishment, in contrast, Saudi Arabia displays a higher percentage of high-level burnout (33.30%), underscoring significant challenges in MBI-PA.

4.4.2 Brief Resilience Scale

Table # (4-6) presents the means and SD scores of BRS among OTs in the four countries with Qatar showing the highest BRS score of 3.42 (SD=0.73), indicating strong resilience, while other countries display lower resilience levels. Overall, the findings suggest a moderate and varied distribution of resilience, with most OTs demonstrating a commendable ability to handle challenges.

Table 4-6Brief Resilience Scale Mean and SD

Place of work	Mean (SD)
Palestine	3.05(0.52)
Jordan	3.17(0.5)
Qatar	3.42(0.73)
Saudi Arabia	3.11(0.71)
Mean (SD) Total	3.1875(0.615)

Figure # (4-8) presents the confirmed results of these trends, with Qatar leading in high resilience, (50%), followed by Saudi Arabia (37.5). In contrast, Palestine (29.30) and Jordan (24.40%) have a higher proportion of low resilience,

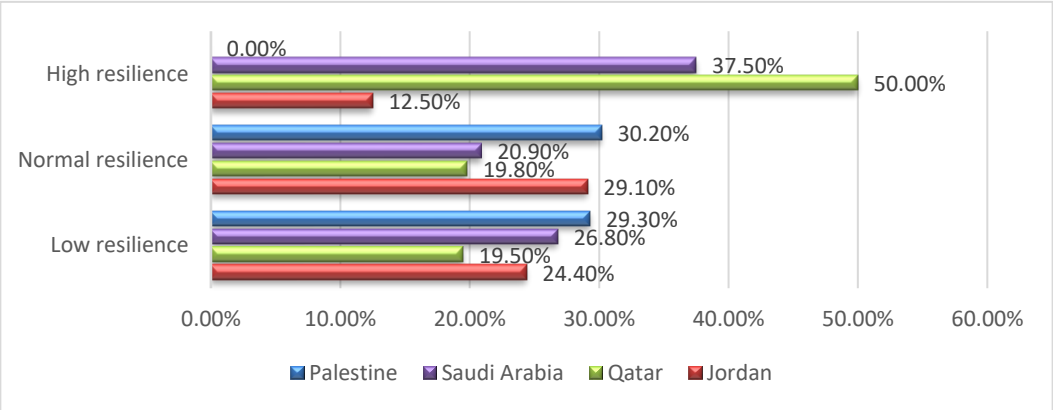

Figure 4-8 Brief Resilience Scale percentages.

This consistency in resilience levels, reflected by lower mean and SD scores of 3.05 SD= 0.52) in Palestine Jordan, and Saudi Arabia, indicates shared experiences among OT professionals.

4.4.3 The Four-Item Patient Health Questionnaire for Anxiety and Depression (PHQ) Scale

Table # (4-7) presents the variations in stress, anxiety, and distress levels among OTs across the four countries, Saudi Arabia shows the highest stress mean score of 4.72(SD=3.215) and Anxiety mean score of 2.66, (SD=1.807), indicating elevated psychological strain while Qatar reports the lowest stress mean score of 2.9 (SD= 2.257) and overall distress mean score of 1.34 (SD= 2.261) and Palestine has the lowest anxiety mean score of 1.63(SD= 1.303).

Table 4-7PHQ anxiety scale presented by mean (SD) scores

Place of work	PHQ- Stress	PHQ Anxiety	PHQ. Total Distress
Palestine	3.61(2.824)	1.63(1.303)	1.97(1.747)
Jordan	4.58(3.879	2.11(1.864)	2.47(2.261)
Qatar	2.9(2.257)	1.55(1.378)	1.34(1.143)
Saudi Arabia	4.72(3.215)	2.66(1.807)	2.06(1.759)
Total	3.95(3.043)	1.96(1.588)	1.98(1.727)

Figure # (4-9) PHQ percentages, confirm these findings, aligning the PHQ scale's severity categories with total mean and SD scores, reinforcing the identified mental health challenges, the data underscores the varied psychological well-being of OTs, with Saudi

Arabia facing more significant, stress and anxiety, while Qatar appears more resilient.

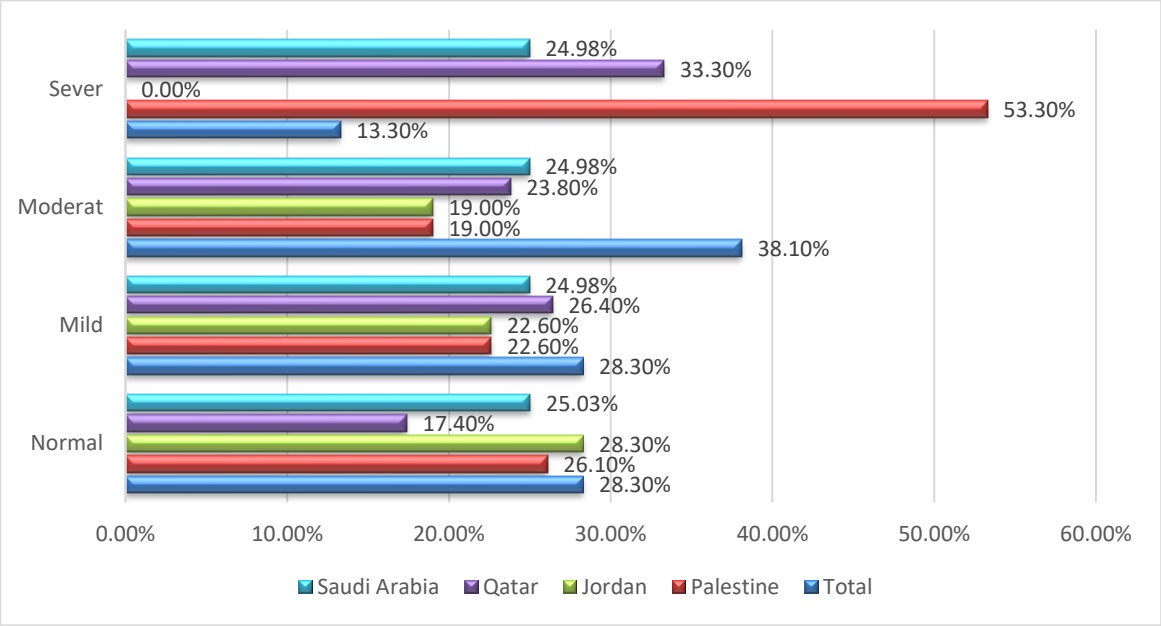

Figure 4-9 PHQ percentages.

4.5 Correlation analysis of variables and burnout

4.5.1 Correlation between MBI domains, mental health, occupational variables, and age

Table # (4-8) presents the correlations between age, stress, distress resilience anxiety, and burnout dimensions among occupational therapists, Age showed weak, non-significant correlations with emotional exhaustion (MBI-EE) (r=-0.091) and depersonalization (MBI-D) (r=-0.132), but a significant moderate positive correlation with personal accomplishment (MBI-PA) (r=0.212, p=0.013), suggesting that older OTs report higher levels of personal accomplishment.

Strong positive correlations were observed between both stress (PHQ-Stress) and Distress (PHQ-Distress) and emotional exhaustion (r=0.694, P<0.001 and r=0.672mp<0.001), respectively), as well as depersonalization (r=0.513, p<0.001 and r=0.515, p<0.001). Resilience (BRS) displayed moderate negative correlations with emotional exhaustion (r=-0.432, p<0.001) and depersonalization (r=-0.312, p<.0.001) while positively correlating with personal accomplishment (r=0.378, p<0.001), indicating its protective role against burnout.

Anxiety (PHQ-Anxiety) was significantly linked to higher emotional exhaustion (r=0.596, p<0.001), and depersonalization (r=0.421, p<0.001), and negatively correlated with personal accomplishment (r=-0.335, p<0.001), underscoring its detrimental impact on both emotional well-being and job satisfaction.

Table 4-8 Age variable correlated with MBI-EE -. MBI-D, BRS, PHQ scale.

Variable	Correlation	Age	PHQ-Stress	PHQ-Distress	BRS	PHQ-Anxiety
MBI-EE	Pearson Correlation/Sig	-0.091 (0.294)	0.694 (0.000)	0.672 (0.000)	-0.432 (0.000)	0.596 (0.000)
MBI- D	Pearson Correlation/ Sig	-0.132 (0.126)	0.513 (0.000)	0.515 (0.000)	-0.312 (0.000)	0.421 (0.000)
MBI-PA	Pearson Correlation /Sig	0.212 (0.013)	-0.339 (0.000)	-0.288 (0.001)	0.378 (0.000)	-0.335 (0.000)

4.5.2 Differences in MBI scores by gender

Table # 4-9 presents the analysis of deference in MBI scores across gender, The data indicated no statistically significant differences based on gender, although females scored higher in all domains of emotional exhaustion, depersonalization, and personal accomplishment. Despite these higher scores, the differences did not reach statistical significance. The data shows no statistically significant differences based on gender. For Emotional Exhaustion, males have a mean score of 24.51 (SD= 13.063), while females have a mean score of 28.80(SD=15.283). The *p*-value is 0.14, indicating that gender does not statistically influence emotional exhaustion. Similarly, for Depersonalization, the males' mean score is 7.24 (SD=6.011), and the females' mean score is 7.31 (SD=7.427). This also shows no significant differences, with a *p*-value of 0.192. Lastly, for personal accomplishment, males have a mean score of 34.35 (SD=10.502), and females have a mean score of 35.32 (SD=9.961), this indicates no significant gender-based differences, as reflected by a *p*-value of 0.533.

