Predictors of Burnout among Mental Health Professionals

Thesis submitted in partial fulfillment of the requirements for the Degree of M.Phil. in Clinical Psychology awarded by the University of Dhaka

Submitted by

Khadiza Begum

MPhil (Part-II)

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Department of Clinical Psychology

University of Dhaka

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Approval of the Thesis

This is to certify that the thesis titled **"Predictors of Burnout among Mental Health Professionals"** submitted by **Khadiza Begum** to fulfill the requirements for the degree of M. Phil in Clinical Psychology is an original work. The research was carried out by her under our guidance and supervision. We have read the thesis and to our knowledge it has been written by her and does not contain plagiarism.

Date:

.....

(Muhammad Kamruzzaman Mozumder)

Professor

Dept. of Clinical Psychology

University of Dhaka

and

.....

(S. M. Abul Kalam Azad)

Associate Professor

Dept. of Clinical Psychology

University of Dhaka

Declaration by the Researcher

This is to certify that the report entitled **"Predictors of Burnout among Mental Health Professionals"** which is submitted to the Department of Clinical Psychology, University of Dhaka in Partial Fulfillment of the Requirements for the Degree of Masters of Philosophy (MPhil), comprises only my original work and due acknowledgement has been made in the text to all other material used. To my best, the study is an authentic one and if there is any error, I am responsible for that.

……..

Khadiza Begum

Abstract

Burnout significantly impacts service, productivity, and wellbeing of mental health professionals. Designing effective intervention strategy to prevent burnout required strong evidence base on the contributors of burnout. This study was designed in the context of limited knowledge on burnout and its contributors among mental health professionals in Bangladesh. With the overarching aim to identify predictors of burnout, this study explored putative contributors of burnout and then carried out multiple regression to identify significant predictors.

Exploration component included desk review and evaluation by a panel with experts which resulted in listing of 16 putative contributors. Suitable tools are assembled to measure these factors. The set of tools included a few already available instruments namely, the Ten Item Personality Inventory (TIPI-B), the Coping Scale, Steel Injustice Inventory, and the Copenhagen Burnout Inventory along with a few custom-built instruments. A cross-sectional questionnaire survey was conducted with a sample of 292 mental health professionals from psychiatry, clinical psychology, counseling psychology, and educational psychology background.

Results identified multiple predictors of burnout for the mental health professionals in Bangladesh. Workplace aggression (β = .235, p < .001), neuroticism (β = -.211, p < .001), and nonadaptive coping (β = -.191, p < .001) were the strongest predictors of personal burnout. Stressful work (β = .225, p < .001), workplace aggression (β = .208, p < .001), and neuroticism (β = -.205, p < .001) were the strongest predictors of work-related burnout. Workplace aggression (β = .255, p < .001), neuroticism (β = -.195, p < .001), and adaptive coping (β = -.197, p < .001) were the strongest predictors of client-related burnout among mental health professionals in Bangladesh. Comparison of burnout revealed statistically

significant difference in personal burnout ($F_{3, 288}$ = 21.508, p < .001), work-related burnout ($F_{3, 288}$ = 8.780, p < *.001*) & client-related burnout ($F_{3, 288}$ = 13.559, p < *.001*) scores among different mental health professional groups. Subsequent multiple comparisons of the mean burnout score indicated clinical psychologist having significantly higher burnout among the four groups in terms of personal (M = 41.22, SD =18.88) and work-related burnout (M = 34.23, SD = 20.02) while psychiatrists have higher client-related burnout (M = 30.67, SD = 22.47).

The findings of the study are likely to be useful for the key stakeholders of mental health service delivery in Bangladesh. This may be especially beneficial in developing and implementing evidence informed strategy to prevent burnout among mental health professionals in Bangladesh.

