Impact of learning communication skills and practicing selfcare on burnout management

By

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Declaration

I, Nuzhat –E- Rahman, M.Phil student of Department of Educational and Counselling Psychology at the University of Dhaka, Session: 2013-2014, declare that this thesis on **"Impact of learning communication skills and practicing selfcare on burnout management"** has been accomplished by myself under supervision of Dr. Mahjabeen Haque and co-supervised by Dr. Mehtab Khanam, Department of Educational and Counselling Psychology, University of Dhaka.

Signature of the author Date:

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Certification

This is to certify that, the thesis entitled **“Impact of learning communication skills and practicing selfcare on burnout management”** submitted by Nuzhat –E- Rahman for the degree of Master of Philosophy in the Department of Educational and Counselling Psychology at the University of Dhaka, is an original work. It was done under my supervision. I recommend the thesis for examination.

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Abstract

Job burnout is a burning concept nowadays that has been incorporated into everyone's lives remarkably. Chronic job stresses have caused many professionals and workers to fall into job burnout in the past few decades. In wide-range, job burnout is an extensive reaction of persistent emotional and interpersonal stressors on the job. The purposes of this study were to assess the need for a burnout management program in hospital settings, to develop an intervention program namely "Communication Skills and Selfcare Enhancement Program" for burnout management, and to evaluate the effectiveness of the intervention program by quantitative and qualitative assessment. With this vision, three studies were carried out in the present M.Phil project. The first study was an FGD to assess the need for a burnout management program. The FGD found a valid need for a burnout management program and identified many sources of burnout, which include lack of good communication skills, un-empathic and un-appreciating environment and lack of knowledge on selfcare. The second study was to develop an intervention program namely "Communication Skills and Selfcare Enhancement Program". It was developed based on FGD findings and the reference of conventional burnout management programs. The intervention program consists of four phases - 1) stress management, 2) communication skills, 3) empathetic communication and behavior and 4) stroking (recognition). Four separate modules have been developed for each workshop from beginning to end with an appropriate time duration that includes brief content. After completion of the module, a pilot execution was conducted before the field study and according to the feedback and suggestions of the pilot test, small changes were made. Thus, the modules were finalized for the field test. The third study was to evaluate the effectiveness of the intervention program by quantitative and qualitative assessment. The intervention was administered once a week for an hour in four consecutive weeks. It was conducted on two groups (experimental and control) following pretest post test design. A total

number of 63 employees were included from two hospitals of Dhaka city where 30 of them received the intervention program and 33 of them did not receive any intervention. The result implied that the intervention significantly reduced the level of burnout. The burnout level dropped from the pretest to the post test phase in the experimental condition and a little hike at the follow-up phase, but not in the control condition. The qualitative assessment which was done by the in-depth interview at the second follow-up of the program further supported the findings. Altogether the outcomes of the present study revealed that the organizations can use this type of program under the guidance of professional psychologists to manage their employee burnout, as they are responsible to look after and maintain the mental health of their employees. This study is a baseline that has opened the further scope of different studies in this field. It has been expected to contribute to improving the mental health and the quality of life of the working people in Bangladesh.

CHAPTER 1

General introduction

The idea of job burnout has been introduced into the life of everyone at such an accelerated rate that chronic job stresses have caused many organizational members to fall into job burnout over the last two decades. It is a protracted response to enduring emotional and interpersonal stressors while on the job.

1.1 Concept of burnout

Maslach and colleagues have conceptualized the term burnout as a distinctive type of stress syndrome, marked by emotional exhaustion, depersonalization and diminished personal accomplishment (Maslach, 1982; Maslach & Jackson, 1981; Pines & Maslach, 1980).

The first dimension, emotional exhaustion is characterized by a lack of energy and a sense that one's emotional resources are drained indicates inadequate selfcare. This 'compassion fatigue' may encompass feelings of frustration and tension as workers realize that they are not being able to give their all or act as responsibly towards their clients as they have in the past; ultimately manifesting itself in the common symptom of dread at the prospect of returning to work for another day.

Depersonalization or dehumanization, the 2nd aspect illustrates a lack of proper communication skills, which is characterized by treating clients as objects rather than individuals. A worker may exhibit a detached and emotionally alienated attitude while being contemptuous towards coworkers, clients and the organization. Visible signs include the use of extensive jargon, negative or abstract words, strict professional life compartmentalization, situation intellectualization, withdrawal, or prolonged conversations with coworkers during longer breaks

(Maslach & Pines, 1977). A textbook analogy would be that of a petty bureaucrat going by the book as opposed to being sensitive towards the client's situation and presenting a solution or an approach according to the client's need (Daley, 1979)

The 3rd and final component of burnout diminished personal accomplishment, is characterized by a propensity to assess oneself negatively. This results in individuals experiencing a sharp decline in job competence, unsuccessful interaction with people as well as developing a perception of a lack of progress or even lost ground. A visible symptom is that of a troubled employee who is consistently receiving disciplinary citations from the supervisor.

1.2 The Burnout process

The burnout process has been conceived in various ways among different researchers. According to Maslach (1978, 1982) emotional exhaustion appears initially as excessive enduring work demands that lead to drainage in an individuals' emotional resources. The worker then adopts a defensive coping strategy, they exclude and alienate themselves from others and distance themselves psychologically. This act of depersonalization offers an emotional buffer between the imposing workloads and the individual. Eventually, individuals acknowledge the inconsistency between their original optimistic expectations and their current attitude about their potential contributions to the agency, organization, or society; resulting in experiencing a sense of insufficiency in terms of their ability to perform their jobs or relate to people.

Studies by Leiter (1988), Leiter & Meechan (1986), and Leiter & Maslach (1988) supported this model, though a study by Lee & Ashforth (1993) found only partial support. Others have argued, however, that there is no fixed sequence; one component is not a certain consequence of another (Schwab & Iwanicki, 1982a).

1.3 Burnout as a type of stress

Stress is defined as a mental, physical or emotional factor that causes bodily or mental tension in a medical or biological sense. Stresses can exist in two forms, external (environmental, psychological or social surroundings) or internal (illness or from a medical procedure). In simpler terms, stress can be described as a state of worry and mental tension caused by complications or obstacles in one's life, work, etc; incidences that induce intense feelings of anxiety or worry; physical force or burden.

According to Ganstar and Schaubroeck (1991), burnout is a type of stress, specifically, a chronic emotional response pattern to stressful work situations, featured with high levels of interpersonal contact.

McGrath (1976) & Schuler (1980) described stress as a complex situation in which a person is confronted with an opportunity, restraint, or demand of being/having/doing what one desires and for which the resolution is professed to have uncertainty but which will lead to significant results. This view can incorporate many different stress problems, including burnout. Shirom (1989) described burnout as a unique type of stress that has been defined and studied mainly as a pattern of responses to stressors at the workplace. The burnout response syndrome commences largely as the emergence of demands, including interpersonal stressors. Hence burnout can be described as a definitive type of job stress, in which a pattern of depersonalization, emotional exhaustion and diminished personal accomplishment (strains) derived from various types of work demands (stressors) particularly those which are interpersonal in nature. The notion of uncertainty is relevant to burnout and other stress which results from work demands and constraints.

As a stress phenomenon, the three-component model that burnout describes is special. Emotional fatigue, which is a typical stress variable, is at its heart. The second part, depersonalization is a new structure not previously included in the stress literature (Jackson, Schwab & Schuler. 1986).

Finally, while the stress literature is familiar with feelings of personal achievement (related to concepts such as self-efficacy), the third aspect of, a decreased degree of this element contributes to the statement that self-assessments are central to the experience of stress.

1.4 Antecedents of burnout

A systematic review study regarding the relationship between burnout and wellbeing by Hall, et. al., (2016) accumulated a vast number of study findings that show a positive correlation between these two factors. Wellbeing has been conceptualized as a spectrum, with a booming, at one end happiness with high wellbeing, and on the other end high depression, anxiety with low wellbeing (Johnson & Wood, 2017). Well-being depends on many human factors that can be latent or active (Saleh, A. M. et. al. 2014). Workload, long shifting work, high risk of accident and injury has a close connection with sleep disturbance, constant fatigue and high level of depression which impairs performance and alertness (Evans & Ball, 2001). It causes such burden that, one becomes preoccupied to resolve these extra burdens which ultimately reduces their day to day efforts on caring for themselves, for example, no eating on time due to work pressure, insufficient sleep, neglecting physical exercise, lack of time for recreation and intimate relationship, etc. These lacking reduce the capabilities of coping with stress and cause exaggerated burnout (Cordes & Dougherty, 1993).

Empirical research showed that, under a heavy workload, the basic communication skills of workers are usually interrupted and overlooked (Cordes & Dougherty, 1993). The more

incapacitated one’s communication system is, the more noteworthy his burdens and a sense of job burnout would be. The ability to communicate properly has often been emphasized as a primary factor, especially in caregiving employment (Shimizu, et. al., 2003). In the healthcare division, the capacity to communicate with patients is seen by some experts as the heart of all nursing care (Darban, et. al., 2016). These skills are so important that without them employees can feel a catastrophic sense of loneliness, anxiety, depression, low self-esteem, occupational failure, and service dissatisfaction (Hemsley B., et. al., 2012). Astonishingly, research suggests nurses' shortcoming in having proper communication or rapport with patients and clinical colleagues (Namdar H., et. al., 2009). What's more, poor communication skills are a solid obstruction to the enrichment of healthcare services (Amiri H., et. al., 2013). Communication skills are mostly procured and learned, and hence clinical experiences have a limited role in their development. At the end of the day, they can and ought to be educated (Zamani A., et. al., 2004).

Self-esteem is another factor associated with wellbeing as well as burnout. Many business and economics-related research brought that workers’ self-esteem increases in how they had been treated and valued by their leaders (Kwag & Kim, 2009). If the leaders use more appreciating languages, acknowledge their contributions with positive words, the self-esteem of the workers rises. On the other hand lack of appreciation causes a decrease in self-esteem and higher burnout. This need for appreciation and recognition has been described as ‘Stimulus hunger’ by Eric Bern in his theory ‘Transactional Analysis’. He chose the word “Stroke” to refer to this hunger. A stroke is a unit of attention that provides stimulation to a person. According to Bern ‘A biological chain may be postulated leading from emotional and sensory deprivation through apathy to degenerative changes and death. In this sense, stimulus hunger has the same relationship to survival of the human organism as food hunger’ (Bern, 1964). Researchers found

that 'stroking' which refers to giving appreciation and recognition plays a great role in boosting the level of confidence of others and reduces burnout (Namdar H. et al., 2009).

Scientific studies found one more variable to play an important role in wellbeing and burnout that is empathetic behavior and communication. A decrease in cognitive and emotive empathy in the workplace is strongly associated with the increase of burnout in every section - depersonalization, emotional exhaustion, and lower personal accomplishment (West, C. P. et. al. 2006). Empathy is positively associated with self-esteem, work engagement and emotional regulation (Wagaman, et. al., 2015) (Ben-Porat & Itzhaky, 2015). On the other hand, daily stress lessens empathy that increases the risk factor of burnout and compassion fatigue (Duarte, et.al. 2016).

The above discussion brought the idea that the antecedents of burnout are composed of many burdens, limitations and factors that can be seen by different variables. The various sources of literature available showed that the most demanding variables are **'communication skills'** where 'stroking' (recognition and appreciation) and 'empathetic communication' plays a vital role**.** At the same time, **'selfcare'** carries an immense influence on burnout, especially when one fails to manage stress properly. Below is an attempt to describe these variables –

1.4.1 Effective communication skill:

"Communication is the process of a transaction between people from which meaning is mutually derived" (Pearson & Spitzberg, 1990). Communication skills incorporate the ability to receive and give different kinds of information from one source to another. It may be verbal, written, or non-verbal, or a combination of several of these. It is a process characterized by change and action that never stops (Pearson & Spitzberg, 1990). These skills are a regular part of our day-to-

day work life, hence communicating in a clear, effective and efficient way is an extremely distinct and worthwhile skill. According to Andrew Salter (1949), assertiveness is the most effective communication that differentiates from aggressive and passive communication. He has been recognized as the originator of assertive training which gained importance in the late 1960s (Pearson & Spitzberg, 1990).

- **Assertiveness:** "Assertiveness is defined as the ability to communicate your own feelings, beliefs and desires honestly and directly while allowing others to communicate their own feelings, beliefs and desires" (Lange, & Jakubowski, 1978). In other words, assertiveness can be defined as being confident and self-assured with the absence of aggression. In the field of psychology and psychotherapy, it is an expertise that can be learned and reinforces innovative reasoning and effective communication.

Assertive communication includes regard for the parameters or boundaries of oneself as well as others. It additionally presumes an interest in the satisfaction of wants and needs through cooperation.

As per the coursebook Cognitive Behaviour Therapy (2008), "Assertive communication of personal opinions, needs, and boundaries has been ... conceptualized as the behavioral middle ground, lying between ineffective passive and aggressive responses" (O'Donohue, W. T. et al. 2012). Daniel Goleman stated such communication "stresses communicating emotions straightforwardly, in an efficient way that won't wind up into aggression" (Watling, C. 1996).

Summarizing from Pearson & Spitzberg, (1990), "aggressive communication" judges, undermines, lies, breaks confidences, stonewalls, and abuses others' limits or boundaries. At the opposite end of the spectrum is "passive communication". One may passively allow others to

abuse their boundaries. In the future, they may return and attack with a feeling of exemption or exemplary resentment. Assertive communication centers on the issue and not the person- it endeavors to rise above these limits and appeals to the common interest of all parties involved. However aggressive and/or passive communication will most likely lead to the termination of a relationship and decreased self-respect.

- **Empathy:** "Empathy is the capacity to understand or feel what another person is experiencing from within their frame of reference, that is, the capacity to place oneself in another's position" (Bellet, P. S., & Maloney, M. J., 1991). In other words, it's the capacity to place oneself in another's position. True empathy on both levels is attained when one person can see the other person's world from his/her point of view and can communicate this understanding back (Egan, 2002). When developed and nurtured properly, empathy enables to assist in improving other's mood and help them cope during challenging circumstances. It involves two specific skills – perception and communication (Patterson & Welfel, 2000) which are considered a key skill in the workplace as it facilitates to build productive teams, resolve conflicts and improve relationships with co-workers, clients, and customers.

According to Carkhuff, (1969) we show two types of empathy - primary empathy and advanced empathy. Primary empathy is the ability to respond in such a way that the other person can realize that he/she has been understood. It is conveyed through nonverbal communication and various verbal responses. In the language of Gladding (2004) "Primary accurate empathy involves communicating a basic understanding of what the client is feeling and the experiences and behaviors underlying these feelings". It helps to establish a good relationship.

Advanced accurate empathy replicates not only what a person state explicitly but also what they imply or state incompletely. It is a process of helping the person to explore themes, issues, and emotions new to his or her awareness (Patterson & Welfel, 2000).

Empathy can be fostered by attentiveness (the percentage of verbal and nonverbal behavior shown). Some verbal and nonverbal behaviors of showing empathy are as follows (Okun, B. F., 1997; Patterson & Welfel, 2000):

Table 1.1

Verbal and non-verbal behaviors to showing empathy

Verbal	Nonverbal
• Uses understandable words	• The tone of voice similar to helpee's.
• Reflects black and clarifies helpee's statement	• Maintain good eye contact
• Appropriately interprets	• Occasional head nodding
• Summarizes for helpee	• Facial animation
• Responds to the primary message	• Occasional smiling
• Uses verbal reinforcers (for example, Mm-mm, I see, Yes)	• Occasional hand gesturing
• Appropriately gives information	• Close physical proximity
• Answers questions about self	• Moderate rate of speech
• Uses humor occasionally to reduce tension	• Body leans toward helpee
• Being non-judgmental and respectful	• Relaxed, open posture
• Adds greater understanding to helpee's statement	• Confident vocal tone
• Phrases interpretations tentatively so as to elicit genuine feedback from helpee	• Occasional touching (with permission)

N.B. Patterson, E., & Welfel, E. R. (2000). The counseling process (5. bs.).

- **Stroke (recognition):** 'Stroke' is a term that indicates a 'unit of recognition' which has been coined by Eric Bern (Stewart & Joines, 1987). Woollams and Brown's definition (1979): "A stroke is a unit of attention which provides stimulation to an individual". For example, a

person is walking along the street, then caught sight of a neighbor coming in the opposite direction. As both were passing by, the person smiled and said: ‘Nice day’! The neighbor also smiled back and replied: ‘Yes, it is!’ Here the person and the neighbor exchanged stroke, which means both of them validated and appreciated their opinion at the same time, recognized their existence, which gave a feeling of warmth, acceptance, and positive regards to both people. Usually, this type of exchange occurs frequently that do not have been noticed, but suppose the scenario was a bit different and the neighbor did not smile or replied and walked past as if no one was there, how would it feel to the person? This is for sure that the person would be surprised at the lack of response and might ask himself ‘what’s gone wrong’. This gives an insight that getting a stroke or recognition is an inborn need of humans and lacking stroke feels deprivation. Research revealed that (Spitz, 1945) – each person has the need for **physical and psychological stimulation** (Stewart & Joines, 1987). He addressed this ‘stimulus hunger’. Berne described that “a stroke may be used as the fundamental unit of social action”. To him, stroke is the infant's need for touching, but as a grown-up, we still crave for physical contact and by the time we also learn to substitute other forms of recognition in place of physical touching. A smile, a compliment, a frown, or an insult – all show recognition to our existence. Bern used the term to describe the need for this kind of acknowledgment by others. Stroke can be verbal or non-verbal, positive or negative, conditional or unconditional. As a matter of fact, various studies and clinical observations have drawn a general conclusion that a negative stroke is better than no stroke at all (Bern, 1964; Woollams & Brown, 1979).

"Stroke filters" are mental filters that are worn all the time by people unconsciously (Woollams & Slanley, 1978). These filters allow only a portion of the strokes to reach the person while blocking and distorting others entirely. For example, if a girl thinks she is lovely, but not very

smart, the filter will allow the beauty-related strokes to pass but will block or distort any positive strokes related to smartness.

After a few years of Eric Bern, Claude Steiner (1974) contributed a valuable extension of the concept of stroke by adding another term 'Stroke economy'. It refers controlled stroking. When there is a limited-circulation of strokes, each person decides upon a particular system for handling the giving, taking and processing of strokes in order to satisfy a person's ever-present need for stimulation, and this is that person's stroke economy (Woollams & Brown, 1979). According to Steiner, our parents trained us with five restricted rules about stroking from childhood (Stewart & Joines, 1987) –

"Don't give strokes when you have them to give"

"Don't ask for strokes when you need them"

"Don't accept strokes if you want them"

"Don't reject strokes when you don't want them"

"Don't give yourself strokes"

Steiner considers that parents do this as a way of controlling their children. By doing this, parents gain the position of stroke monopolist. Knowing that strokes are essential, the child soon learns to get them by acting in ways that parents demand. But according to Steiner (1974), as grown-ups, we still unawarely obey these five rules. As a result, we use much energy in seeking out the strokes we still believe to be in short supply. Steiner mentioned that we are surprisingly deployed and burdened by agencies who manage to set themselves up in the role of stroke monopolist. These may be in different sectors, including government, corporates, advertisers, or entertainers.

To retrieve our awareness, spontaneity and intimacy, Steiner suggests rejecting the restrictive 'basic training' our parents imposed on us regarding stroke exchange. As a replacement for, we can be conscious that strokes are available in limitless supply (Stewart & Joines, 1987).

1.4.2 Selfcare

WHO (2021) characterizes selfcare as "the ability of individuals, families and communities to promote health, prevent disease, maintain health, and to cope with illness and disability with or without the support of a healthcare provider". It is pivotal for our physical, emotional and mental prosperity. Even though it is a straightforward idea in principle, it is something we disregard all the time. Likewise, selfcare is important to remind us that we and our needs are significant as well. It guarantees that one remains sharp, motivated and sound.

A most significant variable of burnout is subjective and quantitative job over-burden. Over-burden and the associated stress and exhaustion can bring less productivity, disorganization and depletion of emotion. Henceforth all sorts of health problems can be brought, from anxiety, depression to insomnia and heart diseases. People encountering qualitative overload feel they come up short on the fundamental abilities or talents to finish the task viably. Quantitative overload refers to the person's discernment that the work is impossible in the distributed time and causes a negative effect on stress, turnover, and job satisfaction (Abbasi T. F., 2015). Riaz Muhammad et.al (2016) found a positive relationship between job stress and employee job satisfaction in a study of 100 nurses from a hospital in Okara. In numerous institutions, this may come about in light of asset shortage and the constant threat of reduction or cutback. Thus staff laborers may regularly be over-burdened with cases, customers, or students (Alghamdi N. G., 2017; Malik O. F. et.al, 2010).

Job overload manifests itself as a scarcity in terms of food habits, taking rest, individual planning, recreation/entertainment, etc. that indicates a lack of selfcare. Any anomaly of the above segments enhances the degree of anxiety, depression, dissatisfaction, animosity and other kinds of negative feelings which legitimately impact an ideally tranquil and sound life. Empirical evidence recommends that enhancing selfcare can manage stress and practicing mindfulness can be used as an effective tool for stress management.

- **Stress management:** While a little portion of stress is a sound method to give us that poke to help comply with deadlines or finish overdue tasks, constant stress and anxiety can adversely affect psychological and physical wellbeing. Smart selfcare propensities like eating healthy, connecting with a friend or family member or, practicing meditation decrease the poisonous impacts of stress by improving one's state of mind and boosting energy and confidence levels (Duane, S. (2010).
- **Mindfulness:** Mindfulness is connected to psychological well-being hypothetically and pragmatically. The essentials of mindfulness are awareness and non-judgmental acceptance of moment-to-moment experiences that are considered as theoretically effective tools to combat against common forms of psychological misery—anxiety, worry, fear, panic attack, anger, and so on— which comprises maladaptive tendencies such as avoiding, suppressing, or over-engaging with distressing thoughts and emotions (Hayes & Feldman, 2004; Kabat-Zinn, 1990). "Awareness" refers to the observation and attentiveness of sensations, thoughts, or feelings of each moment which requires connecting both the ability to put attention on what is occurring, and to deliberately shift attention from one aspect of the experience to another. "Non-judgmental acceptance" in the context of mindfulness is the capability of experiencing events fully, without bottling

up to either extreme preoccupation with or suppression of the emotion rather paralleled with passivity or resignation (Cardaciotto, et. al., 2008).

1.5 Conventional burnout management programs

In the last twenty years Giga, et. al., (2003) reviewed organizational stress management programs that were based on scientific researches: PsycLIT (psychological), SOPAD (sociological) and Medline (medical), in which there is a glance of different types of programs. These programs differ usually with respect to objectives, types of intervention, structure and target group. DeFrank & Cooper (1987) designated that interventions can be provided in three levels:

i. Individual – to address the individuals revealing stress symptoms, construct greater awareness of the adverse effect of chronic strain, demonstrate arousal reduction skills and coping techniques. Intervention includes relaxation and meditation training, cognitive behavior therapy, exercise, time management, lifestyle counselling and education.
ii. Individual-organization interface – to address the role issue (role conflict and ambiguity), relationships at work, person-environment characteristics and employee involvement in decision making. Interventions include co-worker support groups, role feedback and clarification mechanisms and participatory decision-making programs.
iii. Organization – to address areas in the physical, organizational and social environments that may produce stress. Intervention includes organizational restructuring, selection and placement, training and job redesign.

Interventions can be given in some more levels, such as Preventive and curative strategies given by Matteson (1987); primary (stressor reduction), secondary (stress management) and tertiary (employ assistance program) adapted by Murphy (1988), etc.

1.5.1 Different conventional programs of organizational stress management:

Van der Hek, H., & Plomp, H. N. (1997) have described some of the programs that have been used commonly to manage organizational stress which has been grossly supported at the review study by Giga, Coop, & Faragher, (2003):

a) **Relaxation/meditation/mindfulness:** These methods are distinguished into two categories- one is physiologically oriented, aiming to achieve deep muscle relaxation through creating awareness on major muscle groups by contraction-relaxation; another category is a cognitive-oriented method aiming to achieve relaxation and awareness through imagery and mindful meditation. These are frequently used as complementary techniques in multimodal programs and have been evaluated as good examples of alternative methods (Murphy, 1988; Toivanen, 1993; Tsai, 1993).
b) **Biofeedback:** Biofeedback has been evaluated as a separate technique (Murphy, 1988) that usually implies in combination with relaxation. During relaxation exercise, the participants receive immediate feedback from an Electromyogram (EMG). This feedback can be provided by a finger thermometer and galvanic skin-resistance monitor. This method provides the participants an immediate response on the effect of the exercises that especially helps to teach the most effective way of achieving relaxation.
c) **Cognitive coping strategies:** This is based on the idea that human behavior and emotions can be stimulated by a change in cognition. There are two categories of cognitive coping strategies- the cognitive restructuring (aiming to reduce stress); and the

coping skill strategies (aiming to improve skills and competencies to meet the demands of the job). Numerous studies have been conducted using this intervention and have identified an effective way to manage stress (Michenbaum, 1977; Brunings, 1987; Bertoch, 1989; Butcher, 1988). The procedure attempts to modify individual thought patterns accept negative events favorably without attempting to change, discourage or control them (Bond & Bunce, 2000).

d) **Employ Assistance Program (EAP):** This intervention involves different forms of psychotherapy given to highly stressed individuals. EAP can be provided both in-house and outside of the organization (Cooper & Barkham, 1990).