Table 4-9 Results of independent t-test and descriptive statistics of MBI domain and gender variable

Variable	Gender	N	Sig	Df / *P*-Value	Mean (SD)	Mean Difference (95%Ci)
MBI-EE	Male	37	.104	133(0.134)	24.51(-13.063)	-4.282(-4.282-9.899)
	female	98		75.352(0.11)	28.8(-15.283)	-4.282(-4.282-9.551)
MBI-D	Male	37	.192	133(0963)	7.24(-6.011)	-0.063(-0.063-2.762)
	female	98		79.64(0.96)	7.31(-7.427)	-0.063(-0.063-2.532)
MBI-PA	Male	37	.533	133(0.622)	34.35(-10.502)	-0.965(-0.965-4.824)
	female	98		61.958(0.631)	35.32(-9.961)	-0.965(-0.965-4.96)

4.5.3 Differences in MBI scores by years of experience, annual income, daily caseload, daily working hours, and scope of service

Table # (4-10) One-Way ANOVA test was conducted with a Post hoc test using Post Hoc Tukey's Honestly Significant Difference to compare the categories of years of experience with each of MBI domains: for MBI-EE score a One-way ANOVA revealed that statistically no significant main effect of years of experience on emotional exhaustion score found (F (3.146) = 0.194, p =0.901). The post hoc test indicated that there were no significant differences in mean scores between any pair of years of experience groups. Similarly, for MBI-D score the results showed that statistically no considerable effect of years of experience (F (3.146) = 0.989, p =0.117). Tukey's post hoc test demonstrated no significant mean difference between any pain and years of experience. For MBI-PA scores the ANOVA test didn't statistically didn't show a substantial effect of years of experience (F (3.146) = 2.000, p =0.400).

Table 4-10 One-way ANOVA test of the years of experience with (MBI-EE, MBI-D, MBI-PA)

variable	category	N	Mean (SD) X±SS	Sum of squares		Mean Square	F / Sig.
MBI-EE	less than 1 year	27	26.81±14.507	Between groups	129.383	43.128	.194 (*P*=.901)
	1 to 3 years	34	29.21±14.624	Within groups	29162.351	222.613	
	3 to 5 years	12	26.25±17.551	total	29291.733		
	More Than 5 Years	62	27.37±14.735				
MBI-D	less than 1 year	27	7.15±6.144	Between groups	147.309	49.103	.989 (*P*=.117)
	1 to 3 years	34	8.94±7.348	Within groups	6504.424	49.652	
	3 to 5 years	12	7.67±7.679	total	6651.733		.
	More Than 5 Years	62	6.37±7.120				
MBI-PA	less than 1 year	27	33.81±11.422	Between groups	596.387	198.796	2.000 (*P*=.400)

	1 to 3 years	34	32.91±9.514	Within groups	13024.250	99.422
	3 to 5 years	12	32.33±9.820	total	13620.637	
	More Than 5 Years	62	37.29±9.568			

These results suggest that based on the conducted analysis, there are no significant differences in MBI-EE, MBI-D, and MBI_PA scores among OTs with different years of experience. The P-value from both ANOVA and Post hoc test did not reach the conventional significance level of 0.05. indicating that the null hypothesis of no difference in means cannot be rejected, which appears to play a significant role in emotional exhaustion, and potentially impacts depersonalization and personal accomplishment among occupational therapists.

Table 4-11 One-way ANOVA test, level of income with the (MBI-EE, MBI-D, MBI-PA)

variable	category	N	Mean (SD) X±SS	Sum of squares		Mean Square	F / Sig.
MBI-EE	less than- 19999 USD	14	31.43±14.137	Between groups	2882.266	960.755	.003
	20000 - 29999 USD	23	22.39±13.368	Within groups	26409.467	201.599	
	30000 to 39999 USD	22	25.41±13.766	total	29291.733		
	Over 40000 USD	76	19.00±16.432				
MBI-D	less than- 19999 USD	14	8.21±7.134	Between groups	199.487	66.496	.261
	20000 - 29999 USD	22	7.22±6.908	Within groups	6452.246	49.254	
	30000 to 39999 USD	23	5.68±5.826	total	6651.733		
	Over 40000 USD	76	4.93±8.194				
MBI-PA	less than- 19999 USD	23	34.03±9.630	Between groups	774.862	258.287	.053
	20000 - 29999 USD	76	32.57±11.766	Within groups	12845.775	98.059	
	30000 to 39999 USD	22	37.91±9.018	total	13620.637		
	Over 40000 USD	14	40.21±9.349				

The one-way ANOVA results investigated the impact of daily caseload on the MBI 3 domains, scores revealed noteworthy patterns across domains. For MBI-EE, the overall ANOVA showed a marginally significant effect of daily caseload (F (5.129) = 2.176, *p*

=0.061). Post hoc tests using Tukey's indicated that OTs with administrative roles without direct patient care reported significantly higher Emotional Exhaustion compared to therapists treating 3-5 patients per day (Mean Difference =-14.33, p=0.371) and those in an education role providing specialized courses. (Mean Difference = -12.03, p = .023). For MBI-D the ANOVA test revealed a significant effect of daily caseload (F (5.129) = 4.172, p =0.002), Post hoc tests indicated therapists with an administrative role without direct

Table 4-12 One-way ANOVA test of daily caseload and variables correlated with the outcome measures used in the study (MBI all domain)

variable	category	N	Mean (SD) X±SS	Sum of squares		Mean Square	F / Sig.
MBI-EE	3 to 5 Patients Per Day	18	19.67±11.555	Between groups	2278.773	455.755	.061
	Education or Lecturer Providing Specialized Courses	53	29.15±14.806	Within groups	27012.960	209.403	
	Administrative Role with Patient Treatment Responsibilities	35	31.11±15.080	Total	29291.733		
	6 to 8 Patients Per Day	16	24.63±14.592				
	9 Patients or More Per Day	5	34.00±18.748				
	Administrative Role Without Direct Patient Care.	8	22.13±12.029				
MBI-D	3 to 5 Patients Per Day	18	4.94±5.185	Between groups	925.836	185.167	
	Education or Lecturer Providing Specialized Courses	53	7.72±6.553	Within groups	5725.897	44.387	.002
	Administrative Role with Patient Treatment Responsibilities	35	9.54±7.935	Total	6651.733		
	6 to 8 Patients Per Day	16	3.81±4.135				
	9 Patients or More Per Day	5	14.40±11.393				
	Administrative Role Without Direct Patient Care.	8	2.38±4.138				

MBI-PA	3 to 5 Patients Per Day	18	33.50±12.501	Between groups	735.807	147.161	.203
	Education or Lecturer Providing Specialized Courses	53	35.45±9.639	Within groups	12884.830	99.882	
	Administrative Role with Patient Treatment Responsibilities	35	33.06±9.780	Total	13620.637		
	6 to 8 Patients Per Day	16	40.31±6.671				
	9 Patients or More Per Day	5	31.00±14.697				
	Administrative Role Without Direct Patient Care.	8	36.63±9.365				

Patient care reported significantly higher depersonalization compared to those with 3 – 5 patients per day (Mean Difference= -9.46, *p*.063), 6-8 patients per day (Mean Difference = -10.59, *p*=0.028), and regarding MBI-PA the overall ANOVA didn't reveal a statistically significant effect of daily caseload (F (5.129) = 1.473, *p* =0.003). Post hoc tests didn't identify significant differences between specific groups.

Table # (4-13) presents the results of the One-Way ANOVA Test applied to see whether MBI domains differ according to the "daily working hours" variable, The ANOVA results indicated statistically no significant differences in MBI-EE, MBI-D, and MBI-PA scores based on variable of daily working hours (MBI-EE: (F(2, 131) = 0.194, *p* = 0.901) MBI-D: (F(2, 131) = 0.989, *p* = 0.400) MBI-PA: (F(2, 131) = 2.000, *p* = 0.117). Similarly, post hoc Tukey's tests found no specific pairwise differences in MBI scores among the daily working hour categories. These findings suggest that variations in daily working hours did not significantly impact burnout scores in the study.