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Dated: Dhaka Khadiza Begum

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Dedicated to my grandmother 'Aiotonnessa' for her special contribution in my life

&

the Mental Health Professionals who contribute to the wellbeing of distressed people

Chapter 1

INTRODUCTION

Introduction

Burnout is an occupational hazard for professionals from different discipline. It reduces work performance (Adriaenssens et al., 2015; Wright, & Bonett, 1997), job satisfaction (Goldberg et al.,1996; Rossler, 2012), organizational commitment (Salvagioni et al., 2017), self-efficacy (Chang et al., 2018), standard of quality services (Humborstad et al., 2007) and increases absenteeism (Ahola et al., 2017), intention to leave job (Han et al., 2016), personnel turnover (Chang et al., 2018). Burnout syndrome has been found to be correlated with reduced capacity for coping, depression, anxiety, issues with concentration and memory, low self-esteem, difficulty making decisions, irritability, insomnia, dissatisfaction with life, and increased consumption of tobacco and alcohol (Maslach & Leiter, 2016; Salvagioni et al., 2017). It is also linked with health consequences (Giorgi et al., 2017) and is suggested as a risk factor for type 2 diabetes (Melamed et al., 2006). Burnout is one of the most studied stressors among healthcare professionals (Moradi et al., 2015). Chronic workplace stress is known to cause burnout. Burnout occurs when the cumulative impacts of a stressful work environment progressively exceed the person's ability to cope, causing them to withdraw mentally. The causes and correlates of burnout may also differ due to the cultural factors which shape human responses and coping.

1.1. Emergence of the Concept of Burnout

Symptoms of burnout syndrome were first described by Herbert Freudenberger in the 1970s. Freudenberger witnessed a progressive depletion of emotional, cognitive, and physical resources in volunteers as well as in himself while working in a free clinic. He provided a thorough description of this specific form of occupational stress, encompassing feelings of emptiness, cynicism, and exhaustion brought on by pressures in the workplace,

in his influential paper “Staff burnout” (Freudenberger, 1974). He described burnout as “becoming exhausted by making excessive demands on energy, strength and resources” (Freudenberger, 1974). However, his analysis of burnout was based on observation only on a specific clinic. Simultaneously, Christina Maslach noticed the chronic symptoms of weariness, loss of drive, and dedication on the job throughout the same decade. Maslach and her colleagues (1976) conducted interviews with a wide variety of ‘helping' professions. They found that those workers experienced intense difficulties in professional competence and developed negative feelings & perceptions toward their clients followed by frequent feelings of emotional exhaustion (Maslach & Schaufeli, 1993). Maslach and her colleagues adopted the term “burnout” with an operational definition of burnout syndrome. World Health Organization has officially recognized burnout as an “occupational phenomenon” in 2019 and included it in the 11th Revision of the International Classification of Diseases (ICD-11). It has been attributed exclusively to occupational context and not to experiences in other spheres of life (WHO, 2019).

1.2. Defining Burnout

The definition of burnout offered by Maslach and Jackson (1986) is the one that has been most commonly used by researchers. According to them, "Burnout is a syndrome of emotional exhaustion, depersonalization and reduced personal accomplishment that can occur among individuals who do 'people work' of some kind" (Maslach & Jackson, 1986). Emotional exhaustion is defined as “feelings of being emotionally overextended and depleted of one’s emotional resources” (Maslach & Jackson, 1986). Professionals going through this kind of experience feel difficulties in adapting to professional environments. Depersonalization is defined as “a negative, callous, or excessively detached response to other people, who are usually the recipients of one's service” (Maslach & Jackson, 1986). These manifest as irritability, negative attitude, loss of idealism, and avoidance towards

clients and other service recipients. Reduced personal accomplishment is defined as “a decline in one's feelings of competence and successful achievement in one's work” (Maslach & Jackson, 1986). This results in diminished coping capabilities as well as decreased productivity.