Some more intervention programs also have been explored in recent years. Medisauskaite and Kamau (2019) applied a burnout management program to a group of doctors which was evidently successful. The program was comprised of giving education about stress and coping, cognitive intervention and encouragement of selfcare activity including mindfulness, relaxation and meditation, based on text written by the Royal College of Psychiatrists (Sunil, 2017). This finding approves the model of stress management by Judkins and Ingram (2002) that was provided to nurses and found effective.

Above all discussion, the findings brought some eye-opening psychological aspects as a reason for burnout where psychological interventions that have been found in the literature review can work to heal and manage burnout up to some extent. On that note, this research included three small studies on assessing need, development of the intervention and assessment of the intervention.

1.6 Burnout in the context of Bangladesh:

Burnout is considered a vital area of study for a wide range of disciplines as it tends to be costly in terms of loss of work time, lower degrees of profitability as well as an overall loss of the maximum potential of a human's capability. Around 30%-50% of the workforce have had occupational stress or burnout due to the overwhelming psychological stress they are exposed to at work. The workforce has been under excessive stress as they have to keep up with the changes in working life in terms of learning new skills or adjust to new kinds of work, time constraints and excessive pressure for an increase in quality as well as productivity. Liberation in Bangladesh has caused massive privatization and globalization through mergers and acquisitions which has had deleterious consequences on the job market causing the employment industry to be critically affected. There has been a sharp decrease in employment opportunities due to closures and voluntary retirement which induced high levels of psychosocial stress in the workforce. Even in the health sector or human services, the workers are required to do more with lesser returns, expected to attain over-ambitious goals/objectives and are burdened to produce instant success. Burnout has a profound organizational impact in the form of diminished productivity, lower product quality, decreased morale, high rate of absenteeism, increase in the rate of staff turnover, increase in workers claim for compensation, higher injury frequency rates as well as a greater demand on occupational health and safety, along with counselling services. A burnout population is often prone to alcoholism and drug addiction as well as various stress-induced illnesses. Burnout syndrome if left unchecked results in severe economic impacts on the organization and a psychological impact on the staff which should be prevented. The researcher's endeavor is to make individuals and organizations mindful of burnout which should be coined as a significant organizational health issue and should be addressed with top priority.

The spotlight has to be on organizational development as well as occupational health services which can assume a significant role in helping facilitate, listen and provide help centers for the burnout groups.

1.7 Rationale

The modern health-care framework may reap benefits from focusing on worker's mental prosperity and how to accomplish and sustain it within the stressful field of occupation, along with techniques/strategies to help change the health-care framework to permit sustained engagement. It's not only the absence of distress that should be used to define well-being. Resilient and efficient workers can be formed through programs teaching mindfulness, stress reduction procedures and effective communication skills. Longitudinal examinations looking at both well-being and employee distress are expected to recognize and actualize the mediations that have been demonstrated to be successful. Employee's commitment to a mindful communication program is related to both short and long-term prosperity and perspectives related to customer-focused care. This and other different mindfulness-based projects for doctors/physicians have decreased burnout levels (Goodman and Schorling, 2012). As a major aspect of this exertion, the researcher created, actualized, and evaluated a course to teach employees skills regarding effective coping and interpersonal communication skills and analyzed the effect of such on proportions of well-being including burnout, quality of life, and enthusiastic flooding inclinations. It has been conjectured that such training would prompt expanded personal satisfaction, productivity and product quality of employees and diminishes scores of burnout, emotional flooding, absenteeism, rate of staff turnover, etc. This will improve the work environment and create a positive atmosphere among the employees. Based on previous research, it is seen that the organizations affording full-time or part-time mental health services,

obtained a good environment for their workforces. In this context, hiring psychologists is recommended to bring a healthier environment to the organization.

1.8 Objectives

1. Assessing need of burnout management program in hospital settings.
2. Developing "Communication Skills and Selfcare Enhancement Program" for burnout management.
3. Evaluating the effectiveness of the intervention program by quantitative and qualitative assessment.

1.9 Research structure:

This research included three small studies which have been presented rationally and comprehensively chapter-wise.

Chapter 1 – General introduction consists of describing the concept of burnout which includes the definition of burnout, burnout process, burnout as stress and antecedents of burnout. This chapter also described the conventional burnout management programs along with Bangladesh's context of burnout, rationale, objectives, research structure, ethical consideration and the flowchart of the research.

Chapter 2 – Literature review

Chapter 3 (study 1) – Need assessment of burnout.

Chapter 4 (study 2) – This has been dedicated to the development of the intervention program that includes designing 4 workshop modules on stress management, communication skills, empathetic behavior and communication and stroke (recognition).

Chapter 5 (study 3) – This chapter is concentrated on the implementation of the intervention program in the job place and assessing the effectiveness through pre, post and follow-up treatment using the adapted scales as well as in-depth interview and verbal feedbacks of the participants.

Chapter 6 – This chapter is devoted to the general discussion which includes overall discussion taking into account all the studies. Results, the exceptionality of the thesis, applicability, drawbacks and recommendations are discussed.

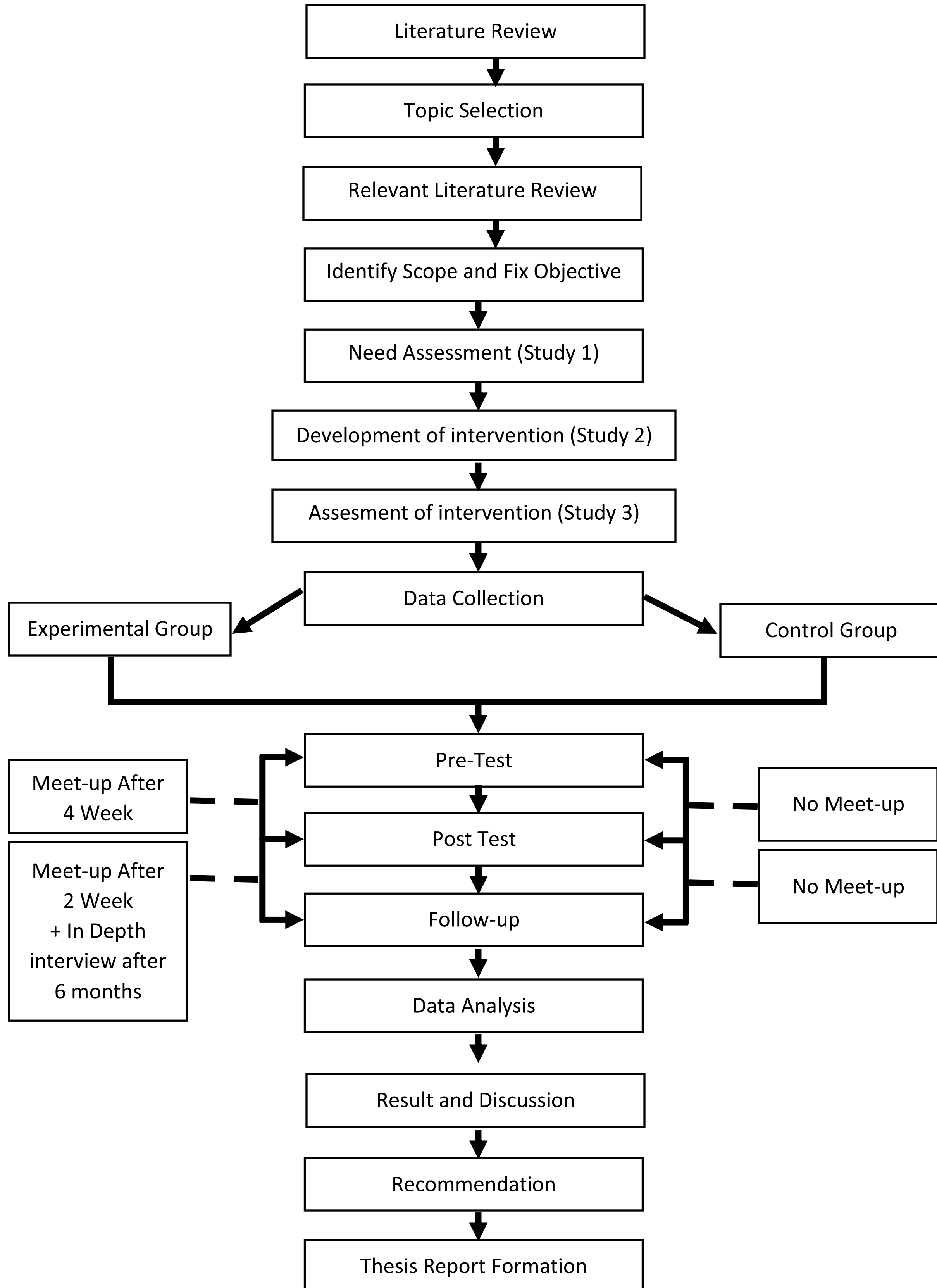
From chapters 3 to 5, all are presented with a relevant introduction, method, result and discussion sections.

1.10 Ethical consideration

The ethical approval was granted by the Ethics Review Committee of the Department of Educational and Counselling Psychology, University of Dhaka.

1.11 The flow chart of the research:

Figure 1.1: *Flowchart of the research*



CHAPTER -2

Literature review

Literature review

The greater part of organized research works on the notion of burnout has concentrated on people in the helping professions, explicitly health, social service and teaching. This is because burnout is considered to be most commonly and strongly experienced due to elevated levels of arousal from direct, frequent as well as intense interactions with clients. According to Maslach (1978) workers involved in helping professions are more prone to emotional strain due to constant interaction with other people and having to deal with their problems. Their work includes thorough and direct face-to-face communication under extremely emotionally charged conditions. Often this can lead to distressing and adverse interactions which can be exhaustive and emotionally taxing on the service providers. Leiter and Maslach (1988) explored the effects of various sources and categories of interpersonal contact in a mental health organization and discovered an immense occurrence of burnout caused by distressful interaction between the worker and supervisor.

According to VanYperen et.al. (1992), nurses have had an imbalance when it comes to their relationship with patients due to elevated levels of burnout. It has been seen that in the nursing profession there is an overwhelming task at hand, shortage of nursing staff, and poor social communication which ultimately leads to exhaustion and causes the nurses to quit (Poncet, et al. 2007; Kiani, et. al., 2016). Job burnout lessens the quality as well as the quantity of nursing care, prompts psychosomatic issues, expands work environment mishaps, and impedes social and hierarchical connections (Rhezaii, et.al., 2006).

Lately assertive communication skills training is widely appreciated to boost one's self-confidence, interactive relationships, and personal accomplishment (Delamater R. J. & McNamara J. R., 1986). In recent years this type of training in such skills has been accepted and

broadly acknowledged as an imperative behavioral intervention. It endorses impartiality in human relationships, enables to act in own best benefits, to raise for selves without excessive anxiety, to exhibit honest feelings easily, and to access own rights without harming human rights (Emmons A. and Michael R., 2001). In a pilot intervention of assertive communication skills at a hospital in Japan, Shimizu T. et al, (2003) found that the personal achievement and the two communication skills such as "accepting valid criticisms" and "negotiation" was notably improved through the training of the intervention group as compared with that of the reference group. The results were implicit that there might have a positive effect of communication skill training on burnout.

A study was conducted (pretest and post test) on two groups of nurses that consisted of a total of 60 persons with the intervention (Darban F. et al., 2016). It consisted of a workshop on communication skills training for the intervention group which took place for 2 days, 8 hours within a week. The results indicated a significant reduction in the intensity of burnout of the intervention group. Nurses trained with communication skills showed a marked improvement in self-efficacy, communication capacity under dire conditions which had directly impacted their mental well-being. Outcomes also showed an increase in adaptability, job productivity as well as success. It has also been seen that there was an improvement in being able to cope constructively with emotional exhaustion and depersonalization along with an increase in sense of individual achievement. Armstrong et al. (2004), in a study, explored the connection between communication abilities and job burnout among doctors who treat cancer. Results of their investigation indicated among the doctors who attended the workshops, 69% of them had emotional exhaustion and depersonalization and 60% had a feeling of personal accomplishment. The unprofessional or distressed behavior of physicians was inspected as part of a professional

advancement program conducted by Jennifer K. Penberthy et.al. (2018). This program was designed to assess the effect of burnout, quality of personal life, and emotional flooding scores of the doctors. The main goal of this program was to improve selfcare through mindfulness, effective communication skills as well as stress reduction which was evaluated in two phases – pre-intervention and post-intervention treatment. Participation and commitment in the programs lead to bring about a fundamentally continued reduction in average emotional flooding.

In the psychological wellness profession, numerous individuals are prone to compassion fatigue, where mindfulness can assist with guarding against it (Shapiro, et. al., 2007). Investigations from the previous decade show the advantages of mindfulness for both physical and mental wellbeing. Williams, I. D. et al. (2010) researched enhancing selfcare for clinicians and therapists to guard against burnout. They attempted diverse selfcare techniques over a range of a week or two through mindfulness meditation, autohypnosis, music, and spirituality. The results indicated that working these consistently assisted the members to be more present, in good connection with others as well as self, a stronghold on emotional flooding, increased awareness of turmoil of mind, reduced stress and botheration in regards to exams or upsetting communication. They could concentrate and improve a portion of their abilities by utilizing affirmation techniques. Also, music alongside spirituality became a viable instrument to alter the mindset and keep themselves at a sound pace.

Killian (2008) found some aspects of selfcare by interviewing clinicians (n=20), these are – having a positive work environment, keeping a social network, holding a sense of self-awareness, being hopeful, dealing with personal trauma history, acquiring consistent supervision, and reprocessing emotional issues with the peer. Moreover, clinicians' capability of maintaining

a family relationship, spiritual practice and regular exercise was found to be helpful as selfcare activity.

A research study conducted by Karimi R. et.al (2014) on 135 Iranian nurses with the purpose of analyzing the level of organizational stress as well as observe if the occupational stress affected by role overload, role conflict, and role ambiguity. The result showed the level of occupational stress is very high and there are noteworthy impacts of role overload, role conflict, and role ambiguity on it.

Salehe P., et. al., (2017) conducted a study on a group of nurses aiming to investigate the effectiveness of stress and burnout management training to help them to comprehend available resources and discover better ways to cope with stress in the workplace. The result found the stress and burnout management training proficient in reducing stress and burnout symptoms in nurses.

A pretest post test study (Stier-Jarmer M., et. al., 2016) aiming to evaluate the impact of an outpatient burnout prevention program in a mono-center health resort setting consisted of a three-week program including stress management intervention, relaxation, physical exercise, etc. was administered to 88 adults with a moderate level of stress. The program showed to be efficient in decreasing apparent stress, emotional fatigue and some other aspects.

CHAPTER – 3

Need assessment of burnout management program

3.1 Introduction

In the previous chapter, the literature review exhibited the global picture of burnout and the effectiveness of burnout management programs. To assess the actual need from the Bangladesh context the researcher conducted a focus group discussion (FGD).

Focus group discussion (FGD) is a good way of getting people with similar backgrounds or perspectives together to explore a particular subject of interest. It is a leading semi-structured interview conducted by a trained moderator. FGD is a qualitative research methodology that offers an opportunity for qualitative researchers to interview several respondents systematically and simultaneously (Babbie, 2011). In recent years FGD is commended and broadly used mostly for the reason of its power of convenience, economic benefit, strong face validity, and rapid results (Krueger, 1988). Researchers often support the idea that FGD is useful in the generation of data because of its purposeful use of social interaction (Merton et al., 1990). To elicit answers and engender thoughts among the participants, the moderator asks broad questions aiming the participants to produce the maximum amount of thoughts and opinions within a specific period.

3.1.1 Objectives:

1. To identify the everyday stress at the workplace that causes burnout
2. To recognize the existing coping mechanism
3. To assess the need for psychological intervention to manage burnout.

3.2 Method

3.2.1 Participants:

The FGD was conducted in a hospital setting with a mixed group of doctors, nurses and administrative officers. It was conducted for one and a half hours. Participants number was 12, among them 8 was male and 4 was female members. Their age range was between 20 to 45 years. Most of them belonged to the middle socio-economical state. The educational level ranged from S.S.C to post-graduation.

Table 3.1

Demographic statistics of participants of FGD

Participants	Total number of participants	Age range	Education level	Socio-economic state
Male	8	20 – 45 years	S.S.C. to post-graduation	Middle class
Female	4			
Total	12			

3.2.2 FGD protocol and procedure:

The FGD was conducted following a protocol used by UNHCR to the Lóvua refugee population at Angola, which has been given below

1. Welcome address: *Good afternoon. Thank you for joining us for the discussion*.
2. Introduction of the facilitator: Name and designation
3. Explain purpose: Clarify the objectives mentioned above in easy and understandable language.

4. Explaining the facilitator's role: *In the coming hour, I will conduct the session by asking questions. I am interested to listen to all the points of view in this room and will not interrupt the flow of the discussion.*
5. Ensure confidentiality: *I am committed to keeping your confidentiality, my interest is in your points of view, not in who said what. I kindly ask you to show respect for the confidentiality of each other and not to discuss when you leave this room. If you would like to share a related story from your society, please keep confidential the name of the people concerned or any detail that might reveal their identity. One more thing I want to notify you that I am taking notes of the discussion to keep records.*
6. Beginning with a small introduction of burnout.
7. Asking open questions to identify the everyday stress at the workplace that causes burnout and what they do to cope.
8. Asking for recommendations of psychological help to improve their situation using open-ended questions to encourage discussion and explore participants' points of view.
9. Summarizing key points by encouraging some general agreement (e.g., *to summarize what has been discussed today, you think…… Does this reflect the essence of what was said today?*)
10. Thanking participants for their time and spontaneous participation in the discussion and concluded with conducting a small breathing exercise.

3.3 Findings and Discussion

The findings from data generated by the FGD has been summarized below:

i. Related to 1st objective - everyday stress:

- **Suppressing emotions:** Participants expressed an eagerness to address the circumstances of their work stress and the effects of stress. This eagerness indicated that they have a deep desire to speak and are inclined to solve the situation. This lack of opportunity to speak generates a sense of bottling up, helplessness, emotional vulnerability, and above all, producing a suffocating working environment.
- **Emotional insecurity:** Dealing with patients who are not mentally stable, imposes a tremendous burden on them. Even though they have training in this area, there is still tension. Mental patients sometimes become aggressive and threaten the hospital staff physically, so they are often at risk of physical damage.
- **Lack of appreciation:** Every day they face a lot of crises and emergencies where they bring so many commitments but they realize at end of the day that no one recognizes their efforts. No one asks what they are going through for their commitments or pats them on their back for their dedication. They feel unacknowledged, unappreciated and demotivated to work which creates a rage, sometimes angry outburst also.
- **Lack of selfcare activity:** Nurses and word boys run for 12 hours, a very long shift. This is why, they have less time to spend on family, selfcare and leisure. Besides the wage range is not up to the mark so they do not spend much on living comfortably. So they sometimes experience an irritable mood, dissatisfaction with life, helplessness, job insecurity and so on. Overall persistent anxiety is caused by these recurrent negative feelings.

- **Psychosomatic issues:** Burnout manifests with some psychosomatic symptoms. They depicted to experience high blood pressure, indigestion, sleep disturbance, stomach ache, headache, frequent allergy attack eg. cold, dust, fever, chest pain, nausea, decreased or increased appetite, etc.
- **Lack of effective communication:** The communication style among them is not much healthy. Either they practice passive or aggressive or passive-aggressive style of communication. So, confusions, misunderstanding, occurs very often. Sometimes they get into an altercation with patients which lowers their quality of care.
- **Displacement of emotions:** They are unable to express all the frustration, rage and disappointment they have at work, which results in a displacement of negative emotions to other locations, such as at home, with a close one, or with a subordinate worker.
- **Lack of empathetic approach:** While they work in a mental health facility, they provide clinical services for patients, but the thing is the workers do not find a welcoming place to take this help for themselves because they have the stigma of using therapeutic help and on top of that, there is little support for their emotional problems from the management side.

ii. Related to 2nd objective - existing coping mechanism

- Mobile phone engagement for recreation, social networking, internet game, etc. 9 among them reported this.
- Most of them talking over the phone more frequently with friends and family as well as strangers also.
- Half of the members do share emotions with colleagues and gossip.
- Commonly passing a long time in front of the TV.

The FGD reflected that the workers work in a very stressful and stigmatized environment that critically impacts their professional and personal life. There are numerous reasons for burnout here, one of them is, serving mentally disordered people, another is long working hours and no opportunity for mental health care for workers. Besides these, there is a lack of empathetic and appreciating attitude in the office culture that minimizes motivation and quality as well as the quantity of care activity which refers support to the findings of Shapiro et. al. (2007). Their emotional burnout exhibited emergent physical symptoms that hamper their productivity as well as their physical health. This finding also justifies the previously mentioned study of Rhezaii et. al (2006) from chapter 2. An important finding of the FGD is the lack of effective communication skills which is common among the worker. Poncet et. al (2007) and Kiani et.al. (2016) found that poor social communication ultimately leads to exhaustion that inflames burnout. The FGD participants also depicted the hitches of poor communications like having altercation and displacing negative emotions to others instead of using assertive communication. Overall the findings showed that they have less idea of the benefits of selfcare and good communication skills which are intimately involved to manage emotional burnout.

From the FGD it was evident that the workers of the organization experience a huge amount of psychological burnout and there is a strong need for mental health care in the organization, which can help them to deal with the entire backlash they get from their job. This finding follows the 3rd objective of the study.

3.3.1 Recommendation

The FGD has created an opportunity to draw some recommendation -

- Offering psycho-education at all levels of the company to come over from stigma and get mental health assistance.
- Illustrating the advantages of selfcare and selfcare teaching methods, including techniques for stress management, mindfulness, relaxation, etc.
- Discussion of the effective communication style; exchanging of psycho-education of different styles of communication and its benefits and drawbacks, and teaching communication skills.
- Offering psycho-education on the advantages of an empathic environment at the workplace and exploring the strategies of being empathetic with others.
- Explaining the advantages of understanding and recognizing the contribution of other individuals and sharing strategies of giving recognition from the context of relevant psychological theories.

CHAPTER 4

Development of the intervention program

4.1 Introduction

The findings of chapter 1, 2 and 3 referred that, the given high prevalence rate and associated adverse effects of job burnout indicated the need for developing a psychological intervention program for workers. Considering the FGD recommendations and the existing literature review of burnout management programs, several aspects had been found to give psychological intervention; – improvement of communication skills, managing stress with more healthy coping strategies by increasing selfcare activities including mindfulness, breathing exercise, etc., giving education on empathetic behavior and stroking (recognition) and the techniques of showing empathy and stroke as both these factors have a close relation of increasing motivation at work and decrease job burnout (West, C. P. et. al. 2006). On this note, the intervention program of "Communication Skills and Selfcare Enhancement Program" was designated. It included four intervention modules–

- Stress management
- Communication skills
- Empathetic behavior and communication
- Stroking (recognition)

Stress management:

The U.K. Health and Safety Executive (2001) defined stress as "the adverse reaction people have to excessive pressures or other types of demand placed on them" (p. 5). Stress stimulates motivation and alertness positively by providing the incentive required to overcome difficult situations. Extreme, constant and unrelieved stress, however, can lead to anger, fear, and frustration and cause a number of short-term and long-term diseases with harmful impacts on

individual emotional and physical well-being (Giga, 2001). In taking measures to address stress in the workplace, there are possible gains for both organizations and employees, and both are likely to suffer if stress is neglected or mismanaged (Quick, Quick, Nelson, & Hurrell, 1997). Therefore, Organizations that strive to build and sustain a healthy atmosphere for their employees' physical, mental and social well-being must also adopt policies that concentrate on improving workplace health and safety issues (Cooper & Cartwright, 1997).