Table 4-13 daily working hours correlated with MBI 3 domains

variable	category	N	Mean (SD) X±SS	Sum of squares		Mean Square	F/ sig
MBI-EE	less than 5 hours a day	8	27.00 ± 11.988	Between groups	1144.351	381.450	.155 P=(.1.77)
	6 to 8 hours a day	107	26.43 ± 14.903	Within groups	28147.382	214.866	
	9 to 11 hours per day	19	34.79 ± 14.140	total	29291.733		
MBI-D	less than 5 hours a day	8	9.00 ± 8.536	Between groups	30.002	10.001	.898 P(=.198)
	6 to 8 hours a day	107	7.18 ± 7.075	Within groups	6621.731	50.548	
	9 to 11 hours per day	19	7.32 ± 6.692	total	6651.733		
MBI-PA	less than 5 hours a day	8	28.63 ± 13.092	Between groups	360.557	120.186	.317 P= (1.187)
	6 to 8 hours a day	107	35.37 ± 10.065	Within groups	13260.080	101.222	
	9 to 11 hours per day	19	35.79 ± 8.567	total	13620.637		

The ANOVA tests results indicated that statistically no significant differences in MBI-EE, MBI-D and MBI-PA based on the scope of service, regarding MBI-EE score ($F(4.130) =1.628, p=0.171$), MBI-D ($F(4.130)=2.087, p=0.086$), and MBI - PA($F(4.130)=1.366, p=0.249$), subsequent post hoc Tukey's test didn't reveal specific findings suggests that the scope of service of occupational therapists do not significantly impact burnout scores in the study.

Table 4-14 One-Way ANOVA test of the scope of service and its impact on MBI 3 domain scores

variable	category	N	Mean (SD) X±SS	Sum of squares		Mean Square	F/ sig
MBI-EE	Pediatric	60	29.38±15.283	Between groups	1397.149	349.287	.171
	Physical	18	27.39±16.198	Within groups	27894.584	214.574	*P*(=.1.628)
	Psychiatric	5	12.20±5.541	total	29291.733		
	Multi-Service Rehab Facility	43	27.35±13.692				
	Other	9	26.22±14.394				
MBI-D	Pediatric	60	8.25±7.717	Between groups	401.445	100.361	. .086 *P*(=2.087)
	Physical	18	4.83±5.404	Within groups	6250.289	48.079	
	Psychiatric	5	3.60±2.608	total	6651.733		
	Multi-Service Rehab Facility	43	8.21±7.096				
	Other	9	3.44±3.504				
MBI-PA	Pediatric	60	33.47±11.095	Between groups	549.455	137.364	.249 .*P*(= 1.366)
	Physical	18	38.56±6.271	Within groups	13071.182	100.548	
	Psychiatric	5	40.60±2.966	total	13620.637		
	Multi-Service Rehab Facility	43	35.44±10.194				
	Other	9	33.67±9.618				

Chapter 5 Discussion and Conclusion

5.1 Chapter overview

This study aimed to evaluate the level of burnout among occupational therapists for further investigation of the factors associated with the levels of burnout in all its dimensions; emotional exhaustion, depersonalization, and personal accomplishment, among occupational therapy professionals. This chapter discusses the sociodemographic of the study, levels of burnout, along with BRS and PHQ sales results, in addition to factors associated with burnout, conclusion, and finalized with recommendations and limitations.

5.2 Discussion

Burnout is a crucial health issue affecting healthcare workers, including occupational therapists. This study highlights the importance of addressing the problem of burnout among occupational therapists in Palestine, Jordan, Qatar, and Saudi Arabia. And comparing the results between these countries. Focusing on understanding the levels of burnout among occupational therapists working in these countries, where the work was done according to a questionnaire distributed online to extended participants from occupational therapists, during the period from the end of September to mid-October 2023. 135 responded (98 females, 37 males) to this questionnaire during the survey period, which lasted 4 weeks.

Varying levels of burnout have been identified. Factors associated with these levels were analyzed, including occupational pressures, working conditions, and social support. The

negative effects of occupational burnout on the performance of occupational therapists and the quality of care provided to patients were also identified.

5.3 Levels of professional burnout among occupational therapists.

The results of this study revealed a significant level of burnout among occupational therapies across the four countries being studied, with 25% of the participants experiencing moderate burnout and another portion 25% facing high-level of burnout, collectively high and moderate levels in the total sample are (50%) notably, the average score for emotional exhaustion (MBI-EE) was 27.46 (SD=14.43), reflecting high levels of emotional exhaustion among therapists. These results align with the findings of previous research that has documented a high prevalence of burnout among occupational therapists. For instance, Akroyd (2003) reported that 40% of occupational therapy participants suffered from emotional execution, highlighting elevated burnout levels within the profession. In contrast to other countries, a survey of occupational therapists in Spain reported even higher burnout levels, with 69.4% of respondents indicating significant emotional exhaustion - surpassing the rates cited for neighboring Portugal (44%) (Reis et al., 2018) and the United Kingdom (32.54%) (Lasalvia et al., 2009). These cross-national trends, as reflected by the percentages reported, underscore the substantial emotional demands faced by practitioners in this field (Galletta et al., 2019). While the specific burnout metrics across studies may not be directly equivalent, the convergence of elevated percentages found presently and in prior investigations collectively suggests vulnerability to burnout amongst occupational therapists that appears linked to location-specific work environment factors. A potential reason for this variation in rates of emotional exhaustion among occupational therapists

between Spain (69.4%) and the current study (50%), as other similar studies rates, like the UK and Portugal, could be related to differences in therapists' demographics and work condition, in Spain, younger OT's, those without children, and those working split shifts or in high0 stress like pediatric and geriatric setting had higher burnout levels, which may not be as prevalent in the OTs surveyed in the current study, leading to lower emotional exhaustion levels. Further comparative research is warranted to more precisely characterize international differences in burnout prevalence and correlates within this professional group.

On the other hand, the study revealed relatively low levels of depersonalization (MBI-D), the data indicate that 25% of the sample participants reported low levels of burnout, while 25% experienced moderate burnout levels, Variation by country is notable: 28% of the therapists in Palestine reported a low level of depersonalization, while Saudi Arabia therapist exhibited a particularly concerning rate at 66.7% in the moderate category. This highlights that, while depersonalization is less prevalent overall, it is a critical issue in specific contexts, especially in Saudi Arabia. The high depersonalization rate in Saudi Arabia 66.7% could be attributed to several factors as indicated in the current study, that more than 43 % of OTs sample in Saudi Arabia working more than 9 hours per day and about 34% cover more than 9 patients daily, combined with a demographic factor that the majority of the sample respondents in Saudi Arabia are single (62%). This indicated by many other studies that being single is one of the main factors contributing to burnout. This condition could contribute to feelings of detachment as a key aspect of depersonalization.

Additionally, the cultural expectations of maintaining professionalism under stress might discourage seeking help, which can lead to high depersonalization rates.

The results about personal accomplishment (MBI-PA) indicate that 42.38% of the occupational therapist's sample reported experiencing burnout at some level in that dimension. Moreover, 21.88% and 35.75% exhibited moderate and high burnout respectively regarding personal accomplishment. This diverse pattern of responses on the MBI-PA scale suggests mixed feelings of achievement among occupational therapists. While many found meaning in their work, a substantial proportion also reported high emotional exhaustion, reflecting some discordance between deriving satisfaction from occupational duties and standing job-related pressures and demands. These findings provide insight into how dimensions of burnout can manifest separately or jointly within an occupational group (Çapri, 2013).

The study further highlights notable differences in burnout levels among the participant countries, with Saudi Arabia demonstrating the highest emotional exhaustion and moderate depersonalization rates, while Jordan had the largest percentage of low-level burnout. This focused examination of occupational therapists across the four countries contrasts with previous research that compared burnout across various health professions. While Akroyd's research indicated lower levels of personal achievement among OTs, compared to the health professions, Abaoglu's work did not directly address this aspect, furthermore, Abaoglu's emphasis on factors associated with burnout, such as working conditions, job satisfaction, and engagement defer from the current study which primarily presents burnout levels without a comprehensive exploration of the contextual influences. However, the results of

depersonalization exhibited meaningful variance between Arab countries. Occupational therapists surveyed in Jordan reported markedly higher levels of depersonalization across several survey items, indicating an enhanced emotional burden. Conversely, therapists in Qatar displayed comparatively lower levels of depersonalization, suggesting a work environment that is less taxing on emotional resources. Certain questions in the Saudi Arabia sample elicited elevated depersonalization, potentially reflecting a notably challenging emotional milieu for occupational therapists within specific contexts therein. Practitioners in Palestine generally reported moderate levels of depersonalization, signifying a balanced yet still concerning degree of emotional disengagement. These cross-country differences in depersonalization may be linked to divergent cultural, organizational, or systemic factors affecting occupational therapists differentially across the Arab region. Further research could aim to elucidate possible reasons for the variances in emotional strain witnessed between Arab countries.

The high levels of burnout across countries being studied can be attributed to several factors, including the demanding nature of occupational therapy work, the emotional demands placed on practitioners, and systemic challenges such as insufficient institutional support and resources.

5.4 Factor associated with burnout and sociodemographic characteristics of occupational therapists.

This study found that burnout among occupational therapy professionals in Jordan, Palestine, Qatar, and Saudi Arabia was associated with many critical characteristics. The

findings revealed a complex connection between demographic variables and professional factors that impact burnout. Occupational stress and working circumstances, particularly elevated daily workload, emerged as a crucial factor, with healthcare providers managing patients between 6 and 8 daily. This result corresponds to the findings of Brown and Pashnik (2018), which highlighted that increased daily caseloads can contribute to feelings of overwhelm, intensifying burnout. The research indicated that occupational therapists in administrative roles without other responsibilities as treating patients had elevated emotional tiredness and depersonalization (MBI-D). This suggests that work conditions, particularly the lack of patient interaction, may promote emotional detachment and exhaustion. The findings from earlier research emphasize the significance of patient relationships in reducing burnout. The data revealed that OT professionals with lower income had more emotional exhaustion, reinforcing that financial stress is a substantial factor in burnout. These results align with Scanlan and Still (2013), who highlighted the influence of financial limitations on work satisfaction and general well-being among healthcare providers. Furthermore, the marginal significance of income level on the personal accomplishment dimension (MBI-PA) indicated that economic stability may enhance practitioners' feelings of success by facilitating access to superior resources and support.