Pines and Aronson (1988) defined burnout as "a state of physical, emotional and mental exhaustion caused by long-term involvement in situations that are emotionally demanding". Schaufeli is one of the leading researchers on the subject. Schaufeli and Greenglass (2001) described burnout as "a state of physical, emotional, and mental weariness caused by prolonged exposure to emotionally stressful work situations".

In ICD-11 burnout is defined as “a syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed” (WHO, 2019). It has been defined by the presence of three dimensions. The first dimension is a sense of one's energies being depleted or exhausted (WHO, 2019). The second dimension is increasing mental detachment from one's employment or thoughts of negativism or cynicism regarding one's job (WHO, 2019). And the third dimension is a perception of ineffectiveness and lack of accomplishment in relation to one's job (WHO, 2019).

Most of the definitions of burnout share some similar ideas. The core element of burnout is exhaustion. In addition, there is preponderance of emotional or mental exhaustion and fatigue. Moreover, symptoms of burnout are work-related and can affect effectiveness and performance followed by negative attitudes.

1.3. Classifying Burnout

Burnout has been classified differently as per its conceptualization by different theoreticians. From the perspective of level of dedication toward one’s work, Montero-Marin (2016) proposed three types of burnouts. Based on the attribution, Kristensen et al.

(2005) also categorized burnout in three dimensions. Examining different perspectives can deepen our understanding of process of development of burnout.

1.3.1. Dedication-based Classification of Burnout

Montero-Marin (2016) proposed that burnout depends on the activities the professional had to go through. According to this, burnout is a developing condition characterized by a gradual decline in professionals' commitment to their work and reaches apathy from enthusiasm. From this theoretical viewpoint, burnout has been staged into the frenetic (high dedication or active coping style), underchallenged (intermediate dedication), and worn-out subtypes (low dedication or passive coping style).

The frenetic subtype (high dedication or active coping style). The frenetic type is prominent in overloaded working environments in which employees perform tirelessly till they are exhausted. Overloaded working contexts include jobs that require employees to be considerably more devoted to their work and, also temporary contractual jobs, alternating shift works, etc. These professionals demonstrate excessive involvement and a need to obtain remarkable achievements. To cope with these, they usually involve in multiple jobs at the same time and spend a high number of working hours weekly. For all these factors, this type is more linked with a sense of negligence of personal life, health, and a high level of burnout (Montero-Marin, 2016).

Under-challenged subtype (intermediate dedication). The under-challenged type is common in professions that are boring and lack stimulation. Tasks of these professions are mostly mechanical, repetitive, and routine. This kind of task needs to provide the necessary gratification to the employees. These professionals find their work monotonous and not rewarding. As a consequence of this, professionals exhibit symptoms of disinterest, boredom, and lack of personal growth. This subtype is associated with a higher level of cynicism (Montero-Marin, 2016).

The worn-out subtype (low dedication or passive coping style). The worn-out subtype is common in professions where workers demonstrate the least devotion. This includes insufficient control over the consequences of their work and acknowledgment of the efforts. As a result, they ultimately choose abandonment and neglect as strategies to deal with any difficulties. They choose a passive style, such as behavioral disconnection, to cope with stress, creating a sense of incompetence and guilt. Therefore, these professionals are highly associated with a sense of inefficiency (Montero-Marin, 2016).

Progressive deterioration of burnout from frenetic stage to the under-challenged and the worn-out stage has been suggested by empirical studies (Demarzo et al., 2020).

1.3.2. Attribution-based Classification

Kristensen et al. (2005) has categorized burnout into three dimensions based on attribution of fatigue and exhaustion to specific contexts of one's life such as personal burnout, work-related burnout and client-related burnout.

According to Kristensen et al. (2005) personal burnout is "the degree of physical and psychological fatigue and exhaustion experienced by the person". Personal burnout is a generic condition of fatigue and exhaustion of a person. On the other hand, work-related burnout is "the degree of physical and psychological fatigue and exhaustion that is perceived by the person as related to his/her work" (Kristensen et al., 2005). For this context, attribution of fatigue and exhaustion is to the factors related to work of a person. Lastly, client-related burnout is "the degree of physical and psychological fatigue and exhaustion that is perceived by the person as related to his/her work with clients" (Kristensen et al., 2005). In this context attribution of fatigue and exhaustion is specific to client related work of a person.