The FGD found a strong need to address the coping strategy of the workers with stress, on that point stress management had been included in the intervention module. Given the literature review on stress management program described by Van der Hek & Plomp (1997) and Giga, Coop, & Faragher, (2003), this module had been designed comprised of relaxation, meditation, biofeedback, CBT, etc. by which workers can get an opportunity to do more selfcare. The intervention of Eisen, Allen, Bollash, & Pescatello (2008) was also followed to develop the program to irradiate on - (i) evolutionary bases of stress, (ii) common physiological and emotional symptoms of stress, (ii) task and interpersonal workplace burdens that increase stress. Moreover, approximately 10 minutes were spent for mindfulness, deep breathing and mini-relaxation exercise at the end of each module following Eisen's (2008) intervention module.

Communication skills:

"Communication skills include the ability of the individual to interact effectively with others in the professional context" (Hargie, O., 1997). It may be verbal, written, or non-verbal, or a combination of several of these. These skills are a regular part of our day-to-day work life, hence communicating in a clear, effective and efficient way is an extremely distinct and worthwhile skill. There are several types of communication, but the most effective way is 'Assertive communication' (Vatankhah, H. et. Al., 2013). According to Vatankhah (2013) Assertiveness

includes actions that encourage a person to act on own interests and to stand up without irrelevant fear to adjudicate his/her rights and comfortably express rightful feelings or try to adjudicate own rights without damaging others rights. Using "Assertiveness", one can convey thoughts, feelings, and boundaries appropriately with keeping respect for other's rights, while maintaining positive affect in the receiver, along with the consideration of potential consequences of the expression (Zeigler-Hill & Shackelford 2017). In various work environments, the need for assertiveness is widely acknowledged, and one has to become assertive to handle the stress of working as part of a team every day (Butt, A., & Zahid, Z. M. 2015). It carries a vital role at the job place to avoid altercation and keep the work environment unwavering that greatly reduces stress burnout. In chapter 3, the FGD findings also depicted the need for assertive communication skills among workers and in this point, assertive communication training had been included in the intervention module to improve their communication skills. Researchers found that teaching communication skills to nurses improve such aptitudes in them and builds patients' fulfillment under critical circumstances (X Liu et al. 2015). As of late, teaching communication skills has become a piece of nurse training programs in developed nations (Curtis JR, et al. 2013).

Empathetic behavior and communication

Stueber, K. (2013) has defined 'Empathy' by two central features characterizing the social nature of human beings: the ability to understand what other people are thinking and feeling, and the ability to interact socially with other people. Empathy thus refers to a wide variety of psychological processes and phenomena related to our ability to understand the state of mind of another person and our ability to be influenced emotionally by how others feel and think about their situation, enabling us to feel like them, feel with them, and be concerned about them. The

FGD findings showed that people have less idea and practice on empathetic behavior and studies showed that giving education and training on benefits and ways of exhibiting empathy helped workers to cope with emotional exhaustion (West, C. P. et. al. 2006) (Kwag & Kim, 2009). Empathy includes listening attentively with giving proper respect by showing verbal and non-verbal cues, trying to understand the point of view of the other person and be respectful to their views as well without judgment; that refers to the psychological term "Empathy" in interaction. It helps the other person feel to be understood and satisfied, which lowers their level of stress (Moudatsou, et. Al., 2020).

Stroking (recognition)

Giving appreciation and recognition plays a great role in effective communication to boost the level of confidence of others (Namdar H. et al., 2009). The approach of appreciation has been courteously addressed by Eric Bern with the term "Stroke" in his theory of Transactional Analysis (Berne, E. 1961). Transactional Analysis (TA) is a theory based on the transaction; concentrating on the content of a person's interactions with one another. According to this theory, crafting change on interaction style is a stimulating pathway of solving emotional problems. Here 'stroke' has been defined as a 'unit of recognition' which plays a good role to build and continue effective communication. Stroking gives a sense of being acknowledged and belongingness; it helps to make a connection with others that is very important in the workplace to build a supportive environment among workers. So understanding different types of strokes and teaching how to practice stroking has been added as another module of training.

4.1.1. General objective:

The general objective of the present study was to develop an intervention program for workplace burnout management based on effective communication skills and selfcare.

4.1.2. Specific objectives:

The present study was carried out –

1. To develop a burnout management program consisting of four modules, that include Stress Management, Communication Skills, Empathetic Behavior and Communication and Stroking (recognition) to enhance communication skill capacity and selfcare.
2. To develop session wise modules to conduct the intervention program in job settings.
3. To assist employees to learn and practice skills needed to cope with burnout.

4.2. Method

4.2.1 Procedure of developing the intervention program:

The development of the intervention program “Communication Skills and Selfcare Enhancement Program” was carried out in the following three steps:

Table 4.1

The procedure of the development of intervention modules

1st step:	Reviewed literature that already has been mentioned at the introduction of this chapter to develop the draft modules on selected four aspects – stress management, communication skills, empathetic behavior and communication, and benefits of appreciation and techniques
2nd step:	The 1st drafts of the module had been submitted for review to the supervisors. After receiving their recommendations, necessary changes and modifications were made to the modules. Each module was designed for a one-hour duration, comprised of basic psycho-education of the concept, teaching the techniques and mindfulness to enhance selfcare.
3rd step:	Pilot execution of the 2nd drafts of all four modules on a small group (N=4). After getting feedback from the pilot execution final modifications were made for field test and the modules had been finalized.

4.2.2. Different techniques of the conducting workshop:

A number of techniques were considered to conduct the sessions which are described below -

- **Grounding activity:**

Grounding activity are things one can do to carry self into contact with the present moment – the present time and place. It is an approach to solidly anchor oneself in the present.

These activities can be fast approaches (like taking three deep "belly breaths") or more detailed formal activities (like meditation). There is no "wrong" approach to ground yourself as different approaches work for different people. The primary point is to keep the psyche and body associated and working side by side. Grounding exercises are useful to divert from distressing recollections, thoughts, or emotions. A few scenarios where grounding exercises work brilliantly are- when an individual gets caught up with intense emotions such as anxiety or anger, or occupied with stressful thoughts, or a flashback, or wake up from a bad dream with a palpitation.

- **Content discussion:**

Selected contents have been mounted up for this program which is brimming with applicable and crucial information and depicted in a simple comprehensible manner. Four modules have been enhanced with an acceptable measure of contents and appropriate examples. These contents have been given to the participants as a hand-out.

- **Role-playing**

Role-playing is a powerful training tool in both industrial and non-industrial settings (Beck, 2011) which has been propelled from the Social Learning Theory of Bandura, 1977. When the trainees rehearse and practice the effective behavior practices shown by the models, the behaviors that make up the particular skill are drilled until the individual can play out the skill precisely.

- **Question & answer**

This is a technique by which participants ask any kind of question regarding the content of the workshop and the facilitator answers them gently and elaborately.

- **Small group work**

Small group work is an effective method to motivate and engage the participants in the workshop, encourage active learning, and develop key to critical-thinking, communication, and decision-making skills. In this technique, participants are divided into several small groups and are assigned to complete selected content-related tasks.

- **Brainstorming**

Brainstorming is a group creativity technique by which efforts are made to find an assumption for a specific problem by gathering a list of ideas spontaneously contributed by the participants. In workshops, the facilitator initiates this activity by inviting the participants to share their ideas about the specific topic and note down all. After jotting down the ideas facilitator shares the original literature with them.

- **Interactive communication**

Interactive communication is a trade of thoughts where the two members are dynamic and can affect each other. It is a dynamic, two-route stream of information. It is useful to give and get the input and feedback that you need. An interactive method is a successful approach to make the content alluring, meaningful and all the more associating with the participants.

- **Mindfulness**

Mindfulness is where an individual uses a method, for example, care, or zeroing in the psyche on a specific article, thought, or action – to prepare attention and awareness, and accomplish an intellectually clear and emotionally calm and stable state. Mindfulness practices allude to the

conscious demonstrations of regulation attention through the perception of thoughts, feelings and body states (Hayes & Feldman, 2004; Kabat-Zinn, 1990). Mindfulness exercises include:

- Mindful non-critical consciousness of breath, body, sentiments, feelings as well as thoughts (in sitting meditation practice or for the duration of the day)
- Mindful walking meditation
- Mindful eating
- Mindful body scan in a sitting or lying down position
- Listening with non-judgment

It decreases stress and burnout, builds focus, versatility, compassion and respect, improves emotional regulation, and mental prosperity just as relational connections. Mindfulness methods have been remembered for this program as a selfcare procedure and support the members to be more aware of self.

4.2.3. Description of the modules:

4.2.3.1. Module 1 - Stress management

Objectives: Participants were able to -

- Define stress
- Recognize the stressors
- Identify major reasons for stress at work
- Learn coping mechanisms for dealing with stress

Materials: Projector, flip chart, marker.

Format: Interactive communication, brainstorming, verbal presentation using powerpoint

Table 4.2

Module 1# Stress management

SL	Activity	Time duration	Tool	Objective
1	Introduction & grounding activity- finding personality strength.	15 minutes	Paper, pen	Introducing selves and purpose of the session and Rapport building
2	Brainstorming - asking about the concept of stress, symptoms and sources of stress at their workplace	15 minutes	one to one interaction	To make them aware of their stress at the workplace
3	Defining Stress - definition, symptoms, sources and thought cycle	15 minutes	Powerpoint presentation	Giving appropriate knowledge of stress and the basic management
4	Mindfulness exercise – butterfly hug	10 minutes	Oral demonstration	To practice mindfulness for healthy mental health
5	Closing feedback	5 minutes	Verbal sharing	Understanding their feeling

Procedure:

Segment 1. Grounding activity

The facilitator acquainted herself with the participants and established some ground rules with them, after that the session began with "Positive resource enhancement" activity. Everybody was solicited to tell two of their quality that, and the facilitator listed down all of them. After the entire thing, the facilitator initiated to present all the characteristics in chorus. This activity functions as an advancement to the participants to being more aware of their qualities rather than zeroing in on their downsides. It builds their enthusiasm regarding the program just as functions as self-affirmation to improve confidence.

Segment 2. Brainstorming on Stress, symptoms and sources of stress

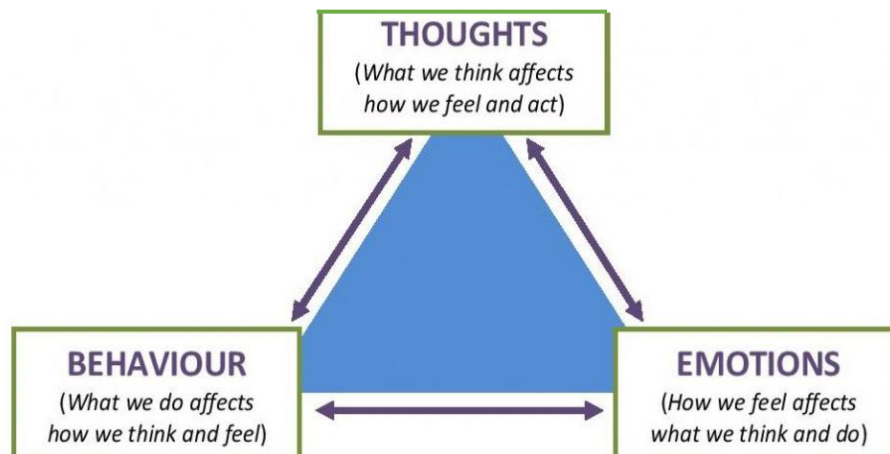
This content was presented with powerpoint presentation in lecture mode. The facilitator requested verbal sharing to the participants about the concept of stress, the symptoms and sources of stress with respect to their present working environment.

Segment 3. Definition of stress & coping

Stress is the body's response to any event that requires a response. The body responds to these progressions with physical, mental, and emotional reactions. Stress is a typical piece of life. One can encounter stress from one's current circumstance, own body, and thoughts. At the point when one discovers a discrepancy between the external demand and the internal assets then stress has been felt, which can be genuine or perceived.

Figure 4.1

Thought cycle



The negative thought cycle adds a huge part to the stress that has been shown above.

Coping with stress (Brainline organization article):

- Recognizing sources of stress, for example, - geographic portability, going to college, moving to another school, getting married, pregnancy, a new position, new lifestyle, divorce, death of a friend or family member, termination from the job, time compression, competition, financial issues, commotion, dissatisfactions and so on
- Identifying manifestations of stress – physical, emotional, psychological and behavioral
- Breaking negative thought cycle
- Body relaxation
- Physical exercise and yoga
- Meditation
- Counselling

Segment 4. Mindfulness

According to the article written by Crowe & associates, the Butterfly Hug is a famous stabilization instrument of EMDR Therapy (Eye Movement Desensitization and Reprocessing) intended to help ease anxiousness and promote calmness at the time. It is achieved by an individual when they fold their arms over themselves, so each hand touches the opposite upper arm or shoulder. They at that point move their hands like the wings of a butterfly, to tap their arms/shoulders in an alternating tempo. (as another option, the individual may very well tap their knees.) While tapping, inhale and exhale through the nose until begin to feel some relief.

The demonstration is as follows:

Figure 4.2

Butterfly hug

- Cross arms over the chest, placing the tip of the middle finger of each hand is set beneath the collarbone. Hand and fingers ought to be as vertical as possible, with the goal that the fingers point towards the neck and not towards the arms
- Eyes can be partially or fully closed
- Alternate the movement of hands, similar to the fluttering wings of a butterfly; let the hands move openly
- Aim to inhale gradually and deeply (abdominal breathing) while seeing, feeling and observing what is happening through the mind and body, for example, thoughts, images, sounds, smells, emotions without changing, driving the thoughts away, or being judgemental.
- Imagine as if watching resembles clouds cruising by
- Stop once feel the body has had enough and then lower the hands to thighs
- Whilst it isn't prescriptive about the time, this should be possible anyplace anytime, and may last only 3-4 minutes, making it a not so long exercise

Segment 5. Closing feedback

Participants were approached to share how they found that session, what noteworthy information they assembled, make an agreement of doing at least one activity as selfcare, for example, maintain a healthy eating regimen or take rest or physical exercise and so forth and utilize the butterfly hug at whatever point they need. After that concluded the meeting with thanks.

4.2.3.2. Module 2 - Communication skills

Objectives: Participants were able to -

- Define effective communication
- Identify the impact of effective communication at work and its need
- Describe different types of communication styles

Materials: Projector, flip chart, marker.

Format: Interactive method, role play, verbal presentation utilizing powerpoint

Table 4.3

Module 2# Communication skills

SL	Activity	Time duration	Tool	Objective
1	Butterfly hug as grounding activity	5 minutes	oral demonstration	For focusing on the session & manage immediate stress
2	Recap of the previous session	5 minutes	Large group sharing	To know about their understanding and practice of previous knowledge
3	Introducing the concept of effective communication and its necessity	10 minutes	Lecture	Explaining the necessity of effective communication
4	Role-playing of 4 types of communication style	15 minutes	modeling	Understanding the communication styles
5	Explaining 4 types of communication	10 minutes	Powerpoint presentation	Giving appropriate knowledge of different types of communication
6	Mindfulness exercise – Gratitude	10 minutes	Music & oral demonstration	To practice mindfulness for healthy mental health
7	Closing feedback	5 minutes	Verbal sharing	Understanding their feeling

Procedure:

Segment 1. Grounding activity

From the subsequent session, the butterfly hug was used to ground the members to help them focus as well as calm them from immediate stress.

Segment 2. Recap of the previous session

Participants approached to share what they accomplished for selfcare for the past week if they discovered anything supportive from the previous day's learning.

Segment 3. Introducing Communication skill concept

Communication is the demonstration of passing on connotations starting with one entity or group to another using commonly understood signs, symbols, and semiotic guidelines.

Segment 4. Role-play

The facilitator demonstrated by role-playing the 4 types of communication before the participants to give them an improved comprehension of it.

Segment 5. Types of communication skill

4 Types of Communication skills – Passive, Aggressive, Passive-aggressive and Assertive (online.alvernia.edu/articles/4-types-communication-styles)

Passive Communication

Passive communication is a style where people have built up a pattern of abstaining from communicating their opinions or emotions, securing their rights, and distinguishing and addressing their necessities. Thus, inactive people don't react plainly to terrible or anger initiating circumstances.

- Soft-spoken/quiet
- Allows others to exploit
- Priorities need of others

- Poor eye contacts/peers down or away
- Do not express own need or needs
- Lack of certainty

Aggressive Communication

Aggressive communication is a style where people express their emotions and opinions and promote their requirements in a manner that disregards the rights of others. Therefore, aggressive communicators are physically and verbally abusive. They regularly attempt to dominate others.

- Easily disappointed
- Uses blame, humiliation and domination
- Speaks loudly and domineering manner
- Reluctant to compromise
- Repeatedly interrupts or does not listen
- Rude towards others

Passive Aggressive communication

Passive-aggressive communication is a style wherein people seem passive on a superficial level but in reality are acting out anger in an inconspicuous, indirect, or behind-the-scenes way. Rather, they express their anger by unobtrusively subverting the object (genuine or envisioned) of their resentments.

- Resentment and resistance to the requests of others.
- Procrastination and deliberate slip-ups in light of others' requests.
- Skeptical, sullen, or hostile demeanor.

- Recurrent complaints about feeling undervalued or cheated.

Assertive communication

Assertive communication is the thing that one should all focus on, as it is the best of both worlds — addressing own issues and the necessities of the other individual; everybody winds up happy.

- Listens without interference
- Ready to compromise
- Evidently states need and wants
- Hold up for own rights
- Consider the need of others
- Confident tone and body posture
- Good in eye contact

How to be Assertive? (Pearson & Spitzberg, 2002)

- **The 3 C's Of Assertive Communication**

Confidence – believe in own capacity to deal with a circumstance.

Clear – deliver the message straightforward and clearly.

Controlled – convey information in a calm, collective and controlled way.

- **State "No" more frequently. First things first!**

For assertive conduct, it is necessary to relinquish the need to satisfy everybody and getting things done according to their desires. At the point when doing this, one might regularly feel disappointed and become more fragile whenever going to request something required. Assertive

communication implies being alright at saying precisely what is the need, however doing it to not offend the other person. This may mean dismissing things you decide are not a solid match for you, but rather than clarifying precisely why have been dismissed. "Because" is an incredible game-changer in correspondence. If one gives solid reasons and states them earnestly, nobody will be vexed that they have got a negative response.

- **Tone of voice.**

The self-control we referenced before ought to be utilized here. Voice should be relaxed; one should sound (and feel) calm. This can take some time, much the same as some other new skill. Be tolerant and don't get irritated on the off chance that people wind up raising their voice without acknowledging or hurrying a conversation since become disturbed. Assertive conduct also implies not indicating hesitation or harshness through voice. Keep it calm and friendly. Talking gradually and utilizing a calmer voice is normally enough to take balance back to the discussion.

- **Focus on the non-verbal communication**

By nonverbal, we imply body language, eye to eye connection, posture, listening cues, and responses. These ought to be managed with no feeling of aggression or passiveness. The former (aggression) will make the other individual go into safeguard mode, while the latter mentioned (passiveness) will cause them to feel disregarded. Keeping an eye to eye connection causes remaining focused. Additionally, it's a simple method to tell the other individual that they have been invested and cared about what they are saying. Expert opinion states that how one directs eyes and how long keeps contact can be much more significant than what has been said.

- **Be present**

The key to powerful communication and framing better connections is to be mindful of what precisely the other individual is attempting to say. Make an effort not to raise past issues or letting the mind get occupied—these come across as disrespectful and can make one lose focus (and hence there may have no option to offer an appropriate response or be assertive). Mindfulness implies being present and not thinking of anyone or anything else who's not around. Disregard the rest of the world, take a look at the individual who has been speaking with at that point, and listen effectively to all that they are saying.

- **"I message"**

It is conceivable to communicate strong emotions without expanding the contention by utilizing "I messages." They help keep the discussion moving the correct way. One can communicate emotions (dissatisfaction, disappointment, outrage, and so forth) and requirements without sounding harsh. "I messages" typically start with the words "I feel" so one won't come across being reproachful of the other individual. "I messages" assist one with taking liability for own thoughts and emotions as opposed to accusing the other individual.

Segment 6. Mindfulness (Gratitude)

A basic mindful gratitude exercise was directed in this session. Gratitude permits us to see the numerous blessings we have and distracts us from the numerous setbacks that we faced. Mindfulness assists us to respond to our mishaps with grace, acceptance, and meditation. Together these two practices support the more joyful self-inside us. Practicing gratitude can prompt noteworthy affectability to the experience of gratitude later on. And that looks good for everybody (Rozario & Das, 2019).

Demonstration (Rozario & Das, 2019) -

- Find a relaxed sitting position
- Take a second to center on self
- Now take a deep breath through the nose. Fill the lungs altogether with air, breathe out through the mouth.
- Take a couple of more deep breaths the same way.
- Now look back the life, recollect the positive things that occurred in life, notice the valuable blessing from God, recognize the beneficial things received each day (food to eat, family care, a bed to sleep, clothes, job and so forth) and say to God "I am grateful for … ." (my life, food, care, work and so on)

Segment 7. Closing feedback

As per the previous session participants expressed how they found that session, what noteworthy information they assembled, agreed with doing at least one activity as selfcare, practicing gratitude exercise every day and utilize the butterfly hug at whatever point they need. After sharing concluded the meeting with thanks.

4.2.3.3. Module 3. Empathetic behavior and communication

Objectives: Participants were able to -

- Define the concept of empathy
- Identify the contrast between empathy and sympathy
- Recognize the need for empathy
- Learn methods of showing empathy

Materials: Projector, flip outline, marker.

Format: Interactive method, verbal presentation utilizing powerpoint, group discussion, question & answer.

Table 4.4

Module 3# Empathetic behavior and communication

SL	Activity	Time duration	Tool	Objective
1	Butterfly hug as grounding activity	5 minutes	oral demonstration	For focusing on the session & manage immediate stress
2	Recap of the previous session	5 minutes	Large group sharing	To know about their understanding and practice of previous knowledge
3	Discussion on Empathy and Sympathy (Large group discussion)	5 minutes	Flip chart, pen, Powerpoint presentation	Understanding the concept of Empathy
4	Discussion on the need for Empathy (brainstorming)	5 minutes	Flip chart, pen, Powerpoint presentation	Recognizing the need for Empathy
5	Techniques of showing Empathy (verbal, non-verbal cues, active listening) (Lecture)	15 minutes	Flip chart, pen, Powerpoint presentation	Giving knowledge of appropriate techniques of showing Empathy
6	Mindfulness exercise – Forgiveness	10 minutes	Music & oral demonstration	To practice mindfulness for healthy mental health
7	Closing feedback	5 minutes	Verbal sharing	Understanding their feeling

Procedure:

Segment 1. Grounding activity

Butterfly Hug was utilized to ground the participants to focus as well as calm them from immediate stress.

Segment 2. Recap of the previous session

Sharing from past session learning and how they utilized their insight and what action they did as selfcare for last one week.

Segment 3. Concept of Empathy and contrast between Empathy and Sympathy

Empathy can be characterized as the ability/capacity to comprehend, feel or recognize what someone else is encountering from inside their frame of reference. At the end of the day, it is simply the ability to put in another's position. At the point when created and properly nurtured, empathy empowers to assist with improving other's state of mind and to help them adapt during difficult conditions. Empathy is viewed as a vital skill in the workplace as it encourages to assemble productive groups, resolve clashes and improve associations with co-workers, customers and clients.

- The distinction between empathy and sympathy

A common mistake is confusing empathy with sympathy, they are completely two different things. Sympathy is the point at which a person feels compassion, sorrow, or pity for the struggles suffered by another person, while empathy is the point at which a person comprehend the feelings of others and put self in the shoes of another (dictionary.com),

Segment 4. Discussion on the need for Empathetic communication at work

The facilitator assisted everybody to communicate their idea about empathetic communication and its need at the workplace.

Segment 5. Techniques of showing Empathy

The facilitator presented the following content by powerpoint presentation

Listen actively.

Listening is one of the best ways you can exhibit empathy to others. When a person is rehearsing active listening, he or she is tuning in with purpose and truly taking in what the other individual is saying. Egan, 2002 has summarized five nonverbal skills involved in active listening by the SOLER model-

- S = Sit squarely confronting the individual. Try not to let gazing float everywhere.
- O = Open posture, don't cross hands or legs, so the individual sitting opposite can feel the openness to acknowledge him in the manner in which they are. Utilize some significant signals, head gesturing, state some promising words like hmm, oh, carry on, I can understand and so forth.
- L = Lean forward, so the person on another side can feel that they are important.
- E = Eye contact. Look at the eyes of the speaker (don't gaze, yet attempt to keep eye contact. However, eye to eye contact is socially based. Certain people feel it's discourteous and numerous autistic individuals feel compromised by it)
- R = Relax while listening.
- Two additional things are required to active listening -

- **Paraphrasing,** what the individual said to show that has been properly comprehended.
- **Reflecting** emotional response. It is a vital part of empathy since it enables the individual to more readily comprehend and manage their own feelings.