Research has shown intricate connections between burnout parameters and demographic characteristics such as age and years of experience. Experienced occupational therapists reported better personal accomplishment and success, suggesting that they may have increased fulfillment from their employment. According to a study, systemic stressors can

persist regardless of tenure, emphasizing the need for continuous support regardless of years of experience. Maslach & Leiter, 2016).

Social support and workplace environments: Disparities in support systems across nations significantly contribute to elevated burnout levels. Moreover, Devery et al. (2018) have supported the elevated resilience percentages and lower burnout levels in Qatar, suggesting more supportive management in the work environment. Conversely, Palestine diminished resilience levels. This could be associated with political and economic instability. This highlights the impact of external circumstances on the resilience levels of practitioners. The findings from the Brief Resilience Scale (BRS) indicated that there is a significant variability in resilience across occupational therapy practitioners, with Qatar scoring the highest resilience scores. This indicates that cultural and social factors such as organizational support and societal recognition of the practitioners may enhance resilience, Devery et al. (2018). On the other hand, ongoing political and economic conflicts may impact the practitioners' ability to recover from stressors, thereby affecting their well-being, a finding that aligns with Martela et al.'s (2022) findings. Jordan and Saudi Arabia demonstrated moderate resilience levels, indicating specific challenges that necessitate tailored interventions to enhance practitioners, flexibility, and coping strategies, as discussed by Pniak (2021). The resilience levels in Qatar and Palestine exhibit stark contrasts; Qatar’s high resilience levels highlight the benefits of supportive working environments and increased institutional support. In contrast, the low resilience levels in Palestine highlight the detrimental effects of political and economic instability on professionals' well-being. While Qatar's high resilience level suggests a robust support

system and favorable working conditions, this comparison emphasizes the importance of contextual factors in shaping occupational therapy practitioners' resilience and overall well-being.

Mental health and psychobiological distress: The Patient Health Questionnaire (PHQ) shows that OT partitioners in Saudi Arabia have high levels of anxiety, stress, and depression, which is likely because they are under a lot of work pressure; Roundy et al. (2023) confirm this. On the other hand, Scanlan et al. (2019) support the notion that Qatar's Lower PHQ scores reveal a significant interconnection between elevated PHQ scores and burnout levels, highlighting the connection between psychological discomfort and the environment of both mental and occupational well-being among OT practitioners. This data collectively underscores the complex nature of burnout among occupational therapy professionals. Factors such as high caseloads, limited finances, and discrepancies in support networks substantially influence burnout experiences. This insight underscores the need for focused interventions that address stress at work while also considering wider systemic concerns, such as remuneration and work support, to successfully alleviate burnout and improve the overall well-being of OT professionals.

Implementing regular mental health checkups, providing access to counseling services, and creating peer support groups can positively reduce stress at work. Additionally, ensuring manageable workloads and offering financial support or bonuses can help alleviate some of the economic pressures faced by professionals. Establishing clear communication channels and promoting a culture of recognition and appreciation can further improve job satisfaction

and well-being. The variation in different factor associations indicates that contextual elements, including cultural attitudes toward mental health and organizational support systems, may significantly influence burnout levels. Customized interventions that address both individual and systemic factors are critical for improving the well-being of occupational therapy professionals in various national contexts.

Moreover, regarding sociodemographic characteristics of the occupational therapy participants and their relation to burnout, this study highlighted the gender imbalance among occupational therapists, which is characterized by a predominantly of female therapists in all the sample respondents among the four countries being studied with rate (72%) of the total sample, this result is consistent with literature that indicates a predominantly female workforce, which can shape workplace dynamics including support systems and culture, both of which can influence burnout levels. In the current study, there was no difference between different genders regarding burnout, while Scanlan & Still, (2013) revealed that women in healthcare encounter unique work stressors, such as gender bias a challenge with balancing their social and family life with work, which can increase emotional exhaustion.

The majority of the participants have a bachelor's degree (77.3%) of the total sample, indicating a solid foundation in educational background. In the current study, there was no correlation with different educational degrees regarding burnout, However, lacking of continuous professional development could contribute to burnout, as indicated by Maslach (2016), who argues that ongoing training and professional development can enhance job satisfaction and reduce possible burnout. That suggests a real need for structured

professional development for employees with equal opportunities to empower occupational therapists to manage the demands of their roles effectively.

Furthermore, the worrying fact that about 56.30% of the total sample earns less than $20,000 annually, with Jordan (86%) and Palestine (73%) of the participants, this level is concerning when considering the rising rates in the living costs in these regions, even though for Qatar (20.70%), and Saudi Arabia (34.40%), Financial limitations in these areas where OT professionals work often encounter economic pressures, and can significantly contribute to stress at work, as confirmed in this study that low-income occupational therapist suffering of deferent levels of burnout. This corresponds to Scanlan & Still (2013) who revealed that financial instability is a key factor for exacerbating burnout, as therapists may struggle to keep balanced life needs with their work demands. Likewise, regarding marital status, with fifty percent of the respondents reporting being single, in the current study there was no correlation between marital status and burnout levels, while other studies indicated that marital status may affect their vulnerability to burnout. Single therapists may lack the emotional support that comes through familial relationships, making them more vulnerable to stress at their work. Maslach and Leiter (2016) emphasized that marital status can impact emotional support systems, and it's crucial for maintaining work-life balance in professions with high stress.

Years of experience, in the current study didn’t influence the risk of burnout. And didn’t show any significant impact on burnout levels in the three dimensions of burnout, while other studies indicated that more than 5 years of experience could serve as a safeguard

against burnout as discussed by Edward and his colleagues (2010), Seasoned therapists often exhibit more resilience and have developed coping strategies to manage occupational stress, as shown by Awa et al. (2010). On the other hand, many participants indicated that they manage between 6 and 8 patients every day, at the current study there was no significant correlation between daily caseloads and burnout, while working with administrative roles without having daily patient therapy sessions showed significant relation to burnout, these results are consistent with previous studies, which indicated association among the elevated caseloads with sensations of overwhelm, and that can increase vulnerability to burnout (Brown & Pashniak, 2018; Painter et al., 2003). The analysis of the employment sector revealed an equal distribution of employment across the public and private sectors, while the correlation didn't find any significant difference wherever OT specialists are working, suggesting that burnout and mental health didn't differ across the sector. On the other hand, previous research suggests that job satisfaction and mental health defer across sectors of employment, with public sector employment providing greater job stability, which may mitigate burnout, while the private sector may face increased job instability, indicating that there is a risk of burnout (Scanlan & Still,2013).

In conclusion, the sociodemographic parameters examined in this study gender, education, income, marital status, experience, and occupational sector, have different impacts among OT professional's burnout. These results highlight the need for tailored treatments that confront the specific pressures encountered by occupational therapists, contingent upon their sociodemographic characteristics.

5.5 Conclusion

This research indicates that the phenomenon of burnout among occupational therapists is significant and has been addressed in several countries, including Palestine, Jordan, Qatar, and the Kingdom of Saudi Arabia. The findings indicated diverse degrees of burnout across the many variables assessed by the Maslach Burnout Inventory (MBI). A significant degree of emotional weariness has been recorded, particularly among occupational therapists in Jordan and Saudi Arabia. This is a concerning symptom that reflects substantial emotional and occupational stress impacting this cohort of healthcare workers. The research indicated significant disparities in burnout levels across the nations studied: Palestine, Jordan, Qatar, and Saudi Arabia. Occupational therapists in Jordan had a greater propensity for depersonalization (diminished personal achievement) than their counterparts in Qatar, suggesting disparities in work settings and support systems. Occupational therapists in Jordan and Qatar reported elevated levels of personal success, but those in Palestine and Saudi Arabia exhibited diminished levels, indicating possible obstacles in work satisfaction in specific situations. The analysis of resilience levels using the Brief Resilience Scale (BRS) revealed significant disparities, with occupational therapists in Qatar exhibiting the greatest resilience, presumably attributable to favorable cultural and institutional influences. Conversely, the people in Palestine exhibited less resilience, perhaps associated with challenging political and economic circumstances. Mental health evaluations with the Patient Health Questionnaire (PHQ) indicated substantial concerns, especially in Saudi Arabia, where elevated levels of anxiety, stress, and depression were documented. This corresponds with the burnout results and emphasizes the need for comprehensive treatments

to enhance the overall well-being of occupational therapy practitioners. The research underscores the intricate and diverse issues encountered by occupational therapists in the Middle East. The disparities seen across nations highlight the need for customized strategies and interventions to address the unique demands and issues of the profession within each country's environment. Prioritizing the mitigation of occupational burnout, the enhancement of resilience, and the promotion of mental health is essential for ensuring the well-being and efficacy of occupational therapy practitioners.