1.3.3. Impact-based Classification

When classifying burnout, a more comprehensive approach involves considering its impact on an individual's physical and mental health. The categorization based on impact evaluates the different outcomes of burnout, including depletion of emotional energy, detachment from work, and decreased sense of achievement (George & Reyes, 2017). The impact-based classification of burnout focuses on the functional and psychological effects of burnout on individuals (Bianchi et al., 2016). This approach recognizes that the severity of burnout can vary significantly from person to person and that the impact of burnout can vary depending on the individual's work environment and personal circumstances. One burnout classification based on its impacts assesses four dimensions: exhaustion, disengagement, cynicism, and professional efficacy (Demerouti et al., 2003).

Another approach to classifying burnout is based on its severity levels, ranging from mild to severe (Zarei et al., 2019). Understanding the severity of burnout helps tailor interventions to match the individual's needs and circumstances.

1.4. Prevalence of Burnout

The reported prevalence rate of burnout among different professionals varies across the world. Prevalence of burnout was found up to 35.7% in medical residents (Rodrigues et al., 2018;) and 67% in physicians around the world (Rotenstein et al., 2018). A burnout rate of 43% for physicians of United States was reported by Medscape National Physician Burnout and Suicide Report in 2020. For primary health care workers of Iran prevalence of burnout was reported 17.3% to 34.5% (Amiri et al., 2016; Bijari & Abassi, 2016). Estimates of burnout among surgical specialists in Kuwait Ministry of Health hospitals was found 76.9% (Akl et al., 2022). For physician prevalence rate of burnout were found 12.6% in Qatar (Elbarazi et al., 2017), up to 70% in Saudi Arabia (Elbarazi et al., 2017) and 54% in United States (Shanafelt et al., 2015). On the other hand, the rate of burnout was 2.6% in

health professionals of Ecuador (Ramirez et al., 2018) and 7% in primary health care staff of Brazil (Silva et al., 2015).

For teachers across the world prevalence of burnout was found to be ranged from 25.12% to 48.37% in a scoping review (Agyapong et al., 2022). Among university professors up to 37% burnout rate was found in most studies as cited in Fernandez-Suarez et al. (2021).

In emergency nurses, average prevalence rate of burnout was found 26% in a systemic review for years 1989 to 2014 (Adriaenssens et al., 2015). For global nurses, prevalence of burnout rate was found to be 11.23% in a systematic review and meta-analysis (Woo et al., 2020) Highest burnout prevalence was found in Sub Saharan African region compared to Europe and Central Asia region (Woo et al., 2020). In a study of Iranian nurses, prevalence of burnout was reported 54% (Khammar et al., 2018). Among Italian physiotherapists 45.8% were found to be affected or at a high risk of developing burnout (Corrado et al., 2019). In clinical professionals and biomedical scientists of United States prevalence rate for personal burnout, work-related burnout and client-related burnout were 52.7%, 47.5% and 20.3% respectively (Messias et al., 2019).

The prevalence of burnout is especially high among the mental health professionals. People who work with the general public or with specific populations, such as those who are disabled, the terminally ill, children, prisoners, or the impoverished, are at an increased risk of experiencing burnout (Felton, 1998). The helping professions are more susceptible to burnout syndrome than other professions due to the emotional aspect of their work (Maslach & Leiter, 2016; Thomsen et al., 1999). Among healthcare professionals, mental health professionals are at higher risk of burnout (Acker, 2012; Rossi et al., 2012).