- **Being non-judgmental**.

This is a significant step while rehearsing empathy and mindfulness. It tends to be truly difficult to retain prompt judgment, particularly when first meeting or collaborating with a person. But then, this is a vital footstep towards being empathetic. However, being judgemental can make the other person feel impervious to share his pain, so keep reminding self only to listen to the individual, not to pass judgment.

- **Opening up.**

Sometimes simply listening to somebody may not fabricate a bridge with a person. Emotional open-up sincerely is an inconceivably troublesome and courageous activity as it will develop and strengthen the connection with another person.

- Empathy is a two-way road. It's tied in with sharing pain and an emotional connection. To rehearse empathy at times it is useful to impart one's own internal scenery to another person as they reciprocate.
- This is not necessary to spill the full biography to each individual. One can choose the person to whom to share, but in practicing empathy, one must be available to the opportunity as well as the possibility of opening up, particularly with the individuals that have been chosen.

- **Offering physical affection.**

Of course one cannot do this for everybody and, clearly, physical affection should be given to somebody with permission to ensure that it is alright (regardless of whether you've known them for some time). Demonstrating physical affection, in any case, can help increasing oxytocin levels and makes to feel better.

- Physical affection can be shown in many ways, giving hug, or putting an arm around the shoulders, or a hand on their arm. In addition to the fact that this will show they have been given full attention and will build a good connection.
- Oxytocin has been known to assist individuals to decipher others' feelings, so a consensual embrace can develop emotional intelligence and empathetic connection.

- **Offering help.**

This shows seeing somebody experiencing difficulties and taking some attempt to make life simpler for them. Offering help is an extraordinary demonstration of empathy since it shows that a person is willing to lend a hand without expecting anything consequently. Gestures can be as basic as keeping the door open for an individual who's entering the same building or purchasing a coffee for the individual behind in line.

Segment 5. Mindfulness (Forgiveness)

Forgiveness has been largely characterized as a cognizant, thoughtful decision to release emotions of rage or retaliation toward an individual or a group who has hurt, whether or not they really merit forgiveness. Forgiveness doesn't refer to forgetting or supporting or pardoning offenses. Forgiveness doesn't eradicate the past, however, views it with empathy. To retain forgiveness keeps alive feelings of hurt, rage and blame which stain one’s view of life. To

forgive, abstain from ruminating on contemplations of being violated. Forgiving intends to relinquish scorn, rather than permitting it to eat you (Rozario & Das, 2019).

Forgiving is not passive, however an active offer of delivering emotions like anger, guilt, and hatred, all of which drain us if we lost ourselves in them. Forgiveness demands presence, advising us that we are not equivalent to the emotions we have in a given circumstance, nor is the individual who we've hurt or who has hurt us (Rozario & Das, 2019).

Customarily, the meditation is done in three sections (Rozario & Das, 2019):

- First, asking forgiveness from those who have been harmed;
- Next, extending forgiveness to the individuals who have hurt; and
- The last practice is that of self-forgiveness, for those occasions we hurt ourselves with judgemental habits of mind.

Demonstration (Rozario & Das, 2019):

- Sit comfortably, and permit the breath to be natural. Start by silently (or discernibly) reciting phrases of forgiveness for those who have been hurt. Recitation can be, “If I have hurt or harmed anyone knowingly or unknowingly, I ask their forgiveness.”
- Notice what comes up. It may find that offering forgiveness to one individual may catalyze recollections of another predicament or individual. Try not to drive these emotions or cognitions away—however keep up attention on the activity, and don't lose all sense of direction in blame or self-guilt about distraction. As different contemplations emerge, guide forgiveness in these new ways.
- Next, start offering forgiveness to the individuals who have caused hurt: "If anybody has harmed or hurt me, purposely or accidentally, I forgive them."

- Once again, pondering past excruciating encounters may trigger emotion. As these emotions, images, and recollections bubble to the surface, simply may recite, "I forgive you."
- Finally, direct concentration toward forgiveness of ourselves. A large portion of people have encountered self-blame—at work, relationships, or simply that have been constantly tried to maintain selves in patterns of perfectionism or compulsiveness. "For all of the manners in which I have harmed or hurt myself, intentionally or unwittingly, I offer forgiveness."

Segment 7. Closing feedback

Participants shared their feeling and learning of the session, make an agreement of doing some selfcare exercises for next, and utilize the butterfly hug and all the mindfulness at whatever point they require.

4.2.3.4. Module 4. Stroking (recognition)

Objectives: Participants were able to -

- Define the idea of stroke
- Learn various types of stroke
- Practice various types of stroke

Materials: Projector, flip chart, marker.

Format: Interactive method, verbal presentation utilizing powerpoint, small group work, question & answer.

Table 4.5

Module 4 # Stroking (recognition)

SL	Activity	Time duration	Tool	Objective
1	Butterfly hug as grounding activity	5 minutes	oral demonstration	For focusing on the session & manage immediate stress
2	Recap of the previous session	10 minutes	Large group sharing	To know about their understanding and practice of previous knowledge
3	Introducing the concept of Stroke	5 minutes	Powerpoint presentation	Explaining the necessity of practicing stroke
4	Explaining 5 ways of practicing Strokes	10 minutes	Powerpoint presentation	Giving appropriate knowledge of different types of Strokes
5	Practicing 5 ways of practicing in a group	15 minutes	modeling	Understanding the Stroking styles
6	Discussion on stroke economy	5 minutes	Lecture	Giving psycho-education about the restriction of practicing stroke acquired from society
7	Mindfulness exercise – Acceptance	10 minutes	Music & oral demonstration	To practice mindfulness for healthy mental health
8	Closing feedback	5 minutes	Verbal sharing	Understanding their feeling
9	Post test	10 minutes	Scales	To measure the difference of training variables

Procedure:

Segment 1. Grounding activity

Butterfly Hug was utilized to ground the participants to focus as well as relieve them from immediate stress.

Segment 2. Recap of the previous session

Sharing from previous learning and how they utilized their insight and what activity they did as selfcare for the most recent week.

Segment 3. Benefits of recognition and concept of Stroke

Stroking, the term picked up by Eric Bern (1964) is a unit of 'recognition' that has been observed as essential in the workplace. It is consequently another attempt at creating effective communication. Stroke can be practiced by recognizing one another verbally or non-verbally, conditionally or unconditionally, even positively or negatively (Stewart & Joines, 1987). For example:

- Hello (verbal) or a smile, hug, nod, wave, and shake hands (non-verbal).
- Well done, you have done a great job! (positive) or go away, a frown (negative).
- You did that well (conditional) or you are wonderful (unconditional).

Segment 4. Ways of practicing Stroke

There are 5 different ways of practicing stroking (Stewart & Joines, 1987):

- Giving
- Asking

- Accepting
- Rejecting
- Self-stroking

Segment 5. Practicing Stroke (small group exercise)

The facilitator separated the members into a group of four and demonstrated them to practice stroke giving, asking, accepting, rejecting and self-stroking to one another. Just as verbal – non-verbal, positive-negative and conditional-unconditional stroke.

Segment 6. The Stroke Economy

According to **Claude Steiner,** society has created a system to control and compete in the giving and receiving of strokes in a person. The system is as follows (Stewart & Joines, 1987) –

"Don't give strokes when you have them to give"

"Don't ask for strokes when you need them"

"Don't accept strokes if you want them"

"Don't reject strokes when you don't want them"

"Don't give yourself strokes"

Attachment to these standards can cause various issues in relationships.

Segment 7. Mindfulness (Acceptance)

Mindful acceptance does not mean to accept a terrible circumstance, it is tied in with accepting the emotions and suffering that can come from an awful circumstance and understanding that these sufferings are made simply by our own minds and can be overseen in an undeniable

manner while a person tackles the circumstance that is causing the distress (Rozario & Das, 2019).

Demonstration (Rozario & Das, 2019):

- Focus on the breath. Take a couple of full breaths, prior to subsiding into natural breathing.
- Recognize the thoughts floating off. Try to develop the ability to perceive when that is occurring without becoming mixed up in the story-line. Simply comment 'thinking, thinking' and bring back attention to the breath.
- Bring to mind a circumstance or issue that is creating suffering at present (think relational clash, monetary pressure, or work-related stress). Question to self 'how am I feeling about this?' and notice the body sensation. Give specific consideration to the throat, chest and stomach.
- After naming the experience, inquire as to whether it is actual. If not, proceed with the inquiry. Bring back the attention to the body whenever lost in thoughts.
- Continue in this manner for a few minutes, inquiring, pausing as well as focusing in a tolerant and nonreactive manner. Maybe the answer will start to develop and disentangle. Be relaxed and patient—with time, as tuning in to heart, the most profound longing will rise.

Segment 8. Closing feedback

Participants shared the learning of the session, made an agreement of doing one activity as selfcare, for example, maintain proper eating regimen or take rest or workout etc. and utilize the butterfly hug at whatever point they need.

Segment 9. Post test data collection

Collection of the post-test data. After that end the meeting with thanks.

4.2.4 Pilot test of the modules

4.2.4.1 Participants:

The researcher conducted a pilot execution of the modules with a group of 4 members.

Table 4.6

Demographic information of the participants of the pilot study

Number	Male	Female	Age range	Education	Profession	Social class
4	1	3	25-30	H.S.C to MSc	Private job	Middle

4.2.4.2 Procedure:

Four modules had been conducted in two weeks on four different days. Participants were clearly described the purpose of these sessions and with their consent, this pilot testing was done. According to the feedback and suggestions, minor changes were made. Thus the modules were finalized for the field test.

4.3. Findings & Discussion

The purpose of this study was to develop an intervention program for job place burnout management. With this goal, the researcher developed the burnout intervention program named "Communication Skills and Selfcare Enhancement Program" comprised of four specific intervention module - Stress management, Communication skills, Empathetic behavior and

communication, and Stroking (recognition). These modules were developed based on available literature and the findings of the need assessment and the researcher's own understanding, comprehension and judgment. Each module was designed to deliver in one-hour duration consisted of various techniques – grounding activity, content discussion, role-play, brainstorming, small group exercise, question and answer and mindfulness exercise. The whole program was designed to deliver interactively.

The first module 'Stress Management' was developed based on the intervention program of Eisen, et. al., (2008). This module was aimed to educate about stress, identifying the sources of stress, the symptoms reflected from stress (physical, emotional and cognitive), healthy coping strategies and introduce a simple technique of mindfulness, in-short, especially this module was to shed a light on the beneficence of selfcare. In the end, the participants shared the noteworthy information they assembled, made an agreement of doing at least one activity as selfcare every day and the facilitator thanked them for their cooperation.

The second module 'Communication Skills' was developed by studying different communication skills training from various previous researches (Vatankhah, H. et. al., 2013) (Zeigler-Hill & Shackelford 2017) which found that coping with emotional exhaustion and depersonalization was notably improved through communication skills training as well as increased adaptability and job productivity (Darban et. al., 2016). This module consisted of giving psycho-education about different types of communication, the pros and cons of each type of communication, identifying the most effective way of communication and the techniques. Starting with a small grounding activity, the participants shared their previous seven days' activity of selfcare as per their commitment. There was a role-play activity of different types of communications in the

session and also a mindfulness exercise, regarding gratitude to bring awareness to the numerous blessings. The session was concluded similarly to the previous session.

The third module 'Empathetic behavior and communication' was developed aiming to enhance effective communication and selfcare as studies found that training on empathy helped workers to feel understood and satisfied that lowers their level of stress and reduces burnout (West, C. P. et. al. 2006) (Kwag & Kim, 2009), (Moudatsou, et. al., 2020). This module was comprised of the concept of empathy, differences between empathy and sympathy, benefits of empathy and techniques of showing empathy with a grounding exercise, sharing and brainstorming activities. The mindfulness exercise included in this module was about creating awareness of forgiveness. The concluding part was almost the same to each module by verbalizing learning of that day and saying goodbye with a commitment to practicing a selfcare activity.

The fourth module 'Stroking (recognition)' was aimed to coach about giving recognition and appreciating to others, benefits of stroke and teaching the techniques of stroke which plays a great role in effective communication to enhance the level of confidence (Namdar et al., 2009). With this purpose this module also progressed with a grounding activity, previous session recap and sharing the experience of practicing selfcare activity, explaining the concept of stroke, five types of strokes and the benefits. There was a small group activity for practicing strokes among them. Afterward, the session was closed with a mindfulness exercise to create awareness of acceptance.

After the development of the whole program, the researcher applied these four modules to a small group (N=4) as a pilot test in two weeks' duration. The participants found the whole program very much useful containing notably relevant psycho-education and management techniques. The role-play of various communication styles was very much appreciated by them.

They mentioned 'the role-play was the catchiest part of the whole program' which has had a profound effect on their mind. The 2nd attractive part mentioned by them was 'types of Strokes' where different people found different lacking in them. The stroke exchange activity within the group was a completely new discovery for them. They reported to increase awareness of emotional difficulties and a sense of getting back a stronghold on emotional flooding, able to focus more in present, identified their passive communication styles and behaviors as well as taken small steps to be assertive, more focusing on listening instead of talking and that helped to keep a good connection with others. Moreover appreciating self and others also gave a feeling of belongingness and gratification that also helped to be more grounded in their place. The feedbacks of the participants also approved the previous findings of researches on selfcare and communication skills training (Moudatsou, et. Al., 2020) (Shapiro, Brown & Biegel, 2007) (Williams et. al., 2010).

Following are some of the verbatim comments of the participants:

"Finally I could switch off my official mobile phone after 8 pm and feeling relieved."

"I liked the Butterfly Hug! It is so soothing.."

"For me attending this program was a kind of having a tour inside me"

"I feel refreshed after the mindfulness activity"

"Now I can reject my supervisor's mockery and insulting attitudes"

"I feel relaxed here to share my feelings, it helped me to let go of some of my previous pain. It was helpful attending this program"

"It was so helpful and I would be very happy to participate in this kind of program next".

Based on the feedbacks of the participants' few modifications and changes were made and thus the modules were finalized for field assessment.

Considering the evidence from the pilot test, it can be assumed that the intervention program of "Communication skills and selfcare enhancement model" is likely to manage job place burnout. This possibility was examined and the findings are presented in the next chapter.

CHAPTER 5

Assessing Effectiveness of Intervention Program

5.1 Introduction

In the previous chapter, the intervention program of "Communication Skills and Selfcare Enhancement Program" for burnout management was developed considering several steps. The present chapter describes the effectiveness of the intervention program in the workplace through qualitative and quantitative measures. The effectiveness of various burnout management programs has been found previously in different studies (Van der Hek, H., & Plomp, H. N., 1997; Giga, Coop & Faragher, 2003, Medisauskaite and Kamau, 2019; Judkins and Ingram, 2002). The program was designed with the purpose to reduce burnout in job place by educating various types of effective communication that have a rigorous and direct impact on stress and encouraging to practice more selfcare to cope with stress. So the program has focused mainly on two aspects:

a) Educating and teaching various types of effective communication
b) Engaging with more selfcare activities by mindfulness, giving selfcare home tasks, healthy stress management techniques, etc.

However the main purpose of this study was to observe the effectiveness of the program in the case of burnout management, the previous literature found (Rhezaii, et.al., 2006; Delamater R. J. & McNamara J. R., 1986) some more variables that are closely related to burnout such as level of anxiety and depression, general health condition and mental wellbeing. So these were also measured along with burnout.

5.1.1 General objective:

The objective of the present study was to assess the effectiveness of the intervention program in the hospital setting by multiple qualitative and quantitative measures.

5.1.2 Specific objectives:

To assess the effectiveness of the developed intervention program through

i) Shimul Burnout Inventory (SBI; Asheek Mohammad Shimul and Shaheen Islam, 2009)

ii) Hospital Anxiety and Depression Scale (HADS ; Zigmond and Snaith, 1983)

iii) Bangla Warwick Edinburgh Mental Wellbeing Scale (WEMWBS)

iv) Bengali version of General Health Questionnaire (GHQ-12)

v) Verbal feedbacks and in-depth interview of the participants

5.2 Method

5.2.1 Participants:

The current research was conducted at two different hospitals in Dhaka. Participants included doctors, therapists, hospital directors, nurses, ward boys and organizational officers of the hospitals. The overall number of participants was 62 of which 30 were the experimental group and 32 were the control group. For the control group 33 data was collected at pretest, but till follow-up 1 participant dropped out, so 32 data were included. On the other hand, there was no dropout of participants in the experimental group. The group comprised with 33 male and 27 female members. The age range was from 23 to 47. A large portion of the members belonged to the middle-income group. The educational level ranged from S.S.C to post-graduation.

Table 5.1

Demographic information of the participants of field study

Experimental group							
Number	Dropout	Male	Female	Age range (years)	Education	Job duration	Socio-economic status
30	0	12	18	25-47	H.S.C-MBBS/M.Sc	1-20 years	Middle
Control group							
Number	Dropout	Male	Female	Age range (years)	Education	Job duration	Socio-economic status
32	1	20	12	23-47	S.S.C-MBBS/M.Sc	1-20 years	Middle

5.2.2 Sampling:

Due to the COVID-19 pandemic, a convenient sampling method was applied in this study. Henceforth, it was impractical to incorporate various organizations to bring them under investigation. Among the hospital employees, those who were agreed to participate in this study were randomly assigned to two groups. At the same time, the researcher was conscious about the minimum equality of distribution in terms of gender, education and job position. After dividing into two groups, experimental and control group was selected randomly.

5.2.3 Design

The research was conducted through a pretest post test design. The experimental group was given four workshops on selfcare and communication skills, which were conducted for an hour once a week. Data has been gathered in three intervals; before providing the workshops, subsequent to completing workshops and following 15 days of the program as a follow-up.

Control group data were also recorded simultaneously without giving any workshops. After 6 months there was another follow-up conducted by an in-depth interview with some available participants of the experimental group. The research design was as follows:

Table 5.2

Design of the study

Experimental group	Pretest (GHQ, SBI, HADS, WEMWBS)	Intervention (once in a week for subsequent four weeks)	Post test (same data) Immediately after administration of intervention	Follow-up (same data) after 15 days of the course	In-depth interview follow-up after 6 months to available(3) participants
Control group	Pretest (GHQ, SBI, HADS, WEMWBS)	No intervention	Post test (same data) after four weeks of pre-test	Follow-up (same data) after 15 days of post-test	No follow-up

5.2.4 Instruments:

The current study utilized the accompanying research instruments for gathering information:

- One demographic and personal information questionnaire
- Shimul Burnout Inventory (SBI; Asheek Mohammad Shimul and Shaheen Islam, 2009)
- Hospital Anxiety and Depression Scale (HADS; Zigmond and Snaith, 1983)
- Bangla Warwick Edinburgh Mental Wellbeing Scale (WEMWBS)
- Bengali version of General Health Questionnaire (GHQ-12)
- Intervention program: Communication Skills and Selfcare Enhancement Program (see chapter 4)

- In-depth interview process (Cao, H. J. et. Al, (2020).

5.2.4.1 Demographic data and personal information questionnaire:

This survey gathered information on name, sex, age, education, marital status, socio-economic background, profession and duration of work. Name was required in light of the fact that it was a pretest post test design where data has to be compared, therefore appropriate confidentiality contracts were enforced.

5.2.4.2 ***Shimul Burnout Inventory (SBI; Asheek Mohammad Shimul and Shaheen Islam, 2009)***

SBI (Shimul Burnout Inventory) is a self-regulated scale comprised of 25 items created by Asheek Mohammad Shimul and Professor Shaheen Islam in 2009 to measure burnout of professionals in Bangladesh. It was developed by applying a sum of 40 experts from various professions of Bangladesh. For developing the SBI, a standard psychometric methodology was preserved such as item analysis, factor analysis, reliability and validity. This is a six-point Likert type scale where the response choices are limited to 'I feel never', 'a few times in a month', 'a few times in a week', 'once in a week', 'more than once in a week' and 'everyday'. For positive items, scores are assigned 1 to 6 accordingly mentioned above and for negative items reversed scoring is followed. Just four items are negative, item numbers 13, 21, 22, 23, where the scoring is reversed. Scores acquired by a subject in all the 25 items are included and the subsequent absolute score is utilized as the index of burnout of the employee. The highest and the least conceivable absolute scores in this scale can be 150 and 25 individually with 87.5 as the midpoint. The higher the score, the higher the burnout of the employee. Various psychometric analysis showed that the scale has test-retest reliability coefficient, $r = 0.803$, $p < .01$, Cronbach

Alpha coefficient $\alpha = 0.87$. The scale has also satisfactory levels of face validity as well as discriminants ($r = -0.33$, $p < 0.05$) and criterion-related validity ($t = 2.971$, $p < 0.01$).

5.2.4.3 Hospital Anxiety and Depression Scale (HADS; Zigmond and Snaith, 1983)

Hospital Anxiety and Depression Scales (HADS) has been created by Zigmond and Snaith (1983) that was utilized to index anxiety and depression. The HADS is a self-report questionnaire created to identify the condition of distress in patients. The HADS has been translated and approved in Bangla by K.A. Chowdhury, Dept. of Clinical Psychology, DU. Four score ranges were used for both of the sub-scales which are classified 'normal' (0-7), 'mild' (8-10), 'moderate' (11-14), and 'severe' (15-21) (Zigmund & Snaith,1983)

Individuals are identified as not clinically depressed/anxious (total score on each sub-scale <8), borderline (score 8-10), or clinically depressed/anxious (score>11). The internal consistency of the two sub-scales as assessed by Cronbach's alpha was 0.93 for anxiety and 0.90 for depression (Moorey et al 1991).

The translation reliability of the Bengali version of HADS was ascertained for both the anxiety and depression sub-scales which are 0.76 and 0.94 separately.

5.2.4.4 Bangla Warwick Edinburgh Mental Wellbeing Scale (WEMWBS)

Warwick Edinburgh Mental Wellbeing measuring Scale for Bangladeshi Population was adapted by Syed Tanveer Rahman and Mostak Ahamed Imran of Department of Psychology, University of Dhaka. It is a 14 item Likert-type scale where each item has 5 options and they are scored from 1 to 5. The highest score of the scale being 14x5=70 and the lowest being 14x1=14. 70 demonstrate the most significant level of wellbeing and 14 show the least degree of wellbeing. The Internal Consistency Reliability was assessed by the Split-half method with a score of 0.867

($\alpha = 0.01$) and the Cronbach alpha 0.770. As well as the Test-retest Reliability scored $r = 0.716$ ($\alpha = 0.01$). The Content validity of the scale was ensured by the sequential system model and expert opinion in different stages and the Construct validity was $r = -0.534$ ($\alpha = 0.01$). The corrected item-total correlation was determined, 14 items were found to have significant (at 0.02 level) correlation coefficients ranged from 0.247 to 0.522.

5.2.4.5 Bengali form of General Health Questionnaire (GHQ-12)

The Bengali version of the General Health Questionnaire (Ilyas and Aeysha, 2002) created by Goldberg (1978) was utilized to quantify the emotional well-being of respondents. It is a self-directed screening test for recognizing minor psychiatric disorders in the general population. Items of the scale were translated into Bengali. Afterward English and Bengali adaptations were administered to 30 respondents with a 7-day gap. Half of the respondents were administered the English version first whereas the second half was administered the Bengali version first. Significant correlation [$r(48) = 0.625$, $p<0.001$] between scores of English and Bengali adaptations demonstrated translation reliability of the scale. The test-retest reliability coefficient of Bengali adaptation was discovered 0.57 with a gap of two weeks. The Cronbach's Alpha coefficient for internal consistency of the Bengali version was 0.82. This 12 item scale contains 6 positive and 6 negative items. It is a Likert-type scale having 4-point response choices, normally scoring from 0-3. The high score on the scale demonstrates high mental health issues. The scoring of the Bengali Scales items is different than that of the English Scales items. The original English scale scoring is 0,1,2,3 from left to right. Then again the Bangla scale scoring is 0,1,2,3 for Positive items (2, 5, 6, 9, 10, and 11) and 3,2,1,0 for reverse items (1, 3, 4, 7, 8, and 12). The typical Score is around 11-12. Score >15 indicates evidence of distress and Score >20 portrays severe problems and psychological distress.

5.2.4.6 In-depth interview

An interview is an important method of qualitative research in which the researcher gathers data directly from the participants to obtain the desired information. In-depth interviews run with a goal and are useful to unfold perceptions, experiences, values and different other aspects of the population under research (Showkat, N., & Parveen, H. 2017). There are 3 types of in-depth interviews, i) structured, ii) semi-structured and iii) un-structured. The structured interview has been followed by a list of the predetermined questionnaire. A semi-structured interview has been followed by a list of topics or areas instead of specific questions. Besides, unstructured interviews are like a daily based conversation. There is no specific set of predetermined questions. One of the most important beneficences of IDI is being more effective and less structured. Session durations can be 30 minutes to 2 hours and should be conducted appointment basis and in a calmer place. Questions should be simple, open-ended, clear and coherent, so the interview would be proceeding in a precise way.