5.6 Limitation

This research offers a thorough examination of burnout experienced by occupational therapy practitioners in Jordan, Palestine, Qatar, and Saudi Arabia; nevertheless, some limitations must be addressed about the sample size and representation: The findings may not apply to the entire occupational therapy population across these four nations, as the sample size and selection may not fully represent the broader population of occupational therapists. To ascertain the long-term impact of burnout within this population, longitudinal studies are necessary to evaluate the progression of burnout over time and its enduring effects on occupational therapists. Self-disclosed utilization of self-reported outcome measures to assess burnout, resilience, and mental health may introduce bias, as participants might under-report or over-report their experiences due to social desirability or recall bias. The study investigated occupational therapists in four nations characterized by diverse cultural, social, and economic situations. This data offers comparative information, although the interpretation of burnout and associated factors may be influenced by contextual

variations.

These limitations emphasize the necessity for future research that can facilitate a more thorough investigation of burnout within this community, encompassing bigger and more diverse samples. Longitudinal research with increased emphasis on institutional and cultural issues.

5.7 Future research recommendations

1) Future studies ought to encompass longitudinal studies to track the evolution of burnout over time among occupational therapists, thereby enhancing comprehension of causative factors and long-term consequences.
2) - An augmented and varied sample: enhancing the sample size and ensuring the representativeness of occupational therapists from diverse countries could enhance the generalizability of the findings.
3) - Qualitative research: it is recommended to incorporate qualitative approaches, such as interviews or focus groups, to clarify the complex experiences and underlying reasons for burnout among occupational therapists.
4) Examination of institutional variables Advise that subsequent studies focus on organizational and institutional factors, such as workload, management practices, and workplace culture, to improve comprehension of their impact on burnout.
5) Interventional research Encourage research on the effectiveness of interventions designed to mitigate burnout and enhance resilience and mental health among occupational therapists, tailored to the specific needs of different countries.

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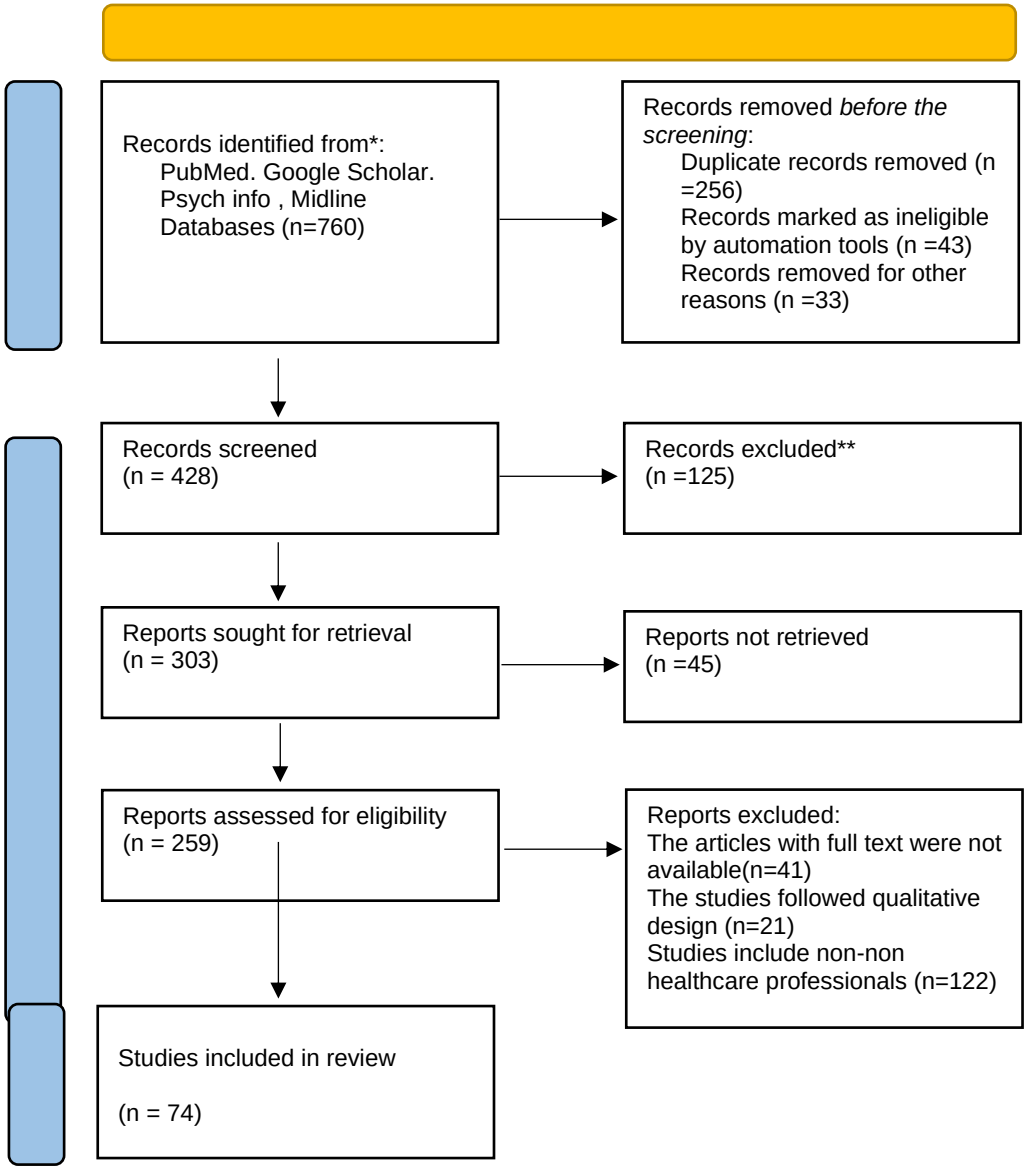
Appendices

Appendix A Prisma



From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews

Appendix B IRB Approval letter

Arab American University- Palestine
Deanship of Scientific Research
IRB committee
Tel: 04-241-8888, ext 1196
E-mail: irb.aaup@aaup.edu

الجامعة العربية الامريكية- فلسطين
عمادة البحث العلمي
لجنة أخلاقيات البحث العلمي
تلفون: ext 04-241-8888 1196
البريد الالكتروني: irb.aaup@aaup.edu

IRB Approval Letter

Study Title: Burnout Syndrome among Occupational Therapists Working in Palestine/ West Bank, Jordan, Qatar, and Saudi Arabia

Submitted by: Khaled Mahmoud Abd Alqader Alkhdour

Date received: 10th June 2023

Date reviewed: 14th August 2023

Date approved: 14th August 2023

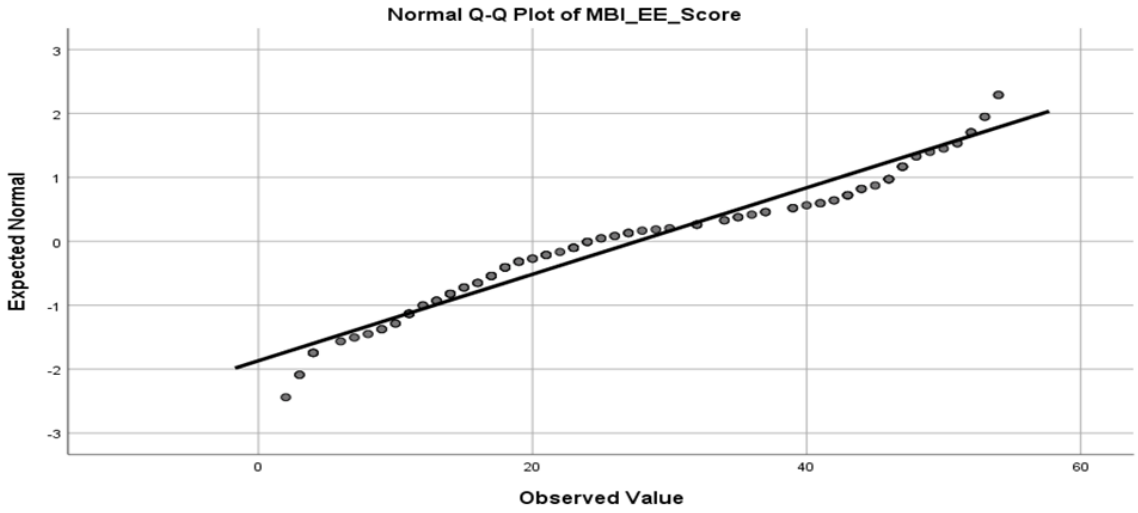
Your Study titled "**Burnout Syndrome among Occupational Therapists Working in Palestine/ West Bank, Jordan, Qatar, and Saudi Arabia**" With archived number 2023/A/153/N was reviewed by the Arab American University IRB committee and was approved on 14th August 2023.