According to some estimates, up to 61 percent of mental health workers show signs of burnout at some point in their careers (Morse et al., 2012). The American Psychological

Association (2020) reports that it is anticipated that two out of every five psychiatrists are suffering from professional burnout. A study of military mental health providers found that 27.8 percent of providers scored in a high level of emotional weariness, 18.6 percent had high scores for depersonalization, and 4.1 percent had a poor degree of personal success. The findings imply that the levels of burnout experienced by military clinicians are comparable to those seen by civilian providers (Ballenger et al. 2011). Garcia et al. (2016) conducted a survey to investigate trauma content, patient characteristics, and mental health service providers' burnout with a sample of 137. Participants were from clinical psychology, counseling psychology, and social work. Findings suggested that high levels of cynicism and exhaustion were found among approximately fifty percent of the participants. In addition, low professional self-efficacy was found among twelve percent. Kok et al. (2016) conducted survey on 488 mental health clinicians working with the military population. A weighted average of 21% of the respondents reported having significant burnout. In a study, 56% emotional exhaustion was found among mental health workers in New York State (Acker, 2012). A high level of burnout has been found among mental health professionals of Singapore (Yang et al., 2015). Studies on burnout among mental health professionals in Bangladesh is limited.

Gayen & Mozumder (2011) conducted a study on burnout with 46 clinical psychology service providers in Bangladesh. They studied demographic and work-related variables. Findings suggested that a significant proportion of clinical psychology service providers in Bangladesh suffer from burnout. Das & Mozumder (2023) conducted another study with 101 professionals in the clinical psychology of Bangladesh. Findings suggested that the respondents had personal burnout rates of 41.6%, work burnout rates of 26.7%, and client burnout rates of 9.9%.

1.5. Impact of Burnout on Mental Health Professionals

Burnout among those working in mental health is harmful not only to the individuals who suffer from it but also to the organizations they work for, their clients, and even the mental health system in general (Salyers et al., 2013). Burnout can significantly contribute to a poor workplace environment (Lasalvia et al., 2009) and lead to decreased organizational commitment (Ashil & Rod, 2011). There is a considerable amount of research supporting that burnout can lead to the turnover of mental health professionals (Acker, 2012; Coates & Howe, 2015; Kim & Lee, 2009; Thomas et al., 2014). There is a possibility that this will have an adverse influence on the well-being of therapists as well as organizations (Lawson & Myers, 2011). Many people view it as unethical to provide services to clients when one is weary, as cited in Skorupa & Agresti (1993).

The foundation of the mental health profession is proficiency in therapeutic relationships. Constantly shifting emotional demands necessitate a professional empathic commitment to the role. Despite these principles, certain professionals can experience burnout owing to prolonged exposure to severe working stress. These factors can result in mental tiredness and may lead to chronic burnout. Substandard service, depersonalization, and retention can compromise the well-being and professionalism of mental health professionals as well as the well-being of their clients (Carrola et al., 2016; Morse et al., 2012; Wurm et al., 2016).

1.6. Contributors of Burnout Among Mental Health Professionals

Researchers have attempted to understand the aspects of burnout and its contributing factors. Numerous factors, such as working for longer hours, having a high caseload, dealing with high number of patients with personality disorders, being female, and being a psychiatrist were found to be linked with higher levels of burnout in United States (Ballenger et al. 2011). Role conflict and ambiguity were found to have a significant

correlation with dimensions of burnout (Acker, 2003). Organizational climate and age were found to have contribution to burnout in a study of United States (Green et al., 2014). Employment conditions and the difficulties encountered by healthcare providers were also reported to contribute to burnout (Acker, 2012). Job stress has been suggested as a factor that leads to emotional exhaustion and, consequently, a potential for turnover (Acker, 2012). Work settings had significant correlation in burnout of professional psychologists in United States (Rupert & Kent, 2007). Use of coping strategy, perceived working condition, mindfulness and compassion satisfaction were explaining 66.9% of variance of burnout in American counselors (Thompson et al., 2014). Components of organizational culture such as professional support and trust, professional values, empowerment, avoidance and control, and organizational environment has been found to predict burnout in the United States (Beatrice, 2020).