5.2.5 Procedure:

To carry out the purpose of the study, the intervention program was conducted to the respective sample group and the scales (SBI, GHQ-12, WEMWBS, HADS) were administered as pre, post and follow-up test measures. To gather more qualitative information to measure the credibility of the intervention, an in-depth interview process was administered after 6 months to few available participants of the experimental group. The participants were ensured that their answers would be kept confidential and will be utilized for research purposes only. There were written contracts for their consent. They were asked to answer all questions as honestly as possible and give each question a moment's thought and then answer. After completion of the questionnaire, answer

sheets were collected and they were thanked appropriately for their sincere cooperation. It took around 15-20 minutes on average.

To measure the effectiveness of the developed intervention (Communication Skills and Selfcare Enhancement Program), the program was carried out according to the modules described in the intervention program (chapter 4). The quantitative data were gathered through individual interviews. Each participant was interviewed personally and independently. Each of them was given separate guidelines for the questionnaire and respective scales and was permitted to inquire as to whether the individual has any inquiry regarding any item. The interviewer addressed each question raised by them and gave all conceivable explanations. For the experimental group, the intervention was administered on four separate groups consisting of 15-17 participants in each group, on the other hand, no intervention was given to the control group apart from administering the pre, post and follow-up tests. The common steps were –

Pre-test: Administering 4 scales (SBI, GHQ-12, WEMWBS, HADS) before the first session.

Intervention: Conducting one-hour session per week for four consecutive weeks (for experimental group)

Post test: Again administering the 4 scales after the 4th session.

Follow-up: Same 4 scales administered after 15 days of conducting the intervention.

Feedback: Attendance records were kept for all sessions. Verbal feedbacks were collected from the participants regarding the intervention program all through the process.

In-depth interview (IDI): After 6 months of conducting the intervention program, 3 available participants (1 male, 2 females, age range 29-45) from the experimental group were interviewed.

A semi-structured interview process was followed and the session duration was 30 minutes for each participant on a pre-appointment basis. Session was conducted by video call maintaining all ethical principles of IDI. Answers were recorded and made transcript for interpretation of the result.

5.3 Result

The following results were calculated to assess the effectiveness of the intervention program. In this study, t-values were computed to measure between group scores (experimental and control) and within group scores (pretest, post test, follow-up). First of all, the test of normality and the baseline comparison was computed.

Table 5.3

Test of normality

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
SBI_Pretest	.085	62	.200*	.978	62	.346
SBI_post test	.100	62	.200*	.955	62	.023
GHQ-12_pretest	.073	62	.200*	.978	62	.326
GHQ-12_post test	.088	62	.200*	.983	62	.548
HADS_pretest	.085	62	.200*	.979	62	.383
HADS_post test	.079	62	.200*	.984	62	.595

a. Lilliefors Significance Correction

*. This is a lower bound of the true significance.

Table 5.3 shows that there is no significant difference in the scores of SBI, GHQ-12 and HADS scales in any of the test periods. These refers that the scores are normally distributed and parametric tests can be used for the analysis of the scores. In this research t-test was used to compare between group and within group scores.

Table 5.4

Baseline comparison

Scales	Group	N	Mean	t	df	Sig. (2 tailed)
SBI_Pretest	Experimental	30	59.53	0.687	60	0.495
	Control	32	57.20			
GHQ_Pretest	Experimental	30	10.66	- 0.575	60	0.567
	Control	32	11.47			
WEMWBS_Pretest	Experimental	30	52.09	- 0.300	60	0.675
	Control	32	52.83			
HADS Anxiety_Pretest	Experimental	30	6.28	- 1.045	60	0.301
	Control	32	7.20			
HADS Depression_Pretest	Experimental	30	6.91	- 0.354	60	0.725
	Control	32	7.17			

Out of 62 people, 32 were in the control group and 30 were in the experimental group. Table 5.4 shows the pretest condition of the participants for different scales. There was no significant difference found between the two groups in terms of burnout, general health, mental wellbeing and hospital anxiety and depression in the pretest. Scores of this table indicate that both groups were more or less in equal condition of burnout, mental wellbeing, general health condition and anxiety-depression.

5.3.1 Burnout assessment:

Table 5.5 presents the mean, standard deviation and the t-value of the SBI scores according to condition and phase.

Table 5.5

Comparison of the scores of burnout between experimental and control group according to pretest, post test and follow up

Phases	Conditions	N	Mean	SD	Df	t
Pretest	Control	32	59.53	15.040	60	.681
	Experimental	30	57.20	11.562		
Post test	Control	32	63.75	13.581	60	3.614*
	Experimental	30	50.87	14.488		
Follow-up	Control	32	64.84	16.189	60	2.376*
	Experimental	30	54.37	18.518		

Note. *$p<0.05$

The result presented in table 5.5 was significant in the post test and follow-up phases of burnout between the control and experimental group. In the pos ttest phase, the t-value was found 3.164 (95% CI:5.753, 20.014, p=.001) and 2.736 was found in the follow-up phase (95% CI:1.655, 19.299, p=.021). but no significant difference was found in the pretest phase between the control and experimental group as referred to in the baseline comparison. The table shows the experimental group burnout scores are lower than the control group in post test and follow-up phase which indicates that there can be a positive impact of the intervention on them.

Figure 5.1

SBI Burnout Scale Mean Comparison

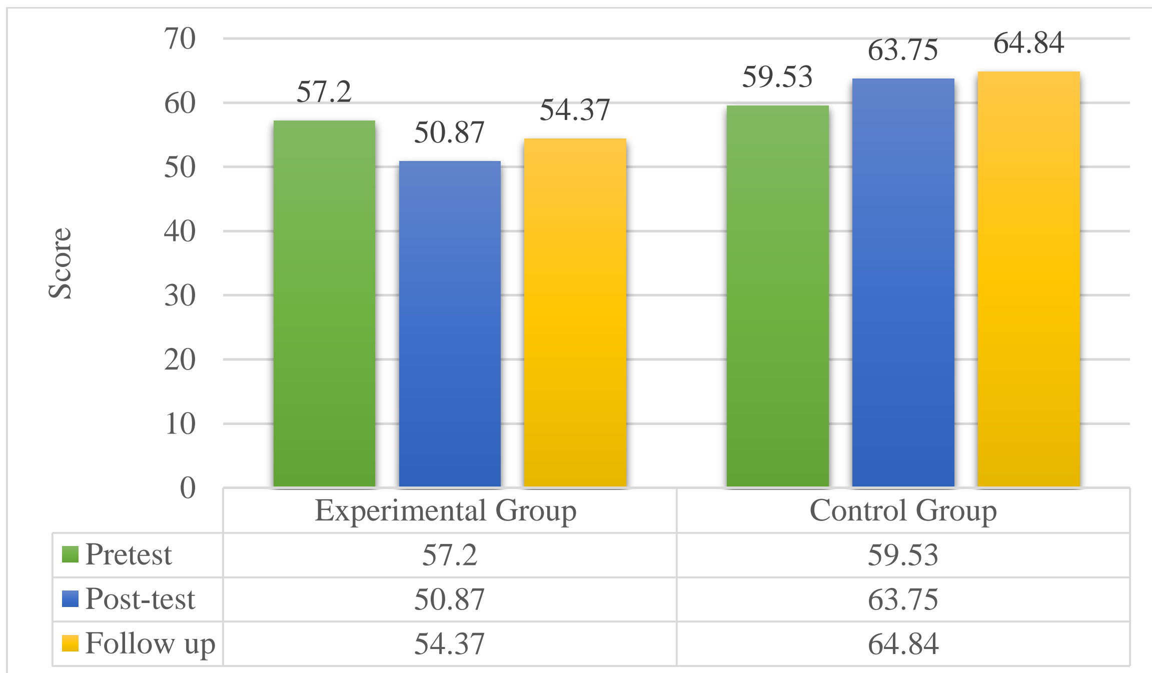


Figure 5.1 shows the comparison of the mean values of the two groups in the pretest, post test and follow-up. In the experimental group, the highest value was recorded as 57.2 in the pretest, the lowest value was in the post test 50.87, and a small hike at follow-up 54.37. On the other hand, in the case of the control group, the mean values of burnout increased gradually (59.53 to 64.84) from pretest to follow-up.

Table: 5.6

Within group (experimental group) comparison of the scores of burnout according to the differences of pretest, post test and follow-up

Paired samples t-test					
	Phases	Mean	SD	Df	t
Pair 1	Pretest – Post test	6.333	9.643	29	3.597*
Pair 2	Post test – Follow-up	-3.500	8.320	29	-2.304*
Pair 3	Pretest – Follow-up	2.833	12.809	29	1.212

Note. $*p<0.05$

Table 5.6 presents that, in the experimental group, a significant difference was found in the two interventions. The difference between the pretest and post test was found significant (mean difference 6.333; 95% CI:2.733, 9.934; p=.001). The difference between post test and follow-up was also significant (mean difference -3.50; 95% CI: -6.607, -.393; p=.029). Here the post test score was lower than pretest and follow-up. In contrast, the difference in pretest and follow-up was not significant in their level of burnout (mean difference 2.339; 95% CI: -1.950, 7.616; p=.235).

5.3.2 General health condition assessment:

Table 5.7 presents the mean, standard deviation and t-values of the GHQ-12 scores according to condition and phase.

Table 5.7

Comparison of the scores of general health condition between experimental and control group according to pretest, post test, follow-up

Phases	Conditions	N	Mean	SD	df	t
Pretest	Control	32	10.66	5.938	60	-.573
	Experimental	30	11.47	5.144		
Post test	Control	32	12.00	6.175	60	1.916
	Experimental	30	9.33	4.611		
Follow-up	Control	32	12.06	6.021	60	.835
	Experimental	30	10.87	5.191		

Note. *$p<0.05$

In table 5.7, no significant difference was found in the three-level of the intervention of general health condition between the control and experimental group. The t-value of the pretest, post test and follow-up was -.573, 1.916, .835 accordingly, p= .569, .060, .407. the confidence interval was 95% in all of the three phases.

Figure 5.2

GHQ-12 Scale Mean Comparison

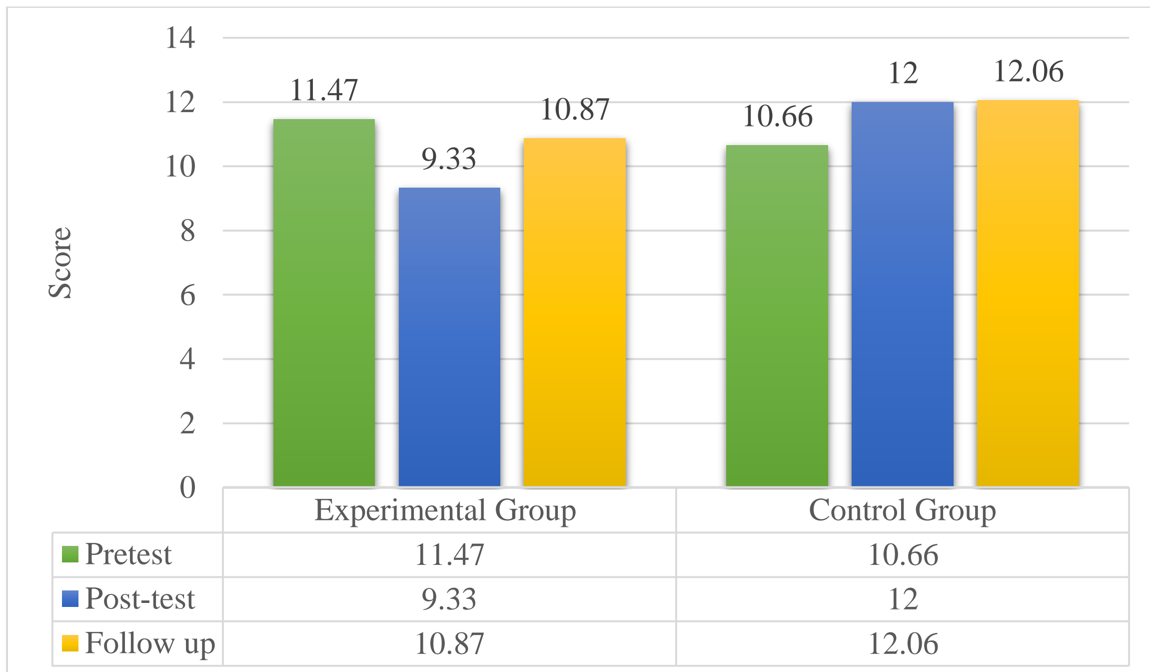


Figure 5.2 presents that, in the experimental group, the mean value was high at pretest (11.47), then there is a drop at post test (9.33), and again a small hike at follow-up (10.87). For the control group, the mean value was increasing from pretest to follow-up.

Table: 5.8

Within group (experimental group) comparison of the scores of general health conditions (GHQ-12) according to the differences of pretest, post test and follow-up

Paired samples t-test					
	Phases	Mean	SD	df	t
Pair 1	Pretest – Post test	2.133	3.693	29	3.164*
Pair 2	Post test – Follow-up	-1.533	3.115	29	-2.696*
Pair 3	Pretest – Follow-up	.600	4.446	29	.739

Note. *p<0.05

Table 5.8 shows that within the experimental group in terms of general health condition, a significant difference was found in both pretest to post test phase (mean difference 2.133; 95% CI: .754, 3.512; p=.004) and post test to follow-up phase (mean difference -1.533; 95% CI: -2.697, -.370; p=.012). On the other hand, no significant difference was found in the pretest to follow-up intervention phase (mean difference .60; 95% CI: -1.060, 2.260; p=.466). That indicates there can be an impact of the intervention program on post test.

5.3.3 Mental well-being assessment:

The table 5.9 presents the mean, standard deviation and t-values of the mental wellbeing scale scores according to condition and phase.

Table 5.9

Comparison of the scores of mental wellbeing scale (WEMWBS) between experimental and control group according to pretest, posttest, follow-up

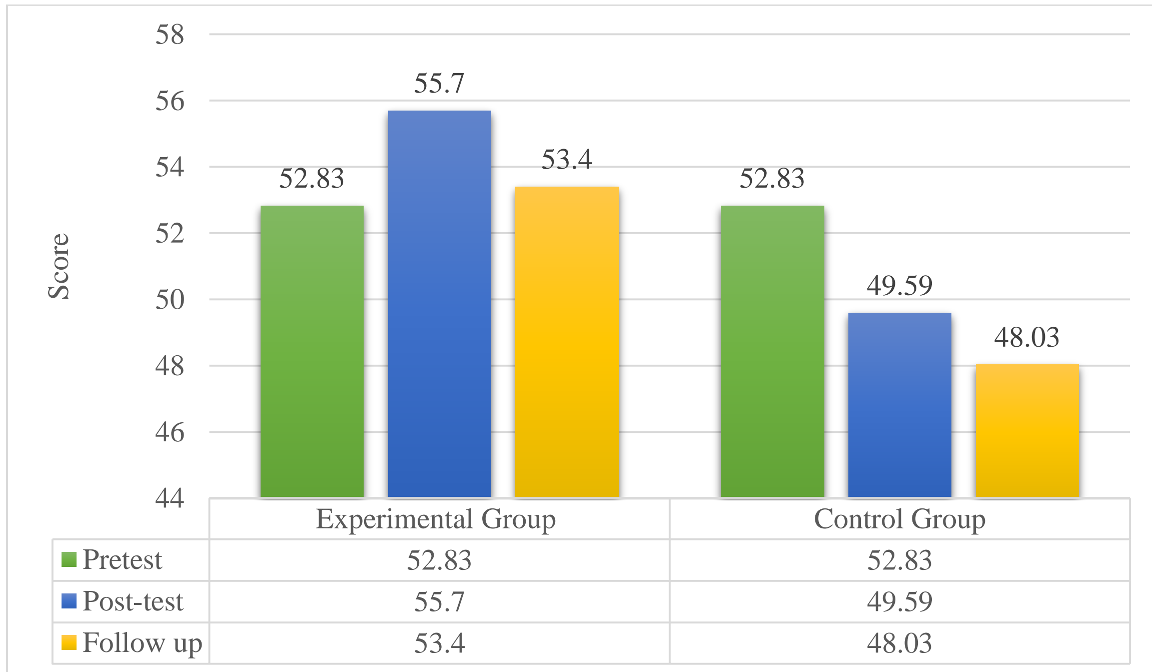
Phases	Conditions	N	Mean	SD	df	t
Pretest	Control	32	52.09	11.165	60	-.297
	Experimental	30	52.83	8.056		
Post test	Control	32	49.59	10.939	60	-2.515*
	Experimental	30	55.70	7.804		
Follow-up	Control	32	48.03	10.849	60	-2.024*
	Experimental	30	53.40	9.978		

Note. *$p<0.05$

In the mental well-being, a significant difference was found in the post test and follow-up intervention phase between the control and experimental group. The t-values were found -2.515 (95% CI: -10.963, -1.250 , p=.015) and -2.024 (95% CI: -10.674, -.063, p=.047). No significant difference was found in the pretest phase as mentioned in the baseline comparison.

Figure 5.3

WEMWBS Scale Mean Comparison



In figure 5.3, it can be seen that in the experimental group a little improvement was observed (from 52.83 to 55.7) from pretest to post test, but again a fall at follow-up (53.4). And throughout the phases, there was a gradual declining trend in the number of mean in the control group (From 52.83 to 48.03). The most improved number (55.7) was found at the posttest in the experimental group that gives a signal of an impact of the intervention.

Table: 5.10

Within group (experimental group) comparison of the scores of mental wellbeing scale (WEMWBS) scores according to the differences of pretest, post test and follow up-test

Paired samples t-test					
	Phases	Mean	SD	df	t
Pair 1	Pretest – Post test	-2.867	3.748	29	-4.189*
Pair 2	Post test – Follow-up	2.300	7.594	29	1.659
Pair 3	Pretest – Follow-up	-.567	8.144	29	-.381

Note. *p<0.05

Table 5.10 shows that, in the mental wellbeing, a significant difference was found in the pretest to post test comparing the result of the experimental group. The mean difference was found -2.67 (95% CI: -4.266, -1.467, p=.001). In contrast, no significant difference was found in the post test to follow-up (mean difference 2.30; 95% CI: -.536, 5.136; p=.108) and pretest to follow-up (mean difference -.567, 95% CI:-3.608, 2.474, p=.706).

5.3.4: Hospital anxiety assessment

Table 5.11 presents the mean, standard deviation and t-values of the HADS scale scores according to condition and phase.

Table 5.11

Comparison of the scores of anxiety (HADS) between experimental and control group according to pretest, post test, follow-up

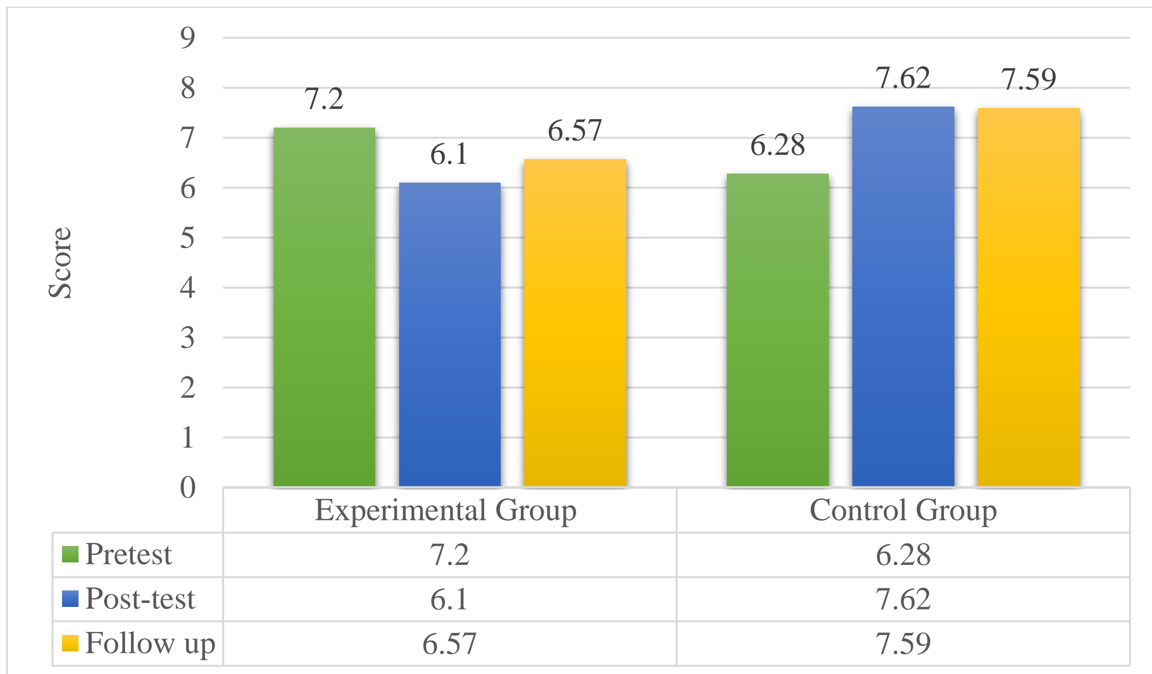
Phases	Conditions	N	Mean	SD	df	t
Pretest	Control	32	6.28	3.245	60	-1.049
	Experimental	30	7.20	3.652		
Post test	Control	32	7.63	3.250	60	1.734
	Experimental	30	6.10	3.670		
Follow-up	Control	32	7.59	3.349	60	1.152
	Experimental	30	6.57	3.674		

Note. $^{*}p<0.05$

No significant difference was found in the level of anxiety in the three-intervention period between the control group and the experimental group. The t-values of pretest, post test and follow-up was found -1.049 (95% CI: -2.671, .834, p=.299), 1.734 (95% CI: -.234, 3.284, p=.088) and 1.152 (95% CI: -.757, 2.811, p=.254).

Figure 5.4

HADS Anxiety Scale Mean Comparison



	Experimental Group	Control Group
Pretest	7.2	6.28
Post-test	6.1	7.62
Follow up	6.57	7.59

Figure 5.4 shows the mean level of hospital anxiety of the two groups. In the experimental group, where the highest mean number was in the pretest (7.2). and the lowest value was in the post test (6.1). In the control group, the mean level was increased from pretest to post test (from 6.28 to 7.62). But later it was decreased to 7.59 at the follow-up.

Table: 5.12

Within group (experimental group) comparison of the scores of the anxiety (HADS) according to the differences of pretest, post test and follow-up

Paired samples t-test					
	Phases	Mean	SD	df	t
Pair 1	Pretest – Post test	1.100	2.591	29	2.325*
Pair 2	Post test – Follow-up	-.467	2.515	29	-1.016
Pair 3	Pretest – Follow-up	.633	3.528	29	.983

Note. $*p<0.05$

Table 5.12 presents that, in the anxiety level, a significant difference was found in the pretest to post test comparing the result of the experimental group. The mean difference was found 1.10 (95% CI: .132, 2.068, p=.027) where the post test value was lower than the pretest value. In contrast, no significant difference was found in the post test to follow-up phase (mean difference -.467; 95% CI: -1.406, .473; p=.318) and pretest to follow-up phase (mean difference .633, 95% CI: -.684, 1.951, p=.334).

5.3.5: Hospital depression assessment:

Table 5.13 presents the mean, standard deviation and t-values of the HADS scale scores according to condition and phase.

Table 5.13

Comparison of the scores of the hospital anxiety and depression scale (HADS depression) between experimental and control group according to pretest, post test and follow-up

Phases	Conditions	N	Mean	SD	df	t
Pretest	Control	32	6.91	2.248	60	-.358
	Experimental	30	7.17	3.395		
Post test	Control	32	7.19	2.416	60	1.228
	Experimental	30	6.27	3.433		
Follow-up	Control	32	7.66	2.522	60	2.872*
	Experimental	30	5.67	2.928		

Note. *$p<0.05$

A significant difference was found in the level of depression in the follow-up phase between the control and experimental group. The t-value was found 2.872 (95% CI: .604, 3.375, p=.006) where the scores of the experimental group were lower than the control group. But no significant difference was found in the pretest and post test comparing the control and experimental group. The score in the pretest was found -.358 (95% CI: -1.714, 1.194, p=.721) and in the post test, the score was found 1.228 (95% CI: -.580, 2.421, p=.224).