Reham Khalaf-Nazzal, MD, PhD
IRB committee chairman
Arab American University of Palestine

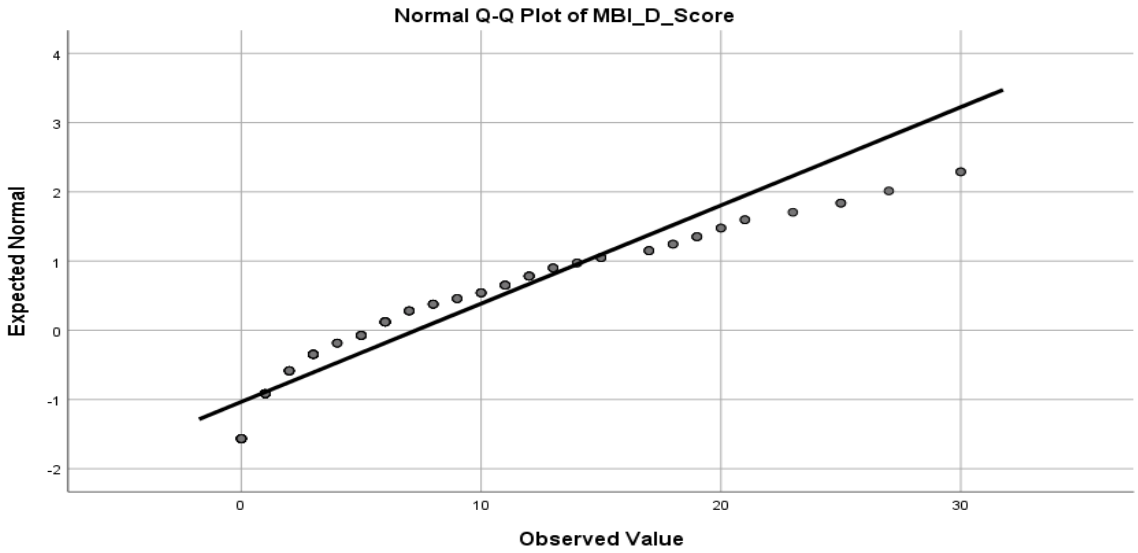
General Conditions:

1. Valid for 4 months from date of approval.
2. It is important to inform the committee with any modification of the approved study protocol.
3. The committee appreciates a copy of the research when accomplished.

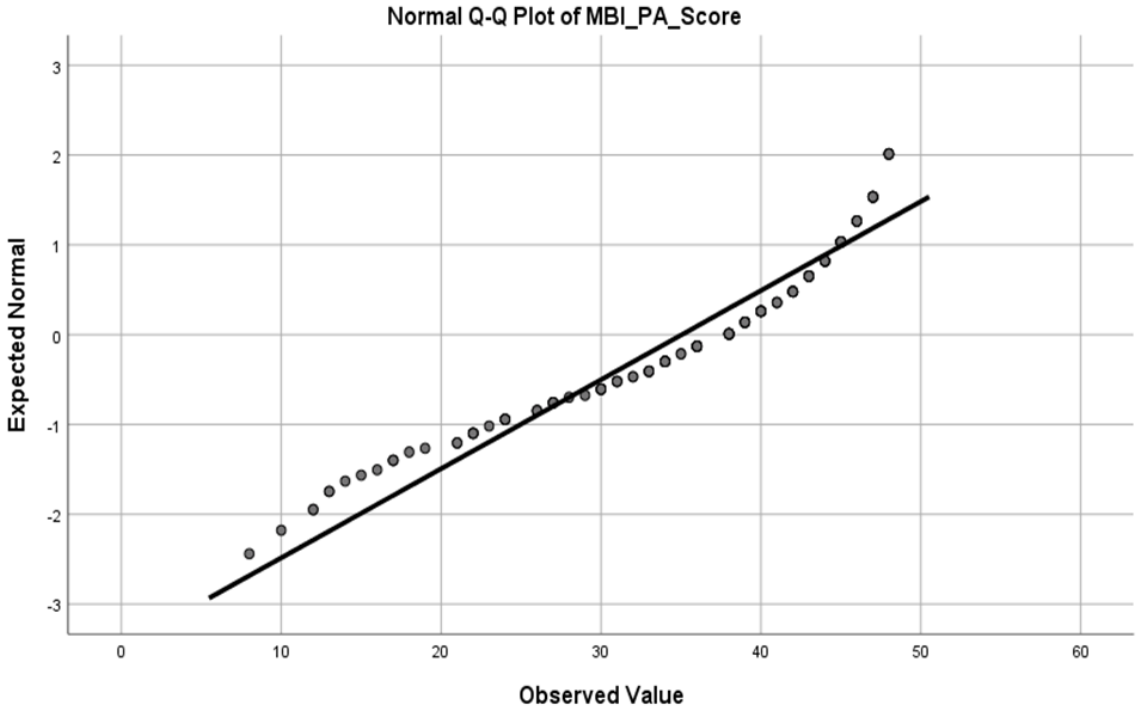
Appendix C Data distribution of MBI-EE scores



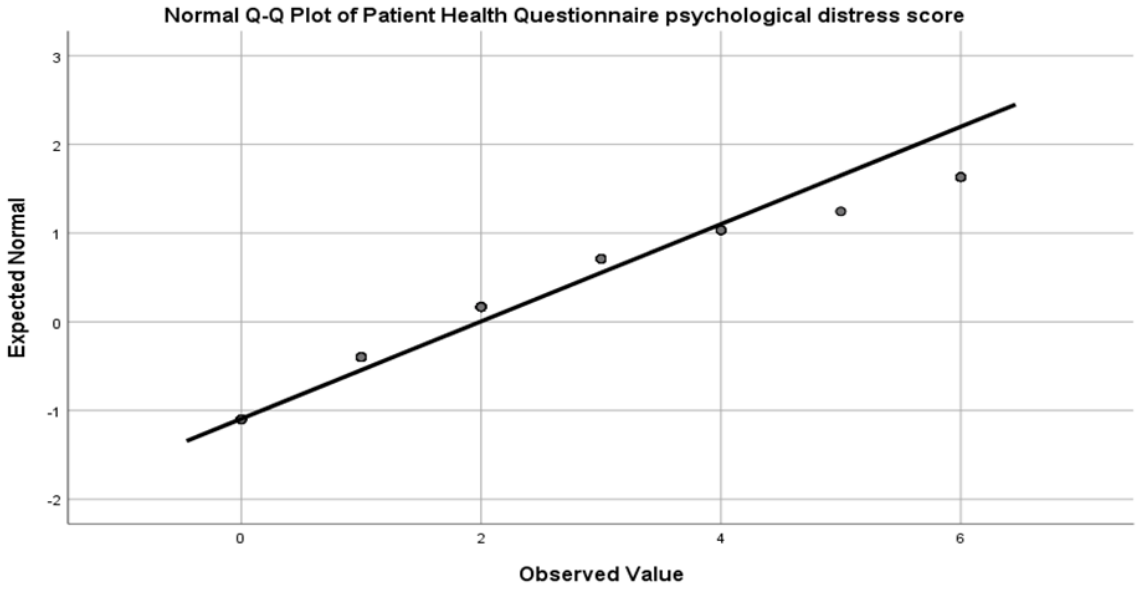
Appendix D Data distribution of MBI-D scores



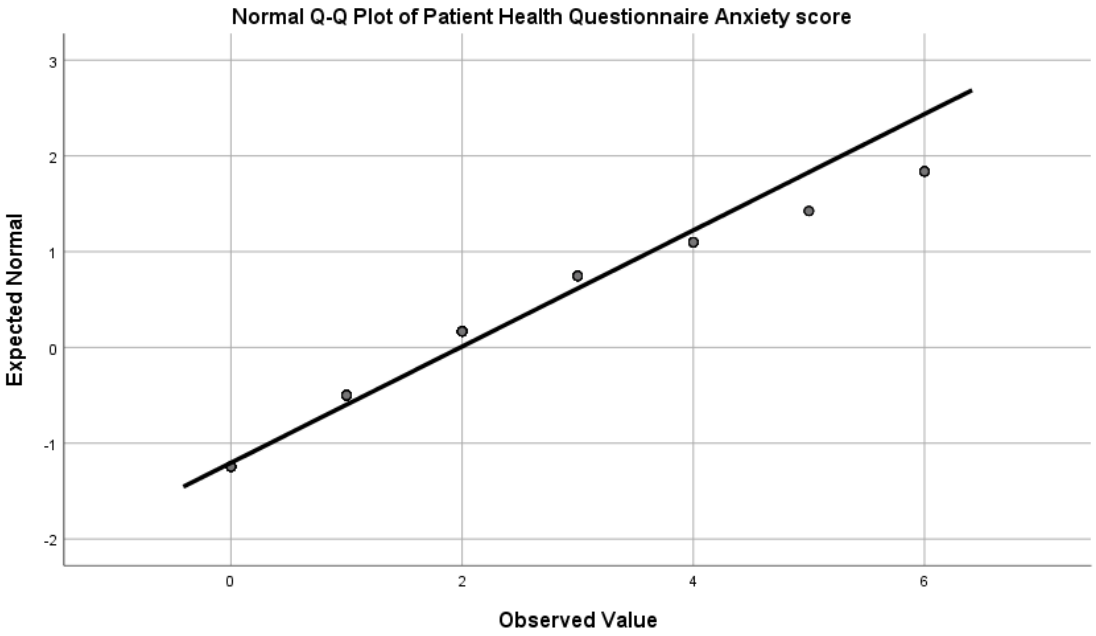
Appendix E Data distribution of MBI-PA scores