Overwork and emotion-focused coping has been suggested as a strong predictor for burnout in a Brazilian sample (Rodriguez & Carlotto, 2017). In other studies work-family conflict and optimism have been shown to contribute to negative experiences of work, explaining a very high proportion of the variance (44%) of negative experiences (Gallavan & Newman, 2013).

Perceived supervision effectiveness and positive supervisory alliance has been found to be associated with burnout in Australia (Livni et al., 2012). Unsatisfactory working environment has been found to be a significant predictor of burnout of specialists of Pakistan (Rafaq et al., 2020). Role conflict has been found to be a contributory factor of emotional exhaustion and depersonalization in Europe (Piko, 2006). Age has been found to be significantly correlated with burnout among psychiatric nurses in India (Chakraborty et al., 2012).

High job demands, low autonomy, work settings, limited support from managers and colleagues, age were identified as contributory factors for mental health workforce (Johnson et al., 2018). Excessive job demands, feeling undervalued at work, and limited latitude in decision making have been reported to be contributory to most aspects of burnout (Evans et al., 2006).

Positive correlation of educational level with emotional exhaustion and negative correlation of age was found with depersonalization in a study of Europe (Blau et al., 2013). On the other hand, age and length of service were negatively correlated with reduced personal accomplishment (Blau et al., 2013). Working long hours, aggressive administrative environment, lacking support from management and too much work were found to be associated factors among psychiatrist in New Zealand (Kumar et al., 2011).

Frequency of face-to-face interaction with clients, weak group cohesion, longer time in mental health and perceived unfairness was found to be predictors of burnout among community mental health staff in Italy (Lasalvia et al., 2009). Coworker relationship was found to have a significant contribution in the development of burnout (Roncalli & Byrne, 2016). Impact of specific client characteristics such as having persistent and severe mental disorders (e.g. personality disorder, eating disorders) was found to be contributory in the development of burnout (Acker & Lawrence, 2009; Ballenger-Browning et al., 2011; Garcia et al., 2016; Warren et al., 2012). Workplace aggression was also found to have a significant contribution in developing burnout in Spain (Merecz et al., 2009;). Physical and non-physical aggression were found to be significantly correlated with emotional exhaustion, depersonalization and inefficacy in a study of Spain (Gascon et al., 2013). The common contributors of burnout reported in research literature have been summarized in the Table 1.1.

Table 1.1

Common Contributors of Burnout Among Mental Health Professionals

Dimensions	List of Contributing Factors of Burnout
Individual Characteristics	Age, Experience, Gender, Family issues, Educational Background, Type of role, Job control (sense of autonomy at work and perceived capacity to influence decisions), Coping Mechanisms, Poor group cohesion, Perceived unfairness, Personality Traits, Ethnicity
Client-Related Characteristics	Impact of specific client characteristics, Types of Clients, Caseload and Client Contact
Environmental/ Organizational Characteristics	Work setting, Professional background, Social supports in the workplace/ Co-workers, Aggression in the workplace, Job Demands and Resources, Stressful involvement, and working with complex clients,

Dimensions	List of Contributing Factors of Burnout
	Lack of /inadequate clinical supervision, Perceived inadequacy of clinical supervision, Team / staff cohesion, Role conflict, role ambiguity, role clarity, Fairness in how staff feel they are treated and a sense of being rewarded for work

Different factors have been found to contribute differently to the specific components of burnout. Predictors of depersonalization were workload, age, position, fairness, license status, and gender for mental health professionals in the United States (Aljami, 2019) while stressful involvement, experience, supervisor support, and psychological job demands among professionals in the United Kingdom (Turnpenny, 2019). In the United States, personal accomplishment aspects of burnout were predicted by values, employee status, work setting, position, and license status (Aljami, 2019). Healing and stressful involvement with clients were found to predict personal accomplishment aspect of burnout in the United Kingdom (Turnpenny, 2019). For emotional exhaustion, the predictors were workload, fairness, control, age, longevity, employee status, and work setting in the United States (Aljami, 2019). The number of years spent working in the position was a significant predictor of emotional exhaustion among clinical professionals in Greece (Sofology et al., 2019). Variation in contributing factors has been found among different regions of the world.