Figure 5.5

HADS Depression Scale Mean Comparison

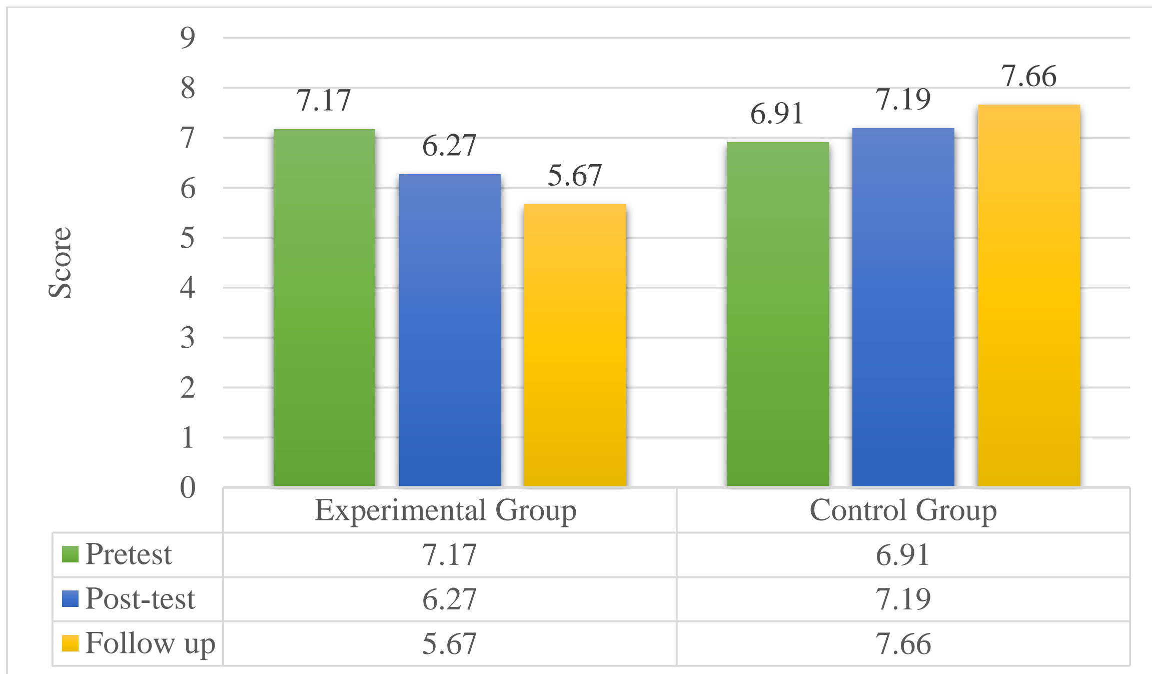


Figure 5.5 shows a gradual decrease in the mean scores of the experimental group from pretest to follow-up (7.17, 6.27.and 5.67). On the other hand, with a gradual increase in the control group from prestest to follow-up, the mean scores are 6.91, 7.19 and 7.66.

Table: 5.14

Within group (experimental group) comparison of the scores of depression (HADS depression) according to the differences of pretest, post test and follow-up

	Paired samples t-test				
	Phases	Mean	SD	df	t
Pair 1	Pretest – Post test	.900	3.122	29	1.579
Pair 2	Post test – Follow-up	.600	2.372	29	1.385
Pair 3	Pretest – Follow-up	1.500	2.543	29	3.231*

Note. $*p<0.05$

Table 5.14 shows that, in the experimental group, the difference in pretest and follow-up phase was found significant in their level of depression (mean difference 1.5; 95% CI: .551, 2.449; p=.003) where the follow-up score was lower than the pretest score. But no significant difference was found in the other two interventions. The difference between the pretest and post test was not significant (mean difference .90; 95% CI: -.266, 2.066; p=.125). The difference between post test and follow-up was also not significant (mean difference .60; 95% CI: -.286, 1.486; p=.177).

5.3.1 Qualitative assessment of the intervention program:

The effectiveness of the intervention program was examined with verbal feedback during the intervention time and with in-depth interviews at the follow-up stage. From the verbal feedback of each session and in-depth interview, three main themes were derived that represent the significance of the program – 1) Effectiveness of the program, 2) Efficacy of the program, 3) Convenience of participating in the program.

5.3.1.1 Theme 1: Effectiveness of the program

Almost all the participants stated that the program was very much effective from several aspects. First of all, the topics of the program were regarding their day-to-day sufferings, which they could not share with anyone. According to them, most of the knowledge they gathered was known to them, but they were not aware of how to implement them. The program made them conscious of practicing the knowledge and enhancing their skills, especially talking assertively, using stroke and experiencing empathetic behavior created positive changes in their communication and managing stress. There are some sub-themes associated with the effectiveness of the program:

Sub-theme 1.1: Most helpful part of the program: Different participants highlighted a different part of the program as helpful.

i) Assertive communication is on the top of this list. Saying 'NO' assertively with maintaining respect to others, maintaining eye contact while talking was widely appreciated. In one's saying –

   "*Now I can separate my work time and personal time which made me calm and relaxed".*

ii) Next comes Butterfly hug, they found it a very helpful tool of stabilization, in their language –

"It gives an instant relief and helps to calm fast".

iii) The practice of stroke was another helpful part mentioned by them. To get knowledge of different levels of stroke and using them to others was reported much obliging.

iv) Participating in the program made them feel more contented with all the knowledge.

Sub-theme 1.2: Skills practiced most:

i) In this list 'taking care of the self' was on top. A majority reported that the knowledge of selfcare helped them to keep it in mind amid a heavy workload.

ii) Half of the participants mentioned that using active listening skills helped them to feel more accepting, important, and warm in their relationship.

iii) Exchange of stroke was reported to be practiced by at least 35% of the participants. They could recognize practicing giving, accepting, and self stroking; asking and rejecting stroke was not much recognized by them. This practice helped to enhance the cohesiveness in the team, came from one authority person –

"Now I listen to my staffs and practice praising and recognizing their work. I can find them to be more enthusiastic to work".

iv) 27% of participants stated that, under a stressful situation, the use of alternative positive thought was easier, they related it with hopeful thinking. An officer said it helped her when she went through job termination.

v) Breathing exercise was another skill that has been reported to be practiced often. A doctor cited –

"I found that I can do more work now and keep my energy. Deep breathing helped me a lot to stay calm"

Sub-theme 1.3: Productivity:

i) 60% of the participants stated being more patient and calm after getting the training which helped them to be more productive and enthusiastic to work. A nurse stated, *"Now I hardly lose temper to a non-cooperative patient"*. In the language of an admin officer –

"I could separate my working hour and personal hour and could accommodate some of my favorite activity in my life. After doing this, I could feel more relaxed and enthusiastic about my work" which relates to practice assertive techniques.

ii) Using active listening skills and giving positive strokes especially at the supervisor level helped them to be connected more with the rest of the team that increased the productivity of the team members. According to a matron –

"when I listen actively to my nurses, I found them to feel closer to me and more enthusiastic to work. Sometimes they spontaneously come to lend their hand for more responsibilities".

Sub-theme 1.4: New knowledge:

i) 'Stroke' was a new term to learn reported by them. Active listening techniques were also new.

"For the first time, I got to know that there is nothing wrong with praising someone"

ii) To some participants, being assertive was also new for them that increased.

"I never know that I can watch directly to someone's eye, it was forbidden in my home. Now I can maintain eye contact while talking and that gives me confidence".

iii) Breathing exercise and its effectiveness, reported by 80% of participants.

iv) Advantages of mindfulness practice, Reported by 90% of participants.

5.3.1.2 Theme 2: Efficacy of the program

80% of the participants mentioned that the program was useful because they could learn some stress dealing hack to their day to day life. A lot of knowledge was latent inside them, that came to the surface through the program and increased their awareness to use it. This program was kind of eye-opening to them about being aware of their mental health and it made a thurst on them to know more and participate more in this type of program.

According to an authority person of a hospital –

"I think it was a very useful program for our wellbeing, it would be very helpful if we could receive such programs in a regular interval".

5.3.1.3 Theme 3: Convenience of participating in the program:

Most participants reported that there was a hesitation initially to participate in the program as they have to find time for it from their pail of work, but after starting the session they got engaged with it and attended sincerely. Though they had no pressure from their authority to participate in the program, most of them completed the course but scheduling was very tough for them. They expressed their expectation that if the authority takes a stronghold of arranging this type of program, then they can overcome the scheduling problem.

"It was a very good program, but it was so tough for me to manage an hour from all of my responsibilities".

5.4 Discussion

The present study was to investigate the effectiveness of the intervention program "Communication Skills and Selfcare Enhancement Program" described in Chapter 4. The intervention program was based on burnout management consisting of 4 different modules on teaching effective communication skills and selfcare. The intervention program was administered to workers in hospital settings. Multi-method was applied in the intervention (e.g. cognitive coping strategies, role play, mindfulness, etc. Bond & Bunce, 2000; Beck, 2011; Hayes & Feldman, 2004; Kabat-Zinn, 1990). Four scales were administered to the employee to measure burnout, general health condition, mental wellbeing, and hospital anxiety and depression in pre and post test phases of the 4 weeks' intervention and follow-up after 2 weeks of the intervention. A semi-structured in-depth interview was conducted after 6 months of the administration of the intervention to 3 available participants from the experimental group. There was no intervention provided in the control condition, but the pretest and the post test measure were taken with the same interval of 4 weeks, and the follow-up after 2 weeks of the post test. Participants' verbal feedback was taken as qualitative analysis.

5.4.1. Effectiveness of the intervention program as assessed by the scales:

The result interpretation of the four scales (i.e., SBI, GHQ-12, WEMWBS and HADS) showed the effectiveness of the intervention program on burnout management and also some impact on general health condition, mental wellbeing, anxiety and depression of the participants. The SBI scale indicated that the burnout scores dropped down from pretest to post test and again increased a little (less than pretest) at the follow-up in the experimental condition, but not in the control condition. This result validates the findings of Armstrong et al. (2004), (Darban F. et al., 2016) and Jennifer K. Penberthy et.al. (2018) where communication skills and mindfulness

training were given as intervention and was found a positive impact. In the point of a decrease in post test scores and again a little increase at follow-up scores, it can be assumed that during the intervention the participants were regularly engaged with the communication and selfcare skills practice, but after completing the program, their enthusiasm to practice the skills might be decreased which caused a small hike of burnout. So it can be recommended to continue this type of program regularly with the convenient interval of the employees.

Scores of GHQ-12 found no significant difference between the experimental and control group. On the other hand, a significant difference was found within the experimental group from pretest to post test and post test to follow-up, where general health condition was improving at the post test and a little decline at follow-up.

A significant difference was found between the two groups on the mental wellbeing (WEMWBS) scores on post test and follow-up phase where experimental group scores were improved than the control group. And significant improvement on mental wellbeing was found from pretest to post test within the experimental group that implies an impact of the intervention.

In the case of anxiety (HADS), no significant differences were found between the two groups in any phase of the intervention, but a significant difference was found within the experimental group from pretest to post test. Anxiety scores were decreased at post test of the experimental groups, from which it can be assumed that talking about anxiety and practicing mindfulness helped them to decrease their level of anxiety immediately, but after the program when their selfcare activities were decreased, the level of anxiety was increased in the consequence. An interesting fluctuation was found in the depression scores, no significant difference in the scores was found during the intervention phase between the experimental and control group and within the experimental group. But a significant improvement was found at the follow-up phase both

between the group and within the group. Interpreting the above scenario of depression it can be deduced that sometimes knowledge prevails inside in a latent way that might not show any immediate reflection on behavior and emotional state but over a while, it comes out gradually.

The above discussion implied that when the participants were actively involved with the program matters and regularly monitored as well as getting an opportunity to release common stresses by sharing at the program, the burnout, well-being and anxiety level was improved (RJ Delamater & JR McNamara, 1986; Emmons A and Michael R, 2001). The findings of the study are consistent with those of other studies on burnout management (Stier-Jarmer M., et.al., 2016; Salehe P., et.al., 2017; Karimi Roohangiz et.al., 2014; Killian, 2008; Williams, I. D. et al., 2010).

5.4.2 Effectiveness of the intervention with qualitative data

Based on In-depth interviews of three individuals from the experimental group and the verbal feedback of the participants during the intervention, three common themes evoked relevant to intervention impact: 1) effectiveness of the program, 2) efficacy of the program and 3) convenience of participating in the program. The content discussion of the program helped them to be aware of their current unhealthy coping strategies of stress and the problematic communication ways they use. They became aware of taking care of themselves that they often skip under a heavy workload. In the in-depth interview after six months, it was found that they could memorize the gist of each content and still following one or two of the skills that they learned in the program which is evidence of the effectiveness of the intervention. Such as one of these three persons who work in a supervisor level reported that practicing eye contact helped her to be more confident; the knowledge of expressing own need and selfcare helped her to reduce her anxiety, and by active listening skills she could bring more cohesiveness among her team. These confirm the findings of the study of RJ Delamater & JR McNamara, (1986). The

second person reported practicing deep breathing regularly helped him to be more patient and calm which confirms the study of Shapiro, Brown, and Biegel, (2007) and Williams, I. D. et al. (2010) where practicing mindfulness was found effective. For the third person, her most valuable pick up and practiced skill from the intervention was the ‘I message’ of being assertive and giving strokes to self and others, which also confirms the study result of Darban F. et al., (2016) where assertive communication training of nurses was found positive.

In this program, they were also taught to identify their negative thoughts using the ‘thought cycle’ and how to use the alternative thoughts that helped them to cope with stress more effectively. To calm their anxious mind and body, they learned butterfly hug, breathing exercise and various mindfulness exercises which were widely appreciated by them. Role-playing the different types of communications and practicing stroke and empathy as group work in the program helped them for clear understanding and to prepare themselves to apply the skills in real life.

Another remarkable part of the program was that in each session the participants committed to do certain activities as a part of selfcare for the next whole week, and in the following session, they shared their feeling and insights regarding these activities. These activities helped them to relate the positive connection of taking care of own self to manage stress in their day-to-day life, which motivated them to incorporate selfcare practices in their daily living.

5.4.3. Limitations

1. Sample size was limited due to the COVID-19 pandemic. The intervention was administered at two organizations only.

2. At 2nd follow-up after six months, only three participants were available for in-depth interview. Therefore it is difficult to draw a concrete conclusion from the second follow-up.

3. Another limitation was that the control group did not receive any treatment throughout the study. Further studies are needed to address this issue

5.4.4. Conclusion

The present study was the first administration and evaluation of the intervention program "Communication Skills and Selfcare Enhancement Program" for workplace burnout management. Findings indicate that the program is effective in reducing burnout in the workplace and thus has the potential to improve employees' mental health and quality of life.

CHAPTER – 6

General Discussion

It is phenomenal that burnout has been a common factor in the global organizational scenario which is also valid for Bangladesh (Shimull, A. M., 2009). Burnout is a prolonged response to chronic emotional and interpersonal stressors on the job and is defined by the three dimensions of emotional exhaustion, depersonalization, and reduced personal accomplishment (Maslach, 1982). Empirical studies showed the prevalence of job burnout and the need for burnout management programs in job place (Johnson & Wood, 2017; Evans & Ball, 2001; Jennifer K. Penberthy et.al., 2018). Hence it is essential to develop programs to manage burnout and provide the necessary support to organizational employees. However, in Bangladesh, such a recognized program has yet to develop. The present M.Phil thesis addressed this issue. Studies were carried out to assess burnout in hospital settings in Bangladesh, develop an intervention program based on the findings of need assessment and global scientific studies, and evaluate the effectiveness of the intervention program.

According to the first objective of the study, a need assessment of burnout was conducted in the context of Bangladesh. Aiming to this goal, a focus group discussion (FGD) was conducted with Bangladeshi hospital employees as described in chapter 3. A standard protocol was followed to conduct the FGD. The FGD was focused to derive answers to the following questions - what is the everyday stress at the workplace that causes burnout; what are their existing coping mechanism; and do they need psychological intervention to manage burnout. The major reasons include unhealthy coping mechanism, suppressing emotion, displacement of anger, huge workload and prolonged working hour, lack of appreciation and recognition, lack of assertive communication, lack of awareness on selfcare, absence of empathetic approach in the working environment, etc. The findings indicated a strong need for burnout management among the staff and recommended to focus on enhancing selfcare through different practices and educating

effective communication including assertiveness, appreciation and empathetic approach to deal with their burnout. The findings approve the previous studies on burnout management (Shapiro et. al., 2007; Rhezaii et. Al., 2006; Poncet et. al., 2007; Kiani et.al., 2016) and the recommendations were drawn based on FGD findings and the conventional burnout programs (Giga et.al., 2003; Matteson, 1987; Murphy, 1988; Van der Hek, H., & Plomp, H. N., 1997) discussed in chapter 1.

The second objective of the study was to develop an intervention program of burnout management for organizational staff. To achieve the goal, the present study developed the "Communication Skills and Selfcare Enhancement Program" consisting of four intervention modules based on conventional burnout programs discussed in chapter 1 and the need assessment findings. The modules are – 'Stress management', 'Communication skills', 'Empathetic behavior and communication' and 'Stroking (recognition)'. The 'Stress management' module is particularly useful for identifying current stress and the stressors, recognizing symptoms of stress and learning healthy coping mechanisms (Murphy, 1988; Giga, 2001; Quick & Quick, 1997). The 'Communication skills' module includes the ability of an individual to interact effectively with others (Hargie, O., 1997). This module is helpful to recognize different types of communications, the benefits of assertive communication and learning how to be assertive. Studies showed that assertive communication is necessary for reducing workplace burnout (Butt & Zahid, 2015; X Liu et. al. 2015). The 'Empathetic behavior and communication' module contains introducing the concept of empathy, the importance of empathy at work and how to be more empathetic. It is beneficial to understand other person's thoughts and emotions which plays a good role to cope with emotional exhaustion (West C.P. et. al. 2006; Kwag & Kim, 2009). The last module 'Stroking' refers to giving appreciation and

recognition to others and self. This module consists of explaining the benefits of stroking, different ways of practicing strokes and how society imposes stroke economy. Stroking brings an opportunity to give a sense of being acknowledged and belongingness that increases cohesiveness at the workplace and boosts the level of confidence which impacts directly on reducing burnout (Namdar H et. al., 2009).

The last objective of the present study was to evaluate the effectiveness of the intervention program in hospital settings. To reach this goal, a pretest post test design was employed in experimental and control conditions. There were follow-ups also in both groups and a second follow-up by in-depth interview only on few participants of the experimental group. The intervention program was conducted for four consecutive weeks in the experimental condition, while no intervention was provided to the control condition. The effectiveness of the program was assessed by four Bengali scales – SBI, GHQ-12, WEMWBS and HADS (which has been described in Chapter 5) and standard IDI protocol. Scores in all four measures indicate that the program was effective to manage burnout, improve the level of anxiety and depression as well as increase general health and mental wellbeing conditions, which was further supported by the in-depth interview.

6.1 The usefulness of the intervention program:

The uniqueness of the program was the combination of some significant psychological aspects related to burnout based on FGD and literature review. This is also cost-effective in terms of time, money, energy and man-power because the program has been designed to provide for only one hour in a week, which is affordable to the employees of organizations while managing their other works. It can be assumed from the result that, regular practice of the given contents and activities might help the organizational members to manage burnout effectively.

Positive feedback from the participants of the experimental group also suggested the effectiveness of the intervention to minimize burnout and enhance emotional stability. To be assured about the findings, it is required to replicate them with a large sample consisting of randomly selected participants.

6.2 Challenges and potentials of using the intervention program in Bangladesh:

Mental health support in the workplace has numerous advantages, such as access to emotionally vulnerable employees, low service delivery cost, reduce stigma regarding mental health service which can play a vital role in reducing workplace burnout and increase productivity. But the benefits of such support programs, however, are not easy to achieve as organizations have various demands to fulfill on priority. Their primary need is to ensure the product-related works, hence, extra-curricular programs like this are often required to validate its place on their busy work schedule.

Another issue is that most of the organizations do not have the scope to release their staff to attend such kind of training or seminars and to hire experts for delivering mental health programs. There is also a possibility that administrators and policymakers may not agree to provide such psychological services showing the inability to bear the cost which can make a huge challenge to incorporate this type of program. This study finding is a good source of evaluation that can provide invaluable empirical evidence to assess the efficacy of such programs.

The assessment of the program refers that during the program the level of burnout was decreased, but few days after completion of the program the level increased though it was lower than pretest. It indicates that there is a need for the continuation of such a program which was

reflected from the participants of in-depth interviews after 6 months. So it is recommended to continue the program for at least 8-10 weeks for a sustainable result. It is noteworthy that, it is employers' responsibility to ensure the mental health of the employees, therefore, organizations can implement this program and appoint professional psychologists to continue providing help to their employees.

6.3 Limitation and future directions of the study:

1. One of the significant limitations was the short duration of the training sessions because of employees’ time constrain. Participants were provided a one-hour session which was too brief to accommodate all necessary information and show the practical use of the techniques. At least 1.5 hours for each session would be helpful so that in the future some more stabilization therapies can be included also.
2. The present intervention program was only provided to hospital settings whereas different sectors of work might have different needs to be addressed. One of the main reasons behind this was the COVID-19 pandemic, so it was not feasible to reach different types of organizations, which has narrowed the potentiality of the intervention.
3. The intervention was provided to comparatively educated people. This is unknown that how it would work for an uneducated population, where a large number of the workforce in Bangladesh are not educationally privileged.
4. There should be follow-up sessions in regular intervals after providing the intervention which was absent in this program. The scores of follow-up and the feedback of IDI validates the necessity of follow-up sessions which might have the opportunity to address some more contemporary issues in their day-to-day life which would increase the usability and effectiveness of the intervention.

6.4 Conclusion

The present thesis assessed the need for burnout management in hospital employees', developed an intervention program namely "Communication Skills and Selfcare Enhancement Program" for workplace burnout management, demonstrated the usability and effectiveness of the program, and suggested various potential application of the program and related materials to ensure the betterment of mental health of the workers of Bangladesh. It is hoped that the product of this M.Phil research will add significant value in the mental health field and organizational sector of the country.

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Appendices

আশ্রয় মাদকাসক্তি পুনর্বাসন কেন্দ্র

মাদকদ্রব নিয়ন্ত্রণ অধিদপ্তর কর্তৃক প্রদত্ত লাইসেন্স নং- ০৪/১৪/-২০১৫

সূত্রঃ তারিখঃ ১ | ৮ | ২০২০

Date: August 01, 2020

To

Managing Director
Asroy Drug Treatment Counselling and Rehabilitation Center
Plot no.-17, Sec-06, Block-B, Road-02, Mirpur
Dhaka-1216, Bangladesh

Subject: Permission for conducting Research work

Dear Sir,
Please be informed that I am an assistant Counselling Psychologist from Department of Educational & Counselling Psychology, University of Dhaka. As the partial fulfilment of M. Phil degree, I am conducting a research where I will administer an intervention - "Communication skills and Self-care on Enhancement Program".

In this circumstance, it would be great enough if I get the opportunity to conduct my research work at your organization to collect some data and carry on an intervention program on the above-mentioned topic. The data to be collected from the staffs of your organization shall be kept confidential and will be used only in research purpose.

I, therefore, would seek your kind response and approval to proceed ahead to carry on my study.

Sincerely Yours,

____

Nuzhat-E-Rahman
Assistant Counselling Psychologist, M.Phil Part-2
Department of Educational & Counselling Psychology
University of Dhaka,
Dhaka, Bangladesh

অনুমোদিত
1.8.20

Date: June 01, 2020

To

Managing Director

Promises Medical Limited

House: 17, Road: 20, Block: J, Baridhara Dhaka-1212, Bangladesh

Subject: Permission for conducting Research work

Dear Sir,

Please be informed that I am an assistant Counselling Psychologist from Department of Educational & Counselling Psychology, University of Dhaka. As the partial fulfilment of M. Phil degree, I am conducting a research where I will administer an intervention - "Communication skills and Self-care on Enhancement Program".

In this circumstance, it would be great enough if I get the opportunity to conduct my research work at your organization to collect some data and carry on an intervention program on the above-mentioned topic. The data to be collected from the staffs of your organization shall be kept confidential and will be used only in research purpose.

I, therefore, would seek your kind response and approval to proceed ahead to carry on my study.