Appendix F Data distribution of PHQ scale psychological distress cores



Appendix G data distribution of PHQ scale anxiety scores



Appendix H demographic data, values presented as numbers and percentage

Variable		Total population n (%)	Palestine. n (%)	Jordan. n (%)	Qatar n (%)	Saudi Arabia n (%)
Gender						
	Male	37(27.40)	08(21.10)	09(25.0)	09(25.00)	11(31.00)
	Female	98(72.60)	30(78.90)	27(75.0)	20(69.00)	21(65.60)
Level of Education						
	Diploma	03(10.00)	00(00.00)	0(0)	02(06.90)	01(03.00)
	BA	104(77.30)	27 (71.10)	33(91.7)	20(14.80)	24(75.00)
	MSc	25(18.40)	09(23.70)	02(05.6)	07(24.10)	07(21.90)
	PhD	01(00.70)	01(02.60)	00(00.00)	00(00.00)	00(00.00)
	OTD	02(01.50)	01(02.60)	01(02.80)	00(00.00)	00(00.00)
Annual income						
	Less than 20000 $	76(56.30)	28(73.70)	31(86.10)	06(20.70)	11(34.40)
	20000-30000$	23(17.00)	09(23.70)	02(05.60)	08(27.60)	04(12.50)
	30000-40000$	22(16.30)	01(02.60)	02(05.60)	05(17.20)	14(43.80)
	More than 40000$	14(10.40)	00(00.00)	01(02.80)	10(34.50)	03(09.40)
Marital status						
	Single	74(54.80)	20(52.60)	29(80.60)	05(17.20)	20(62.50)

	Married	54(40.00)	18(47.40)	06(16.70)	23(79.30)	07(21.90)
	Divorced	06(04.40)	00(00.00)	01(02.8)	00(00.00)	05(15.60)
	Separated	01(00.47)	00(00.00)	00(00.0)	01(03.40)	00(00.00)
Years of Experience						
	Less than 1 year	27(20.00)	11(28.90)	11(30.60)	01(03.40)	04(12.50)
	1 to 3 years	34(25.20)	10(26.30)	13(36.10)	00(00.00)	11(34.40)
	3 to 5 years	12(08.90)	01(02.60)	04(11.10)	05(17.20)	02(06.30)
	More than 5 years	62(45.90)	16(42.10)	08(22.20)	23(79.30)	15(46.90)
Daily Caseload						
	3 to 5 pts daily	18(13.30)	03(07.90)	07(19.40)	06(20.70)	02(06.30)
	6 to 8 pts daily	53(39.30)	14(36.80)	13(36.10)	13(44.80)	13(40.60)
	9 pts or more daily	35(25.90)	10(26.30)	11(30.60)	03(10.30)	11(34.40)
	Administrative with treatment responsibilities	16(11.90)	05(13.20)	01(02.80)	05(17.20)	05(15.06)
	Administrative role only.	05(03.70)	02(05.30)	01(02.80)	02(06.90)	00(00.00)
Daily working hours						
	Less than 5 hours a day	08(05.90)	04(10.50)	03(08.30)	00(00.00)	01(03.10)

	6 to 8 hours a day	107(79.30)	33(86.80)	29(80.60)	28(96.60)	17(53.10)
	9 to 11 hours per day	19(14.10)	00(00.00)	04(11.10)	01(03.40)	14(43.80)
	12 hours or more per day	01(00.70)	01(02.60)	00(00.00)	00(00.00)	00(00.00)
Working Agency						
	Governmental	59(43.70)	08(21.10)	06(16.70)	25(86.20)	20(62.50)
	NGO	05(03.70)	03(07.90)	01(02.80)	00(00.00)	01(03.10)
	Private sector	61(45.20)	23(60.50)	24(66.70)	04(13.80)	10(31.30)
	Own a Private Rehab Center	04(03.00)	02(05.30)	02(05.60)	00(00.00)	00(00.00)
	Other	06(04.40)	02(05.30)	03(08.30)	00(00.00)	01(03.10)
Scope of service/specialty						
	Pediatric	60(44.40)	16(42.10)	20(55.60)	11(37.90)	13(40.60)
	Physical	18(13.30)	08(21.10)	02(05.60)	05(17.20)	03(09.40)
	Psychiatric	05(03.70)	01(02.60)	02(05.60)	01(03.40)	01(03.10)
	Multi-Service Rehab	43(31.90)	12(31.60)	12(33.30)	05(17.20)	14(43.80)
	Other	09(06.70)	01(02.60)	00(00.00)	07(24.10)	01(03.10)

Appendix I Outcome Measures / Survey of all Questionnaires formed by Google forms

Measuring Burnout Syndrome Among Occupational Therapists who Works in Palestine, Jordan, Qatar and Saudi Arabia

Dear participant,

We invite you to participate in a study on burnout among occupational therapists in Palestine, Jordan, Qatar, and Saudi Arabia. This study aims to understand how common burnout is among occupational therapists in these countries and what factors influence it. Your participation is crucial to the success of this study. The results will help us find ways to prevent and manage burnout, leading to greater job satisfaction and better patient care. Your participation is anonymous, and all information you provide will be treated confidentially. Your data is stored securely and is only available to the research team. The results will be communicated in a way that protects your identity. Participation or revocation is possible at any time without giving reasons.

Thank you for your contribution to this study.

* Indicates required question

1. By selecting the "I agree" option below, you confirm your voluntary consent to participate in this research study. You have the option to print out a copy for your personal records. *

Mark only one oval.

- ◯ I Agree
- ◯ I do not agree *Skip to section 6 (**Participation declined**)*

Demographic information

Please provide accurate and complete information in this demographic section"

2. What Is Your Age? *

_____

3. Gender *

Mark only one oval.

- ◯ Male
- ◯ Female

4. Marital status *

Mark only one oval.

- ◯ Single
- ◯ Maried
- ◯ Divorced
- ◯ Seperated
- ◯ Widow
- ◯ Other

5. Current Place of Work *

Mark only one oval.

- ◯ Palestine
- ◯ Jordan
- ◯ Qatar
- ◯ Saudi Arabia

6. Education Level *

Mark only one oval.

- ◯ Diploma
- ◯ Bachelor's degree
- ◯ Master's degree
- ◯ PhD.
- ◯ OTD

7. Amount of Annual Income In USD *

Mark only one oval.

- ◯ less than 19999 USD
- ◯ 20000 - 29999 USD
- ◯ 30000 to 39999 USD
- ◯ Over 40000 USD

8. Years of Experience as an Occupational Therapist *

Mark only one oval.

- ◯ less than 1 year
- ◯ 1 to 3 years
- ◯ 3 to 5 years
- ◯ More Than 5 Years

9. Daily Case load / responsibilities. *

Mark only one oval.

- ◯ 3 to 5 Patients Per Day
- ◯ 6 to 8 Patients Per Day
- ◯ 9 Patients or More Per Day
- ◯ Administrative Role With Patient Treatment Responsibilities
- ◯ Administrative Role Without Direct Patient Care.
- ◯ Education or Lecturer Providing Specialized Courses

10. Daily working hours *

Mark only one oval.

- ◯ less than 5 hours a day
- ◯ 6 to 8 hours a day
- ◯ 9 to 11 hours per day
- ◯ 12 hours or more per day

11. Working Agency: *

Mark only one oval.

- ◯ Governmental
- ◯ NGO
- ◯ Private
- ◯ Own's a Private Rehab Center
- ◯ Other: _____

12. Scope of service / specialty *

Mark only one oval.

- Pediatric
- Physical
- Psyciatric
- Multi Service Rehab Facility
- Other

Indicate How Frequently The Following Statements Apply To You

13. 1- I feel emotionally drained from my work *

Mark only one oval.

- Never
- Few times per year
- Once a month
- A few times per month
- Once a Week
- A few times per week
- Every day

14. 2- I am at the end of my patience at the end of my work day. *

Mark only one oval.

- Never
- Few times per year
- Once a month
- A few times per month
- Once a Week
- A few times per week
- Every day

15. 3- I feel tired when I get up in the morning and have to face another day at work. *

Mark only one oval.

- Never
- Few times per year
- Once a month
- A few times per month
- Once a Week
- A few times per week
- Every day

16. 4- Working with people all day long requires a great deal of effort. *

Mark only one oval.

- ◯ Never
- ◯ Few times per year
- ◯ Once a month
- ◯ A few times per month
- ◯ Once a Week
- ◯ A few times per week
- ◯ Every day

17. 5- I feel like my work is breaking me down. *

Mark only one oval.

- ◯ Never
- ◯ Few times per year
- ◯ Once a month
- ◯ A few times per month
- ◯ Once a Week
- ◯ A few times per week
- ◯ Every day

18. 6- I feel frustrated by my work. *

Mark only one oval.

- Never
- Few times per year
- Once a month
- A few times per month
- Once a Week
- A few times per week
- Every day

19. 7- I feel I work too hard at my job. *

Mark only one oval.

- Never
- Few times per year
- Once a month
- A few times per month
- Once a Week
- A few times per week
- Every day

20. 8- It stresses me too much to work in direct contact with people/ patients *

Mark only one oval.

- Never
- Few times per year
- Once a month
- A few times per month
- Once a Week
- A few times per week
- Every day

21. 9- I feel like I'm at the end of my rope. *

Mark only one oval.