Sincerely Yours,

Nuzhat-E-Rahman

Assistant Counselling Psychologist, M.Phil Part-2

Department of Educational & Counselling Psychology

University of Dhaka

Dhaka, Bangladesh

অঙ্গীকারপত্র

প্রিয় অংশগ্রহনকারী,

আমি ঢাকা বিশ্ববিদ্যালয়ের এম.ফিল. কোর্সের একজন শিক্ষার্থী। এম.ফিল. গবেষণার কিছু তথ্য-উপাত্ত সংগ্রহের জন্য আমি এখানে কিছু প্রশ্নমালা ও ব্যক্তিগত তথ্যের তালিকা সংযুক্ত করেছি যেখানে আপনার সাহায্য আমার অত্যন্ড়প্রয়োজন। এখানে সংযুক্ত সকল তথ্য শুধুমাত্র বিশ্ববিদ্যালয়ের এই বিশেষ গবেষণাকাজেই ব্যবহার করা হবে। আপনার এই সকল তথ্যের সম্পূর্ণ গোপনীয়তা রক্ষা করা হবে। আপনি যদি অনুমতি দেন তাহলে নিচে চিহ্নিত স্থানে স্বাক্ষর করুন। আপনার সহযোগীতার জন্য অসংখ্য ধন্যবাদ।

গবেষকের স্বাক্ষর | অংশগ্রহনকারীর স্বাক্ষর

নাম :

বয়সঃ :

লিঙ্গ :

আর্থসামাজিক অবস্থান :

শিক্ষাগত যোগ্যতা :

বৈবাহিক অবস্থান :

পেশা :

চাকুরীর স্থায়ীত্বকাল :

সম্মতিপত্র (প্রিটেষ্ট - এক্সপেরিমেন্টাল গ্রুপ)

প্রিয় অংশগ্রহনকারী,

আমি ঢাকা বিশ্ববিদ্যালয়ের এম.ফিল. কোর্সের একজন শিক্ষার্থী। এম.ফিল. গবেষণার জন্য আমি চার সপ্তাহব্যাপী একটি মনোসামাজিক সহায়তামূলক প্রশিক্ষণ কোর্স তৈরী করেছি। এই কোর্সের মাধ্যমে আপনি মানসিক স্বাস্থ্য সুরক্ষায় কিভাবে নিজে নিজেকে সাহায্য করতে পারেন তা শিখতে পারবেন। প্রতি সপ্তাহে একদিন একঘন্টা ব্যাপী এই প্রশিক্ষণ প্রদান করা হবে। প্রশিক্ষণের শুরুতে আপনার কাছ থেকে কিছু তথ্য-উপাত্ত সংগ্রহ করা হবে যেগুলো শুধুই গবেষণাকাজে ব্যবহার করা হবে এবং এসব তথ্যের সম্পূর্ণ গোপনীয়তা রক্ষা করা হবে। প্রশিক্ষণ শেষে আপনি নিজেকে কতটা সাহায্য করতে পারছেন তা বোঝার জন্য আবারো একই তথ্য সংগ্রহ করা হবে। আপনার সহযোগীতার জন্য অসংখ্য ধন্যবাদ।

গবেষকের স্বাক্ষর

অংশগ্রহনকারীর স্বাক্ষর

সম্মতিপত্র (পোস্টটেষ্ট - এক্সপেরিমেন্টাল গ্রুপ)

প্রিয় অংশগ্রহনকারী,

চার সপ্তাহব্যাপী মনোসামাজিক প্রশিক্ষণ কোর্স আজ শেষ হলো। এতদিন এই কোর্সে অংশগ্রহন করে আপনার মূল্যবান সময় দেওয়ার জন্য অসংখ্য ধন্যবাদ। আশাকরি এই কোর্সের বিষয়গুলো আপনার নিজের মানসিক স্বাস্থ্য উন্নয়নে সহায়তা করেছে। এই পর্যায়ে প্রশিক্ষণের শুরুতে সংগৃহীত তথ্যগুলো পুনরায় সংগ্রহ করার জন্য আপনার সহযোগীতা কামনা করছি।

গবেষকের স্বাক্ষর

অংশগ্রহনকারীর স্বাক্ষর

সম্মতিপত্র (ফলোআপ - এক্সপেরিমেন্টাল গ্রুপ)

প্রিয় অংশগ্রহনকারী,

আপনি ১৫ দিন আগে চার সপ্তাহব্যাপী মনোসামাজিক প্রশিক্ষণ কোসর্টি শেষ করেছেন। এই কোর্সে অংশগ্রহন করে আপনার মূল্যবান সময় দেওয়ার জন্য অসংখ্য ধন্যবাদ। এই কোর্সের বিষয়গুলো আপনার নিজের মানসিক স্বাস্থ্য উন্নয়নে কতটা সহায়তা করেছে তা বোঝার জন্য এই পর্যায়ে প্রশিক্ষণের শেষে সংগৃহীত তথ্যগুলো পুনরায় সংগ্রহ করা প্রয়োজন। এক্ষেত্রে আপনার সহযোগীতা কামনা করছি।

গবেষকের স্বাক্ষর

অংশগ্রহনকারীর স্বাক্ষর

সম্মতিপত্র (প্রিটেষ্ট - কন্ট্রোল গ্রুপ)

প্রিয় অংশগ্রহনকারী,

আমি ঢাকা বিশ্ববিদ্যালয়ের এম.ফিল. কোর্সের একজন শিক্ষার্থী। এম.ফিল. গবেষণার জন্য আপনার কাছ থেকে কিছু তথ্য-উপাত্ত সংগ্রহ করা হবে যেগুলো শুধুই গবেষণাকাজে ব্যবহার করা হবে এবং এসব তথ্যের সম্পূর্ণ গোপনীয়তা রক্ষা করা হবে। একমাস পর আবারো একই তথ্য সংগ্রহ করা হবে। আপনার সহযোগীতার জন্য অসংখ্য ধন্যবাদ।

গবেষকের স্বাক্ষর

অংশগ্রহনকারীর স্বাক্ষর

সম্মতিপত্র (পোস্টটেষ্ট - কন্ট্রোল গ্রুপ)

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আমি ঢাকা বিশ্ববিদ্যালয়ের এম.ফিল. কোর্সের একজন শিক্ষার্থী। একমাস আগে এম.ফিল. গবেষণার জন্য আপনার কাছ থেকে কিছু তথ্য-উপাত্ত সংগ্রহ করা হয়েছিল এই পর্যায়ে পূর্বে সংগৃহীত তথ্যগুলো পুনরায় সংগ্রহ করার জন্য আপনার সহযোগীতা কামনা করছি। উল্লেখ্য তথ্যগুলো শুধুই গবেষণাকাজে ব্যবহার করা হবে এবং এসব তথ্যের সম্পূর্ণ গোপনীয়তা রক্ষা করা হবে। আপনার সহযোগীতার জন্য অসংখ্য ধন্যবাদ।

গবেষকের স্বাক্ষর

অংশগ্রহনকারীর স্বাক্ষর

সম্মতিপত্র (ফলোআপ - কন্ট্রোল গ্রুপ)

প্রিয় অংশগ্রহনকারী,

আমি ঢাকা বিশ্ববিদ্যালয়ের এম.ফিল. কোর্সের একজন শিক্ষার্থী। এর আগে দুইবার এম.ফিল. গবেষণার জন্য আপনার কাছ থেকে কিছু তথ্য-উপাত্ত সংগ্রহ করা হয়েছিল, এই পর্যায়ে পূর্বে সংগৃহীত তথ্যগুলো পুনরায় সংগ্রহ করা প্রয়োজন, আর এজন্য আপনার সহযোগীতা কামনা করছি। উল্লেখ্য তথ্যগুলো শুধুই গবেষণাকাজে ব্যবহার করা হবে এবং এসব তথ্যের সম্পূর্ণ গোপনীয়তা রক্ষা করা হবে। আপনার সহযোগীতার জন্য অসংখ্য ধন্যবাদ।

গবেষকের স্বাক্ষর

অংশগ্রহনকারীর স্বাক্ষর

SBI – Burnout scale

নিচে কিছু উক্তি আছে , প্রতিটি উক্তি মনোযোগ সহকারে পড়ুন এবং প্রত্যেকটি আপনার দৈনন্দিন জীবনে মাসে, সপ্তাহে, অথবা প্রতিদিন কতবার ঘটে তা টিক (√) চিহ্ন দিয়ে নির্দেশ করুন। প্রতিটি উক্তির জন্য শুধু একটি টিক দিন। মনে রাখবেন, আপনার প্রকৃত মতামতের উপরই আমার গবেষণার গুনগত মান এবং সাফল্য নির্ভর করবে।

আপনার দেওয়া তথ্যের গোপনীয়তা সম্পূর্নভাবে রক্ষা করা হবে এবং কেবল গবেষণার কাজেই ব্যবহার করা হবে। আপনার সহযোগীতার জন্য ধন্যবাদ।

	স্কেলের উক্তি	কখনোই হয় না	মাসে অল্প কয়েকবার	সপ্তাহে অল্প কয়েকবার	প্রতি সপ্তাহে একবার	সপ্তাহে বেশ কয়েকবার	প্রতিদিনই হয়
১	আমার সেবার পর গ্রাহকদের কি হলো না হলো তা নিয়ে আমি মাথা ঘামাই না।						
২	মানুষের সাথে কাজ করাটা আমার উপর সরাসরি চাপ প্রয়োগ করে।						
৩	যদিও আমি পর্যাপ্ত পরিমানে ঘুমাই, তথাপি আমি অনেক ক্লান্ড়						
৪	আমার চাকরিতে আমি একঘেয়েমি কাজ করতে করতে বিরক্ত হয়ে যাই।						
৫	কাজের চাপে মাঝে মাঝে আমার চোখ দিয়ে পানি চলে আসে।						
৬	আমি বহুদিন সত্যিকারভাবে ছুটি উপভোগ করছি না।						
৭	আগে আমি যেসব কাজে উৎসাহ পেতাম সেসব কাজে এখন আর তা পাই না।						
৮	কাজের দিন শেষে মনে হয় আমি নিঃশেষিত হয়েছি।						
৯	আমি যখন ঘুম থেকে উঠি তখন আমার ক্লান্ড় লাগে এবং মনে হয় কর্মময় আরেকটা দিন আমাকে মোকাবিলা করতে হবে।						
১০	কাজের ফলে আমি ধীরে ধীরে একা হয়ে যাচ্ছি।						
১১	কাজের চাপে আমি আমার কাজগুলো সুশৃংখলভাবে সাজাতে পারছি না।						
১২	অতিরিক্ত কাজের চাপে আমি প্রায়ই সিদ্ধান্ড় নিতে গিয়ে অহেতুক ভুল করছি।						
১৩	আমার কাজের দ্বারা আমি অন্য মানুষদের জীবনে ইতিবাচকভাবে প্রভাব বিস্ড়ার করছি।						
১৪	আমি আমার গ্রাহকদের সাথে যেমন খুশী তেমন আচরন করছি।						
১৫	আমি অল্পতে বিরক্ত হয়ে যাই।						
১৬	খুব সামান্য ও সাময়িক অসুবিধা আমার মধ্যে বিরাট বিরক্তি তৈরী করছে।						
১৭	আমি আমার কাজের প্রতি উৎসাহ হারিয়ে ফেলেছি।						
১৮	আমার আত্নীয়-স্বজন ও নিকট বন্ধুদের সাথে আমার দেখা সাক্ষাৎ কম হচ্ছে।						
১৯	কাজের ফলে আমি ধীরে ধীরে একা হয়ে যাচ্ছি।						
২০	আমি আমার কাজে কঠোর পরিশ্রম করছি।						
২১	আমি আমার কাজের সময় অন্যের আবেগীয় সমস্যাগুলো খুব ধীরে ও শান্ড়ভাবে মোকাবেলা করি।						
২২	আমি আমার গ্রাহকদের সাথে কাজের শেষে নিজেকে বেশ প্রানবন্ড় অনুভব করি।						
২৩	আমি কাজের সময় খুব উদ্দম অনুভব করি।						
২৪	আমি ঘন ঘন পেটে ব্যাথা, মাথাব্যাথা অথবা পিঠে ব্যাথা অনুভব করি।						
২৫	চাকুরীতে আমার সহকর্মীদের সাথে কথা বলার সুযোগ কম হয়।						

Hospital Anxiety & Depression Scale (HADS ;Zigmond &Snaith, 1983)

নিচের প্রতিটি প্রশ্ন পড়ুন এবং প্রতিটি প্রশ্নের নিচে চারটি করে উক্তি দেয়া আছে। সেই উক্তিটির পাশে টিক চিহ্ন দিন যা গত এক সপ্তাহে আপনি যেমন অনুভব করছেন তার সাথে সবচেয়ে মিল আছে। উত্তর দেবার ক্ষেত্রে খুব বেশি সময় না নিয়ে তাৎক্ষনিক ভাবে আপনার যা মনে হবে সেই অনুযায়ী প্রতিটি প্রশ্নের নিচের উক্তিতে টিক চিহ্ন দিন।

১। আমি উত্তেজিত বোধ করি অথবা আমার মনে হয় যে আমার সবকিছু গোলমাল পাকিয়ে যাচ্ছে।(Anxiety)

□বেশির ভাগ সময়
□অনেক সময়ই
□সময় সময় , মাঝে মাঝে
□একদমই না

২।আমার এমন ভীতিজনক অনুভুতি হয় মনে হয় যেন খুব খারাপ কিছু ঘটতে যাচ্ছে।(anxiety)

□ নিশ্চিত ভাবেই এবং খুব খারাপভাবে
□ হ্যাঁ, কিন্তু ততটা খারাপভাবে নয়
□ সামান্য , তবে এতে অত চিন্তিত হই না
□ একবারেই না

৩। দুশ্চিন্তাপূর্ণ চিন্তা আমার মনের মাঝে আনাগোনা করে ।(anxiety)

□অনেক সময়ই
□বেশির ভাগ সময়
□মাঝে মাঝে
□ খুবই কম

৪।আমি নিশ্চিন্তে বসে থাকতে পারি এবং আরাম বোধ করতে পারি ।Anxiety

□অবশ্যই
□সাধারণতঃ
□প্রায় সময়ই না
□একেবারেই না

৫।আমি এমন এক ধরনের ভয় পাই যে আমার মনে হয় পেটের মাঝে সবকিছু ওলট পালট খাচ্ছে। Anxiety

□একদম না
□মাঝে মাঝে
□অনেক সময়ই
□ বেশির ভাগ সময়

৬।সারাক্ষন আমি অস্থির বোধ করি, মনে হয় আমাকে সবসময়ই সচল থাকতে হবে। Anxiety

□ খুবই সঠিক
□সঠিক
□ঠিক ততটা নয়
□একেবারেই না

৭।আমার খুব ভয়ংকর আতংকের অনুভূতি হয়। Anxiety

□বেশির ভাগ সময়ই হয়
□প্রায় সময় হয়
□ প্রায় সময়ই হয় না
□একেবারেই না

৮।আগে আমার যে সব জিনিস ভালো লাগতো এখনও আমার সেগুলো ভালো লাগে । Depression

□সম্পূর্ণ আগের মত
□ঠিক আগের মত নয়
□খুব সামান্য
□একদম না

৯।আমি হাসতে পারি এবং ঘটনার কৌতুক পূর্ণ দিকটা দেখতে পারি Depression

□ ঠিক আগে যতটুকু পারতাম
□ঠিক আগের মত না
□নিশ্চিত ভাবে এখন ততটা না
□একেবারেই না

১০। আমি আনন্দ বোধ করি। Depression

□কখনোই না
□প্রায় সময়ই না
□মাঝে মাঝে
□বেশির ভাগ সময়ই

১১। আমার মনে হয় আমি যেন পিছিয়ে যাচ্ছি । Depression

□প্রায় সব সময়ই
□প্রায়ই
□মাঝে মাঝে
□একদম না

১২। আমি এমন চেহারা সম্পর্কে আগ্রহ হারিয়ে ফেলেছি । Depression

□নিশ্চিত ভাবেই ঠিক
□যতটা যত্ন আমার নেওয়া উচিত তা নেই না
□আমি হয়ত তেমন যত্ন নেই না
□আমি আগের মতই নিজের যত্ন নেই

১৩। আমি আনন্দ লাভের জন্য আগ্রহের সাথে অপেক্ষা করি। Depression

□ঠিক আগে যেমন করতাম
□আগের থেকে কিছুটা কম
□আগের থেকে অনেক কম
□ একেবারেই না

১৪। ভাল বই, রেডিও বা টেলিভিশনের অনুষ্ঠান উপভোগ করতে পারি। Depression

□প্রায়ই
□মাঝে মাঝে
□প্রায় সময়ই না
□খুবই কম

Bangla Warwick Edinburgh Mental Wellbeing Scale (WEMWBS)

ওয়ারউইক এডেনবারা মানসিক কল্যাণ মাপকাঠি (WEMWBS)

নিজস্ব অনুভূতি ও চিন্তা ভাবনা নিয়ে কিছু বিবৃতি দেয়া হল। দয়া করে ঐ বাক্সে টিক চিহ্ন দিন যা আপনার গত ২ সপ্তাহের অভিজ্ঞতার সাথে মিলে।

বর্ণনা	কখন ও নয়	কখন কখন	মাঝে মধ্যে	প্রায়ই	সব সময়
আমি ভবিষ্যত নিয়ে আশাবাদী					
আমি নিজেকে প্রয়োজনীয় মনে করি					
আমি শান্ত অথবা হালকা বোঢ করছিলাম					
আমি অন্য মানুষের ব্যাপারে আগ্রহী বোধ করছিলাম					
আমার বাড়তি শক্তি ছিল					
আমি সমস্যাগুলোর মোকাবেলা ভালভাবে করতে সক্ষম ছিলাম					
আমি পরিষ্কারভাবে চিন্তা করতে পারি					
আমি নিজের ব্যাপারে ভাল বোধ করি					
আমি অন্যদের কাছাকাছি আছি অনুভব করি					
আমি আত্মবিশ্বাসী বোধ করেছিলাম					
বিভিন্ন বিষয়ে আমি নিজে নিজে সিদ্ধান্ত নিতে সক্ষম ছিলাম					
আমাকে পছন্দ করা হয় বলে বোধ করেছিলাম					
আমি নতুন বিষয়ে আগ্রহী ছিলাম					
আমি আনন্দিত বোধ করেছিলাম					

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গোল্ড বার্গের মানসিক স্বাস্থ্য বিষয়ক প্রশ্নমালা

নিম্নের প্রশ্নগুলি আপনার মানসিক অবস্থা বা অনুভূতির সাথে সম্পর্কিত। প্রতিটি প্রশ্নের জন্য চারটি সম্ভাব্য উত্তর ১) মোটেই না ২) কিছুটা৩) বেশ খানিকটা ৪) সর্বাধিক পরিমাণ

দেয়া আছে। অনুগ্রহ করে আপনি প্রতিটি প্রশ্নের সাথে প্রদত্ত চার ধরনের উত্তরের যেটির সাথে একমত তার উপর টিক(✓) চিহ্ন দিন।

	প্রশ্ন	১	২	৩	৪
		মোটেই না	কিছু টা	বেশ খানিক টা	সর্বাধিক পরিমাণে
১	ইদানিং আপনি যা করছেন তাতে কি মোটেই মনোনিবেশ করতে পারছেন?				
২	অত্যন্ত দুশ্চিন্তা আপনার নিদ্রায় ব্যাঘাত করে কি?				
৩	আপনি আজকাল আপনার প্রয়োজনীয় কাজে মনোযোগ দিতে পারেন কি?				
৪	আপনি বর্তমানে কোন কিছু সম্পর্কে সিদ্ধান্ত গ্রহন করতে সমর্থ কি না?				
৫	আপনি সর্বদা মানসিক পীড়নে ভোগেন কি না?				
৬	ইদানিং আপনি কি মনে করেন যে, বাধাগুলো দূর করতে আপনি সক্ষম হচ্ছেন না?				
৭	আপনার দৈনন্দিন সাধারন কাজগুলো উপভোগ করতে সক্ষম কি না?				
৮	আপনি ইদানিং আপনার সমস্যাগুলোর মোকাবেলা করতে সক্ষম?				
৯	আপনি কি ইদানিং অসুখী ও বিমর্ষ বোধ করেন?				
১০	বর্তমানে আপনি কি আত্মবিশ্বাস হারিয়ে ফেলেছেন বলে মনে করেন?				
১১	ইদানিং আপনি নিজেকে একজন মূল্যহীন ব্যক্তি হিসেবে গণ্য করেন কি?				
১২	সমস্ত কিছু বিবেচনা করে বর্তমানে আপনি নিজেকে মোটামোটি সুখী মনে করেন কি?				

মডিউল ১: মানসিক চাপ ব্যবস্থাপনা

মানসিক চাপ ও এর সাথে মানিয়ে নেওয়া :

মানসিক চাপ হলো পরিবর্তিত পরিস্থিতির সাথে ব্যক্তির খাপ খাইয়ে নেওয়ার জন্য এক ধরণের স্বতস্ফূর্ত শারীরিক পরিবর্তন। এই ধরণের পরিবর্তনের প্রতি ব্যক্তির শরীর ও মন প্রতিক্রিয়া করে থাকে। মানসিক চাপ আমাদের প্রাত্যহিক জীবনের অপরিহার্য্য বিষয়গুলির মধ্যে একটি। আপনার চারপাশের পরিবেশ, আপনার শরীর এবং আপনার ব্যক্তিগত চিন্তাধারা আপনার মানসিক চাপের উৎস হিসাবে কাজ করতে পারে। আমাদের মস্তিষ্কের ঋণাত্মক চিন্তার চক্র আমাদের মানসিক চাপ তৈরীতে বিশেষ ভূমিকা রাখে।

ঋণাত্মক চিন্তার একটি চক্রের তিনটি উপাদান হলো :

- চিন্তা (আমরা যা চিন্তা করি আমাদের অনুভূতি ও আচরণ সে অনুযায়ী হয়)
- আচরণ (আমাদের চিন্তা ও অনুভূতি অনুযায়ী আমরা আচরণ করি)
- আবেগ/ অনুভূতি (চিন্তা ও আচরণের ধরণ অনুযায়ী আমাদের অনুভূতি পরিবর্তিত হয়)

মানসিক চাপের সাথে মানিয়ে নেওয়ার কৌশল :

- মানসিক চাপের উৎসগুলি নির্দিষ্ট করা - ভৌগলিক গতিশীলতা, স্কুল পার হয়ে কলেজে যাওয়া, চাকুরী বদলের কারণে সন্তানের স্কুল পরিবর্তন, বিবাহ, গর্ভধারণ, নতুন চাকুরী লাভ, জীবন ধারণের নতুন নতুন পদ্ধতি, বিবাহ বিচ্ছেদ, ভালোবাসার মানুষের মৃত্যু, চাকুরীচ্যুত হওয়া, সময়ের চাপ, প্রতিযোগিতা, আর্থিক সমস্যা, হট্টগোল, হতাশা ইত্যাদি।
- আপনি আপনার মানসিক চাপ চারটি বিশেষ উপায়ে চিহ্নিত করতে পারেন, যথা––
  শারীরিক, আবেগীয়, জ্ঞানীয় ও আচরণগত।
- নেতিবাচক চিন্তার চক্রকে ভাঙ্গা
- দৈহিক শিথিলায়ন
- শারীরিক ব্যায়াম ও যোগব্যায়াম (ইয়োগা)
- ধ্যান করা
- কাউন্সেলিং সেবা গ্রহণ ইত্যাদি।

মডিউল ২: যোগাযোগ দক্ষতা

যোগাযোগ দক্ষতা কি?