- Never
- Few times per year
- Once a month
- A few times per month
- Once a Week
- A few times per week
- Every day

22. 10- I feel I look after certain patients/clients impersonally as if they are objects. *

Mark only one oval.

- ◯ Never
- ◯ Few times per year
- ◯ Once a month
- ◯ A few times per month
- ◯ Once a Week
- ◯ A few times per week
- ◯ Every day

23. 11- I have become more insensitive to people since I've been working. *

Mark only one oval.

- ◯ Never
- ◯ Few times per year
- ◯ Once a month
- ◯ A few times per month
- ◯ Once a Week
- ◯ A few times per week
- ◯ Every day

24. 12- I'm afraid that this job is making me uncaring *

Mark only one oval.

- Never
- Few times per year
- Once a month
- A few times per month
- Once a Week
- A few times per week
- Every day

25. 13- I really don't care about what happens to some of my patients/clients. *

Mark only one oval.

- Never
- Few times per year
- Once a month
- A few times per month
- Once a Week
- A few times per week
- Every day

26. 14- I have the impression that my patients/clients make me responsible for some of their problems *

Mark only one oval.

- Never
- Few times per year
- Once a month
- A few times per month
- Once a Week
- A few times per week
- Every day

27. 15- I am easily able to understand what my patients/clients feel. *

Mark only one oval.

- Never
- Few times per year
- Once a month
- A few times per month
- Once a Week
- A few times per week
- Every day

28. 16- I look after my patients'/clients' problems very effectively. *

Mark only one oval.

- ◯ Never
- ◯ Few times per year
- ◯ Once a month
- ◯ A few times per month
- ◯ Once a Week
- ◯ A few times per week
- ◯ Every day

29. 17- Through my work, I feel that I have a positive influence on people. *

Mark only one oval.

- ◯ Never
- ◯ Few times per year
- ◯ Once a month
- ◯ A few times per month
- ◯ Once a Week
- ◯ A few times per week
- ◯ Every day

30. 18- I feel full of energy. *

Mark only one oval.

- Never
- Few times per year
- Once a month
- A few times per month
- Once a Week
- A few times per week
- Every day

31. 19- I am easily able to create a relaxed atmosphere with my patients/clients. *

Mark only one oval.

- Never
- Few times per year
- Once a month
- A few times per month
- Once a Week
- A few times per week
- Every day

32. 20- I feel refreshed when I have been close to my patients/ clients at work. *

Mark only one oval.

- Never
- Few times per year
- Once a month
- A few times per month
- Once a Week
- A few times per week
- Every day

33. 21- I accomplish many worthwhile things in this job. *

Mark only one oval.

- Never
- Few times per year
- Once a month
- A few times per month
- Once a Week
- A few times per week
- Every day

34. 22- In my work, I handle emotional problems very calmly *

Mark only one oval.

- Never
- Few times per year
- Once a month
- A few times per month
- Once a Week
- A few times per week
- Every day

Please indicate your response to each statement by selecting the appropriate option provided

Please choose one answer of the following options

35. 1- I tend to bounce back quickly after hard times *

Mark only one oval.

- Sytrongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

36. 2- I have a hard time making it through stressful events. *

Mark only one oval.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

37. 3- It does not take me long to recover from a stressful event. *

Mark only one oval.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

38. 4- It is hard for me to snap back when something bad happens. *

Mark only one oval.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

39. 5- I usually come through difficult times with little trouble *

Mark only one oval.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

40. 6- I tend to take a long time to get over set-backs in my life *

Mark only one oval.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

Please indicate your response to each statement by selecting the appropriate option provided

Over the last two weeks, how often have you been bothered by the following problems?
Choose one answer.

41. 1- Feeling nervous, anxious or on edge *

Mark only one oval.

- Not at all
- Several days
- More than half the Days
- Nearly every day

42. 2- Not being able to stop or control worrying *

Mark only one oval.

- Not at all
- Several days
- More than half the Days
- Nearly every day

43. 3- Feeling down, depressed or hopeless *

Mark only one oval.

- Not at all
- Several days
- More than half the Days
- Nearly every day

44. 4- Little interest or pleasure in doing things *

Mark only one oval.

- ◯ Not at all
- ◯ Several days
- ◯ More than half the Days
- ◯ Nearly every day

Participation declined

You elected not to participate, you can click the submit or simply close your browser

Appendix G Permission to use the MBI questionnaire

Permission for Khaled Alkhdour to administer within three years of September 03,2023

Maslach Burnout Inventory™

MBI Forms and Scoring Keys:

Human Services - MBI-HSS
Medical Personnel - MBI-HSS (MP)
Educators - MBI-ES
General - MBI-GS
Students - MBI-GS (S)

License to Administer

By Christina Maslach, Susan E. Jackson, Michael P. Leiter,
Wilmar B. Schaufeli & Richard L. Schwab

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Permission Letter

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The above-named person has made a license purchase from Mind Garden, Inc. and has permission to administer the following copyrighted instrument up to that quantity purchased:

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Sample Items:

MBI - Human Services Survey - MBI-HSS:
I feel emotionally drained from my work.
I have accomplished many worthwhile things in this job.
I don't really care what happens to some recipients.

MBI - Human Services Survey for Medical Personnel - MBI-HSS (MP):
I feel emotionally drained from my work.
I have accomplished many worthwhile things in this job.
I don't really care what happens to some patients.

MBI - Educators Survey - MBI-ES:
I feel emotionally drained from my work.
I have accomplished many worthwhile things in this job.
I don't really care what happens to some students.

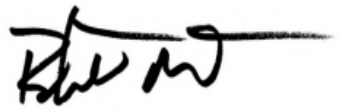
MBI - General Survey - MBI-GS:

I feel emotionally drained from my work.
In my opinion, I am good at my job.
I doubt the significance of my work.

MBI - General Survey for Students - MBI-GS (S):

I feel emotionally drained by my studies.
In my opinion, I am a good student.
I doubt the significance of my studies.

Sincerely,



Robert Most
Mind Garden, Inc.
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الملخص

مقدمة :معالجة الاحتراق الوظيفي بين المعالجين الوظيفيين أمر بالغ الأهمية، نظرا للطبيعة الصعبة لمهنهم. ومع ذلك، فإن الأبحاث التي تدرس على وجه التحديد الاحتراق الوظيفي بين المعالجين الوظيفيين في فلسطين والأردن وقطر والمملكة العربية السعودية محدودة، وتؤكد هذه الفجوة المعرفية الحاجة إلى إجراء بحث شامل لفهم التحديات الفريدة التي يواجهها هؤلاء الاخصائيين. الأهداف: هدفت هذه الدراسة إلى تقييم وجود الإرهاق بين المعالجين الوظيفيين العاملين في فلسطين والأردن وقطر والمملكة العربية السعودية. بالإضافة إلى ذلك، سعت إلى تحديد العوامل المرتبطة بالاحتراق الوظيفي لدى هذه الفئة من المهنيين. المنهجية: أجريت دراسة مقطعية شملت عينة ملائمة من المعالجين الوظيفيين، من البلدان المذكورة أعلاه. تم استخدام مسح ماسلاك للعاملين في المجال الصحي كمقياس للنتائج الأولية، بالإضافة إلى مقياس المرونة الموجز، وتم استخدام استبيان صحة المريض النفسية كمقاييس إضافية. تم تحليل البيانات باستخدام برنامج التحليل الاحصائي الإصدار 26. النتائج: كشفت النتائج أن نسبة كبيرة من المعالجين الوظيفيين عانوا من مستويات متفاوتة من الإرهاق تظهر مستويات متوسطة وعالية، مما يدل على أن هناك عددا كبيرا من المتخصصين في العلاج الوظيفي، يعانون من الاحتراق الوظيفي، خاصة في بعد الإرهاق العاطفي (25%) متوسط و(25%) مرتفع وأظهر الإنجاز الشخصي أن (35.75%) لديهم مستويات عالية. وبالمقارنة (22%) سجلت مستويات احتراق معتدلة. أكدت مقاييس المرونة الموجز ومقياس صحة المريض النفسية أن المتخصصين بالعلاج الوظيفي في قطر يتمتعون بمرونة عالية مع حالة صحية عقلية مقبولة. في المقابل، أظهر المعالجين الوظيفيين في المملكة العربية السعودية والأردن وفلسطين مستويات منخفضة من المرونة وحالة الصحة عقلية معتدلة. الخلاصة: تسلط هذه الدراسة الضوء على وجود الاحتراق الوظيفي بين المعالجين الوظيفيين في فلسطين والأردن وقطر والمملكة العربية السعودية، وتلعب العوامل الاجتماعية والديموغرافية والتنظيمية، إلى جانب استراتيجيات المواجهة، دورًا مهمًا في ظهور الاحتراق الوظيفي، وهناك حاجة إلى اهتمام أسرع لتنفيذ التدخلات التي تهدف إلى معالجة الاحتراق الوظيفي وتعزيز الرفاهية بين المعالجين الوظيفيين في هذه البلدان، وهذه النتائج لها آثار على أنظمة الرعاية الصحية

على مستوى العالم بالتأكيد على أهمية دعم المهنيين الصحيين لمنع الاحتراق الوظيفي وضمان الرعاية المثلى للمرضى.