চিহ্ন, প্রতীক এবং বিভিন্ন দৈহিক অঙ্গভঙ্গির মাধ্যমে এক অপরের সাথে মনের ভাব আদান-প্রদানের যে কৌশল তাকে যোগাযোগ দক্ষতা বলে।

যোগাযোগ দক্ষতার ধরণ :

যোগাযোগ দক্ষতাকে চারটি ধরণে ভাগ করা যায়; যেমনঃ

নিষ্ক্রিয় যোগাযোগ দক্ষতা,

আক্রমণাত্মক যোগাযোগ দক্ষতা,

নিষ্ক্রিয-আক্রমণাত্মক যোগাযোগ দক্ষতা ,

দৃঢ়তাসূচক যোগাযোগ দক্ষতা ইত্যাদি।

- **নিষ্ক্রিয় যোগাযোগ :**

এই ধরনের যোগাযোগের ক্ষেত্রে ব্যক্তি তার নিজের অনুভূতি ও মতামত প্রকাশ করতে পারে না। নিজের অধিকার রক্ষা করা, নিজের প্রয়োজন সুনির্দিষ্ট করা এবং তা পূরণ করা এই ধরণের মৌলিক বিষয় থেকে ব্যক্তি নিজেকে বিরত রাখে। ফলে এই নিষ্ক্রিয় ব্যক্তিরা বেদনাদায়ক ও রাগপূর্ণ পরিস্থিতিতে সরাসরি কোন প্রতিক্রিয়া করতে পারে না।

আচরণগত বৈশিষ্ট্যঃ

- নরম সুরে কথা বলা / শান্ত থাকা
- অন্যদের সুযোগ-সুবিধা লাভের ব্যবস্থা করে দেওয়া
- অন্যের প্রয়োজনকে অগ্রাধিকার দেওয়া
- কারো চোখের দিকে তাকিয়ে কথা বলতে না পারা
- নিচের দিকে তাকিয়ে কথা বলা
- নিজের প্রয়োজন ও চাহিদা কখনো প্রকাশ না করা
- আত্ম-বিশ্বাসের অভাব

আক্রমণাত্মক যোগাযোগ :

আক্রমণাত্মক যোগাযোগ দক্ষতাসম্পন্ন ব্যক্তিরা তাদের অনুভূতি, মনোভাব, তাদের অধিকার ও প্রয়োজনের কথা এমনভাবে প্রকাশ করে যাতে অন্যরা ক্ষতিগ্রস্থ হয়। এভাবে এ ধরণের ব্যক্তিরা ভাষাগত ও শারীরিকভাবে অন্যদের অবমাননা করে। তারা সবসময় অন্যদের উপর প্রভাব বিস্তার করতে চায়।

আচরণগত বৈশিষ্ট্য:

- সহজেই হতাশাগ্রস্থ হওয়া
- সমালোচনা করা, অবমাননা করা ও কর্তৃত্বপূর্ণ মনোভাব তাদের আচরণের প্রধান বৈশিষ্ট্য
- অত্যন্ত উচ্চস্বরে কথা বলা ও অধৈর্য্যভাব প্রদর্শন করা
- আপোষ-মিমাংসা করতে অনিচ্ছুক
- অন্যের কথা মনযোগ দিয়ে না শোনার পাশাপাশি দলীয় আলোচনায় বারবার ব্যাঘাত ঘটানো
- অন্যদের অসম্মান করা ইত্যাদি।

নিষ্ক্রিয়-আক্রমণাত্মক যোগাযোগ :

এই ধরণের যোগাযোগ পদ্ধতি অনুশীলণকারী ব্যক্তিগণ বাহ্যিক নিষ্ক্রিয়ভাব প্রদর্শণ করলেও তারা একটি সূক্ষ, অপ্রত্যক্ষ ক্ষোভ ভিতরে পুষে রাখে। সরাসরি রাগ প্রকাশ করার পরিবর্তে তারা বিষয়টিকে সংক্ষিপ্ত করে তাদের ক্ষোভ প্রকাশ করে।

আচরণগত বৈশিষ্ট্য:

- অন্যের চাহিদার প্রতি বিরক্তিপূর্ণ মনোভাব ও বৈপরিত্য প্রকাশ করা
- অন্যের দাবীর প্রেক্ষিতে বিলম্ব ও ইচ্ছাকৃত ভুল
- ছদ্মবেশী, দুর্বল বা প্রতিকূল মনোভাব
- অপ্রতিরোধ্য বা প্রতারণার অনুভূতি সম্পর্কে প্রায়শই অভিযোগ করা ইত্যাদি।

দৃঢ়তাসূচক যোগাযোগ:

দৃঢ়তাসূচক যোগাযোগ দক্ষতা অনুশীলণই আমাদের সকলের লক্ষ্য হওয়া উচিত। এখানে উভয় পক্ষই তাদের চাহিদা পূরণে সমর্থ হয়। উভয় পক্ষই সন্তুষ্টি নিয়ে যোগাযোগ প্রক্রিয়া সম্পন্ন করে।

আচরণগত বৈশিষ্ট্য:

- আলাপচারিতায় বাঁধা প্রদান না করা, অপরের কথা মনযোগ দিয়ে শোনা
- আপোষ-মীমাংসার মনোভাব পোষণ করা
- নিজের প্রয়োজন এবং চাহিদা পরিষ্কারভাবে প্রকাশ করা
- নিজের অধিকারের পক্ষে দাঁড়ানো

- অন্যের প্রয়োজনের প্রতি সম্মান প্রদর্শন করা
- শারীরিক অঙ্গভঙ্গি ও কণ্ঠস্বরে বিশ্বস্ততা প্রকাশ করা
- সামনের ব্যক্তিটির চোখের দিকে তাকিয়ে কথা বলা কথা বলা ইত্যাদি।

দৃঢ়তাসূচক আচরণ দক্ষতা অর্জনের কৌশল:

দৃঢ়তাসূচক আচরণ দক্ষতার প্রথম তিনটি কৌশল হলো

- ✓ যেকোন ধরণের পরিস্থিতি নিয়ন্ত্রণে নিজের উপর আস্থা রাখা
- ✓ পরিষ্কার ও সহজ ভাষায় নিজের চাহিদার কথা বলা
- ✓ কথোপকথনে তথ্য প্রদানের সময় শান্ত থাকা এবং নিয়ন্ত্রিত আচরণের অনুশীলণ করা

"না" বলতে শিখুন , আগের কাজ আগে করুন :

দৃঢ়তাসূচক আচরণের ক্ষেত্রে সকলকে খুশি করা থেকে নিজেকে বিরত রাখতে হবে বরং তাদের প্রত্যাশা অনুযায়ী কাজ করতে হবে। অপরকে খুশী করার জন্য কাজ করলে আপনি অধিকাংশ সময়ই হতাশ হবেন এবং পরবর্তীতে নিজের প্রযোজনে অপরের কাছে চাওয়ার ক্ষেত্রে নিজেকে দুর্বল মনে করবেন। দৃঢ়তাসূচক যোগাযোগের ক্ষেত্রে, আপনি আপনার চাওয়াকে পরিষ্কারভাবে প্রকাশ করবেন কিন্তু খেয়াল রাখবেন যাতে অন্যরা এতে কষ্ট না পায়। এটা এমন হতে পারে যে, কেউ আপনার কাছে কিছু চাইলো এবং আপনি তা প্রত্যাখ্যাণ করলেন। এক্ষেত্রে আপনি কেন প্রত্যাক্ষাণ করলেন তা সঠিকভাবে ব্যাখ্যা করতে হবে। "কারণ" শব্দটি যোগাযোগের একটি শক্তিশালী গেম-চেঞ্জার হিসাবে কাজ করে। আপনি অন্যের কাজটি প্রত্যাখ্যাণ করার পরও সে কষ্ট পাবে না, যদি আপনি আপনার সিদ্ধান্ত জানানোর পাশাপাশি প্রত্যাক্ষাণের শক্তিশালী একটি কারণ তাকে জানান।

আপনার কণ্ঠস্বর খেয়াল করুন :

আমরা আগে যে স্ব-নিয়ন্ত্রণের কথা বলেছি তা এখানে ব্যবহার করা উচিত। আপনার কণ্ঠে শান্ত, ধীর-স্থির, স্বাচ্ছ্যন্দপূর্ণ ভাব বজায় থাকা উচিত। এটি অর্জনে অন্যান্য দক্ষতার মতো কিছুটা সময় নিতে পারে। বিরক্তিপূর্ণ অনুভূতির কারণে হয়তো আপনার কণ্ঠস্বর উচ্চ হতে পারে অথবা আপনি দ্রুততার সাথে কথোপকথন শেষ করতে পারেন । সেক্ষেত্রে নিজের উপর বিরক্ত না হয়ে বরং ধৈর্য্য ধরুন। দ্বিধা কাটিয়ে কণ্ঠে কঠোরতা প্রকাশ করাও দৃঢ় আচরণের অন্যতম বৈশিষ্ট্য। এর সাথে কণ্ঠে বন্ধুত্বপূর্ণ ও শান্তভাব বজায় রাখুন। আস্তে আস্তে কথা বললে এবং শান্ত ভাব বজায় রাখলে আলাপচারিতায় ভারসাম্য ফিরিয়ে আনা সম্ভব।

অবাচনিক যোগাযেগের প্রতি মনযোগী হোন :

দৈহিক অঙ্গভঙ্গি, চোখের দিকে তাকিয়ে কথা বলা, শালীনতাপূর্ণ পোশাক পরিচ্ছদ, শ্রবণ দক্ষতা এবং প্রতিক্রিয়া করা এই বিষয়গুলি যোগাযোগের অবাচনিক দক্ষতা। আক্রমণাত্মক ও নিষ্ক্রিয়ভাব ছাড়াই আমাদের এই বিষয়গুলির প্রতি মনযোগী হতে হবে। আপনার আক্রমণাত্মক ভাব প্রদর্শণের কারণে, উক্ত ব্যক্তিটি আপনার প্রতি প্রতিশোধপরায়ণ হয়ে উঠতে পারে। আবার নিষ্ক্রিয়ভাব প্রদর্শন করলে ব্যক্তি ভাবতে পারে আপনি তাকে অবহেলা করছেন। কথোপকথনের সময় অপরের চোখের দিকে তাকিয়ে কথা বললে আপনি মূল বিষয়ে মনযোগ ধরে রাখতে পারবেন। এছাড়া এর মাধ্যমে সহজেই অপরপ্রান্তের ব্যক্তিটি ভাববে আপনি তার কথা গভীর মনযোগ দিয়ে

শুনছেন, তাকে গুরুত্ব দিচ্ছেন। বিশেষজ্ঞগণ বলেন, আপনি একজন ব্যক্তিকে কি বলছেন তার থেকে গুরুত্বপূর্ণ হলো আপনি তার দিকে কিভাবে আর কতক্ষণ তাকাচ্ছেন।

বর্তমানে থাকুনঃ

অপর ব্যক্তি প্রকৃতপক্ষে আপনাকে কি বোঝাতে চাচ্ছে সেটার প্রতি যদি আপনি অনেক বেশি মনযোগী হওয়াই ফলপ্রসূ যোগাযোগ তথা একটি উত্তম সম্পর্ক গড়ে তোলার মূলমন্ত্র । অতীতের বিষয় বারবার নিয়ে আসলে ব্যক্তি বর্তমান বিষয়ে মনযোগ ধরে রাখতে পারে না- এর অর্থ আপনার সামনে থাকা ব্যক্তিটিকে আপনি অসম্মান করছেন এবং অতীতের বিষয় বার বার আনার কারণে আপনি বর্তমানে মনোযোগ ধরে রাখতে পারছেন না (সেক্ষেত্রে আপনি দৃঢ়তাসূচক সঠিকউত্তরটি দিতে পারছেন না। “মাইন্ডফুলনেস” শব্দটির অর্থ হলো, এই মুহূর্তে আপনার আশেপাশে নেই এমন বিষয়গুলো বাদ দিয়ে সম্পূর্ণরূপে বর্তমানে থাকা, পৃথিবীর অন্য সবকিছুর কথা ভুলে গিয়ে আপনি এই মুহূর্তে যার সাথে আলাপ করছেন তার কথার প্রতিটি অংশ গভীর মনযোগ দিয়ে শোনা।

“আমিসূচক বার্তা”ঃ

“আমিসূচব বার্তা” ব্যবহার করে আন্তব্যর্ক্তিক দ্বন্দ্ব এড়িয়ে নিজের শক্তিশালী অনুভূতিগুলি প্রকাশ করা যায়। এই বার্তাগুলি কথোপকথনকে সঠিক দিকে পরিচালিত করতে পারে। কোনরকম অভিযোগ না করে আমরা আমাদের বিভিন্ন আবেগগুলি (হতাশা, নিরাশা, রাগ ইত্যাদি) প্রকাশ করতে পারি। “আমিসূচক বার্তা” সাধারণত শুরু হয় “আমার মনে হয়” এরকম বাক্য দিয়ে, তাই সেখানে আপনি অন্যে কারো সমালোচক হিসাবে পরিগনিত হবেন না। এখানে আপনার নিজের অনুভূতি প্রকাশিত হয়, আপনার সাথে ঘটে যাওয়া ঘটনাটি আপনি কিভাবে অনুভব করছেন এবং এই পরিস্থিতি পরিবর্তনের জন্য আপনি কি করতে পারেন। “আমিসূচক বার্তা” অন্য ব্যক্তিকে দোষারোপ করার পরিবর্তে আপনাকে আপনার নিজের ধারণা ও অনুভূতির জন্য দ্বায়বদ্ধ থাকতে সাহায্য করে।

মডিউল ৩: সমানুভূতিপূর্ণ যোগাযোগ

সমানুভূতির ধারনাঃ

একজন ব্যক্তি যখন অন্য আরেকজন ব্যক্তিকে ঐ ব্যক্তির ফ্রেম অফ রেফারেন্স (ব্যক্তিগত মানচিত্র) থেকে বোঝা বা অনুভব করার দক্ষতা অর্জন করে তখন তাকে সমানুভূতিপূর্ণ আচরণ হিসাবে চিহ্নিত করা যায়। অন্য কথায়, নিজেকে অন্যের অবস্থানে রাখার ক্ষমতা। আপনি সঠিক বিকাশ ও সঠিকভাবে লালন-পালনের মধ্যে বড় হলে প্রয়োজনে অন্যদের মন ভালো করতে বা ঝুঁকিপূর্ণ পরিবেশে ব্যক্তি কীভাবে খাপ খাওয়াতে পারে সে জন্য আপনি অন্যকে সাহায্য করতে পারেন। সমানুভূতিপূর্ণ মনোভাব কর্মক্ষেত্রে একটি মূল দক্ষতা হিসাবে বিবেচিত হয়, কারণ এটি উৎপাদনশীল দল তৈরী করতে, বিভিন্ন দ্বন্দ্বের সমাধান করতে, সহকর্মী, ক্লায়েন্ট এবং গ্রাহকদের সাথে সম্পর্ক উন্নত করতে সহায়তা করে।

সমানুভূতি এবং সহানুভূতির মধ্যে পার্থক্যঃ

সহানুভূতি এবং সমানুভূতি দুটি সম্পূর্ণ ভিন্ন জিনিস হলেও একটি সাধারণ ভুল এ দুটির মধ্যে দ্বন্দ্ব সৃষ্টি করে। সহানুভূতি হলো যখন আপনি অন্যের অনুভূতিকে ভাগ করে নেন বিশেষ করে দুর্ভাগ্যজনিত দু:খবোধের অনুভূতি; আর সমানুভূতি হলো অন্যের অনুভূতিকে তার জায়গা থেকে বোঝা। উদাহরণস্বরূপঃ একজন ব্যক্তি রাস্তায় একটি দু:খজনক ঘটনা দেখে কাঁদতে পারে, যদিও সে এ বিষয়ে কিছু জানেনা। সহানুভূতির অনুশীলণ ব্যক্তি কখনো সমানুভূতির দিকে নিয়ে যায় কিন্তু সবসময়ই যে এমনটা হতে হবে তা নয়।

সমানুভূতির কৌশলঃ

১. সক্রিয়ভাবে শুনুনঃ

শ্রবণশক্তি আমাদের অন্যের প্রতি সহানুভূতিশীল হতে কার্যকর উপায় হিসাবে কাজ করে। আপনি যখন সক্রিয় শ্রবণের অনুশীলণ করছেন তখন আপনি উদ্দেশ্য নিয়ে শুনছেন। আপনি আপনার ফোনে কথা বলছেন না, বা আপনি আজ রাতের খাবারের জন্য কি তৈরী করতে যাচ্ছেন তা ভেবে দেখছেন না, অন্য ব্যক্তি কি বলছে তা আপনি সত্যই গ্রহন করছেন।

- ব্যক্তির মুখোমুখি কোণাকুনিভাবে বসুন। স্থিরদৃষ্টিতে একটানা তাকিয়ে থাকবেন না।
- আপনার অঙ্গভঙ্গিগুলো উন্মুক্ত রাখুন। হাত এবং পা ক্রস করে বসবেন না। প্রয়োজনীয় কিছু অঙ্গভঙ্গি করতে পারেন যেমন মাথা নাড়ানো, কিছু উৎসাহজনক শব্দ বলুন যেমন হুঁ, ওহ্, চালিয়ে যান, আমি বুঝতে পারি ইত্যাদি।
- সামনের দিকে ঝুঁকুন, যাতে অন্য ব্যক্তি বুঝতে পারে যে তারা গুরুত্ব পাচ্ছে।

- বক্তার চোখের দিকে তাকান (একটানা তাকিয়ে থাকবেন না, কিন্তু চোখের যোগাযোগ বজায় রাখুন, মনে রাখবেন সংস্কৃতি অনুযায়ী ব্যক্তির চোখের যোগাযোগ হয়ে থাকে। কিছু মানুষ এটাকে অত্যন্ত খারাপ চোখে দেখে, অনেকে ভয় পায়। আপনি নিশ্চিত না হলে তার কাছে জানতে চাইতে পারেন যে সে কি ধরণের চোখের যোগাযোগ করে থাকে)
- কাউকে যখন শুনবেন তখন রিল্যাক্স থাকুন।
- সক্রিয় শ্রোতা হওয়ার জন্য আরও দুটি জিনিস প্রয়োজন -

প্রথমত ব্যক্তি যা বলছে তা যে আপনি সত্যিই শুনেছেন এবং বুঝেছেন তা বোঝাতে আপনি তার বক্তব্যের বিষয়বস্তু তাকে শোনান। এটি একটি সাধারণ শোনার দক্ষতাও।

দ্বিতীয়ত আপনার সংবেদনশীল প্রতিক্রিয়ার প্রতিফলন ঘটান। প্রতিক্রিয়া করা সমানুভূতির একটি গুরুত্বপূর্ণ অংশ কারণ এটি ব্যক্তিকে তার নিজস্ব আবেগকে আরও ভালোভাবে বুঝতে ও নিয়ন্ত্রণ করতে সহায়তা করে। অন্যের প্রতি সমানুভূতিশীল হওয়ার এটি একটি মূল কারণ। অন্যের প্রতিক্রিয়া আমাদের নিজেদের প্রতিক্রিয়া ব্যক্ত করতে ও পৃথিবীকে বুঝতে সাহায্য করে।

২. বিচার না করা:

সমানুভূতি ও মননশীলতা অনুশীলণ করার সময় এটি একটি গুরুত্বপূর্ণ পদক্ষেপ। প্রথম আলাপচারিতায় দ্রুত সিদ্ধান্তে পৌঁছানো কঠিন। এবং এক্ষেত্রে সমানুভূতি প্রদর্শণ করাটাও কঠিন। কিন্তু আপনি যদি ব্যক্তিটিকে বিচার করতে থাকেন তবে সে কখনোই তার কষ্টের কথা আপনাকে বলবে না। মনে রাখবেন, আপনি তাকে বিচার করতে নয় বরং তাকে শুনতে বসেছেন।

৩. সম্পূর্ণরূপে নিজেকে প্রকাশ করা:

কারো কথা শুনলেই দুজনের মধ্যে সেতু তৈরী হচ্ছে না। আবেগীয় বিষয়গুলি প্রকাশ করা কঠিন তবে এটি দুজনের মধ্যে সংযোগকে দৃঢ় করে।

- সমানুভূতি একটি দ্বিমুখী রাস্তা। এটি একে অপরের দুর্বলতা ও আবেগীয় সংযোগকে ভাগাভাগি করে নেয়। কখনো কখনো সত্যিকারের সমানুভূতির অনুশীলণ করা আপনার নিজের অভ্যন্তরীণ বিষয়গুলো কারো সাথে ভাগ করে নেওয়ার ক্ষেত্রে সহায়তা করে।
- এর মানে এই নয় যে আপনি আপনার জীবনের গল্প সকলের সাথে বলবেন। আপনি কার সাথে নিজের গল্প ভাগ করে নিতে চান তা স্থির করে নিতে পারেন। তবে সমানুভূতি অনুশীলণের ক্ষেত্রে আপনাকে নিজেকে উন্মুক্ত রাখা প্রয়োজন।

৪. শারীরিক স্নেহ প্রদান:

আপনি শারীরিক স্নেহ সকলে জন্য ব্যবহার করতে পারেন কিন্তু অবশ্যই পূর্বেই এ ব্যাপারে অপরের সম্মতি আছে কি-না জেনে নিবেন (যদি ব্যক্তিটি আপনার পরিচিত হয় তবুও)। শারীরিক স্নেহ শরীরে অক্সিটোসিনের মাত্রা বাড়িয়ে দেয় তখন উভয়েই ভালো অনুভূতি বোধ করে।

- আপনার সুপরিচিত ব্যক্তি হলে আপনি তাকে আলিঙ্গণ পারেন অথবা তার কঁধে একটি হাত রাখতে পারেন অথবা তার বাহুতে একটি হাত রাখতে পারেন। এর অর্থ শুধুমাত্র এই নয় যে, আপনি তার প্রতি মনযোগী বরং তার সাথে আপনার একটি ভালো সংযুক্তি তৈরী হচ্ছে।
- অক্সিটোসিন মানুষকে অন্য ব্যক্তি আবেগকে আরো ভালোভাবে বুঝতে সাহায্য করার জন্য সুপরিচিত, সুতরাং একটি আলিঙ্গণ দুটি ব্যক্তির আবেগীয় বুদ্ধিমত্তাকে বাড়িয়ে দিতে পারে।

৫. **সাহায্যের প্রস্তাবঃ**

এক্ষেত্রে, আপনি দেখুন যে একটি মানুষ কি ধরণের পরিস্থিতির মধ্য দিয়ে যাচ্ছে এবং তার জীবনকে আরও একটু সহজ করার জন্য আপনি কি সাহায্য করতে পারেন। সাহায্যের প্রস্তাব সমানুভূতির একটি বড় ধরণের কাজ, কারণ এতেই প্রদর্শিত হচ্ছে যে আপনি কোন প্রতিদান গ্রহন ছাড়াই অন্য একজন মানুষকে সাহায্য করতে চাচ্ছেন।

মডিউল ৪: স্ট্রোক বা স্বীকৃতি

স্ট্রোকের ধারণাঃ

স্টোককে "স্বীকৃতি" হিসাবে সংজ্ঞায়িত করা যেতে পারে যেটা কর্মপরিবেশে একটি গুরুত্বপূর্ণ ভূমিকা পালন করে। সুতরাং স্ট্রোককে স্বীকৃতির সমষ্টি হিসাবে চিহ্নিত করা যায় যেখানে একজন অপর জনকে স্বীকৃতি দিবে বা ভালো কাজের প্রশংসা করবে। কার্যকর যোগাযোগ স্থাপনের জন্য স্ট্রোক দেওয়া একটি গুরুত্বপূর্ণ বিষয় হতে পারে। এরিক বার্ন তার ট্রানজ্যাকশনাল এ্যানালাইসিস তত্ত্বে স্ট্রোকের ধারণাটিকে প্রতিষ্ঠিত করেন।

স্ট্রোকের প্রকারভেদঃ

পাঁচটি উপায়ে স্ট্রোক ব্যবহার করা যায়।

- ✓ স্ট্রোক দেওয়া
- ✓ স্ট্রোক চাওয়া
- ✓ অন্য কেউ স্ট্রোক দিলে সেটা গ্রহণ করতে পারা
- ✓ অপ্রয়োজনীয় স্ট্রোক পরিত্যাগ করা
- ✓ আত্ম-প্রশংসা/ আত্ম-স্বীকৃতি

স্ট্রোকগুলি বাচনিক -অবাচনিক, শর্তযুক্ত বা শর্তহীন হতে পারে। উদাহরণস্বরূপঃ

- ✓ হ্যালো (বাচনিক) অথবা হাসি (অ-বাচনিক)
- ✓ আপনাকে দেখে ভালো লাগছে (ইতিবাচক) অথবা আপনি এখন চলে গেলেই ভালো হয় (নেতিবাচক)
- ✓ আপনি এটি ভালো করেছেন (শর্তাধীন) অথবা আপনি দারুন (শর্তহীন)।

স্ট্রোক ইকোনমিঃ

ক্লড স্টেইনার, মনরোগবিশেষজ্ঞ এবং ট্রানজ্যাকশনাল এ্যানালাইসিসের প্রশিক্ষক কিছু বছর আগে সংস্কৃতির কিছু নেতিবাচক নিয়ম সম্পর্কে লেখেন। সেখানে আমাদের অনেকগুলি পূর্বধারণা উত্থাপিত হয়েছিল যা আমাদের স্ট্রোক প্রদান ও স্ট্রোক গ্রহণের বিষয়ে সতর্ক করে দেয়।

এই অস্বাস্থ্যকর নিয়মগুলি হলোঃ

- ✓ স্ট্রোক দেওয়ার সুযোগ আসলেও কাউকে স্ট্রোক দিবেন না
- ✓ আপনি স্ট্রোকের প্রয়োজনীয়তা বোধ করলেও অন্য কারো কাছে স্ট্রোক চাইবেন না
- ✓ প্রয়োজনীয় স্ট্রোকগুলি স্বীকার করবেন না
- ✓ অপ্রয়োজনীয় স্ট্রোককে বাদ দিবেন না
- ✓ নিজেকে স্ট্রোক দিবেন না

এই নিয়মগুলোর মধ্যে যারা নিজেদেরকে আটকে রাখে তাদের ব্যক্তিগত ও সামাজিক সম্পর্কগুলোতে অসংখ্য সমস্যার সৃষ্টি হয়।