For the present study, the special interest was to identify predictors of burnout among mental health professionals in Bangladesh. Studies on the contributors of burnout is limited

for professionals in general and is only handful for the mental health professionals in Bangladesh. In a study of Burnout in physicians of Bangladesh, potential sources of physician burnout were found as time pressure, limited control and a loss of autonomy, feelings of isolation, conflict between career and family (Arafat & Kabir, 2017). For mental health professionals, Gayen & Mozumder, (2011) found income, family issues, and time management as the predictors of burnout among clinical psychology service providers in Bangladesh.

1.7. Rationale of the Present Study

Mental health is an emerging profession in Bangladesh; therefore, professionals have to face many crises regarding professional and personal issues. The reported number of psychiatrists and psychologists is 0.13 and 0.12 respectively per 100000 people in Bangladesh, a country with a high prevalence (18.7%) of mental health problems (WHO, 2017; NIMH 2019). This suggests that fewer experts are available to provide services to a very high number of patients, Thus, it is reasonable to believe that this circumstance contributes to the mental and emotional fatigue among the specialists. Additionally, Bangladesh is a low to middle income country with high level of stigma around mental health problems is likely to interfere with smooth service delivery. This may also create additional challenge in professional service delivery.

Numerous studies have investigated the phenomenon of burnout and its predictors among mental health service provides worldwide. However, as mentioned earlier, the literature on burnout among mental health professionals are limited in Bangladesh. The single published study (Gayen & Mozumder, 2011) explored burnout only among clinical psychologists leaving aside the other mental health professionals.

Additionally, it has been known that cultural and contextual factors play important role in contributing to burnout (Alkaabi et al., 2020; Molodynski et al., 2021; Rattrie et al.,

2020). Context specific understanding of burnout and its contributors is necessary for designing and implementing interventions to reduce burnout in an effective manner.

Local context and cultural diversity have a substantial influence on the behavior and presentation associated with mental health problems (Gopalkrishnan, 2018). Subsequently, professional practice guidelines are shaped by the context specific components of practice. Coping and responding to the stressors of an individual are also influenced by cultural aspects (Aldwin, 2004). Therefore, the way a professionals will respond and cope the demands of the professional practice is likely to vary across the country and context. The earlier sections (e.g., contributors of burnout among mental health professionals) presented the differential contributors of burnout among different country (i.e., cultural context).

Due to concerns related to the varied nature of impact of culture on behavior and burnout, the finding of studies conducted over the globe may not be readily applicable for Bangladesh context. Therefore, this study was conceived to identity the contributors of burnout as well as to assess if the known contributors of burnout found across the globe perform similarly in the Bangladesh context.

1.8. Study Objectives

The overarching objective of this study is to identify the predictors of burnout among mental health professionals in Bangladesh. To achieve this general objective, the following specific objectives of this study were devised.

1. To prepare a list of putative contributors of burnout for mental health professionals in Bangladesh.
2. To identify significant predictors of burnout for mental health professionals in Bangladesh.
3. To compare level of burnout among different mental health professionals in Bangladesh.

1.9. Hypothesis

The first objective involved qualitative exploration through desk review and expert's opinion and no presupposed hypothesis was formed. For the second objective, it was hypothesized that the listed predictors will significantly predict burnout among the mental health professionals in Bangladesh. For the third objective, it was hypothesized that there would be significant differences in the level of burnout among different mental health professionals in Bangladesh.

Chapter 2

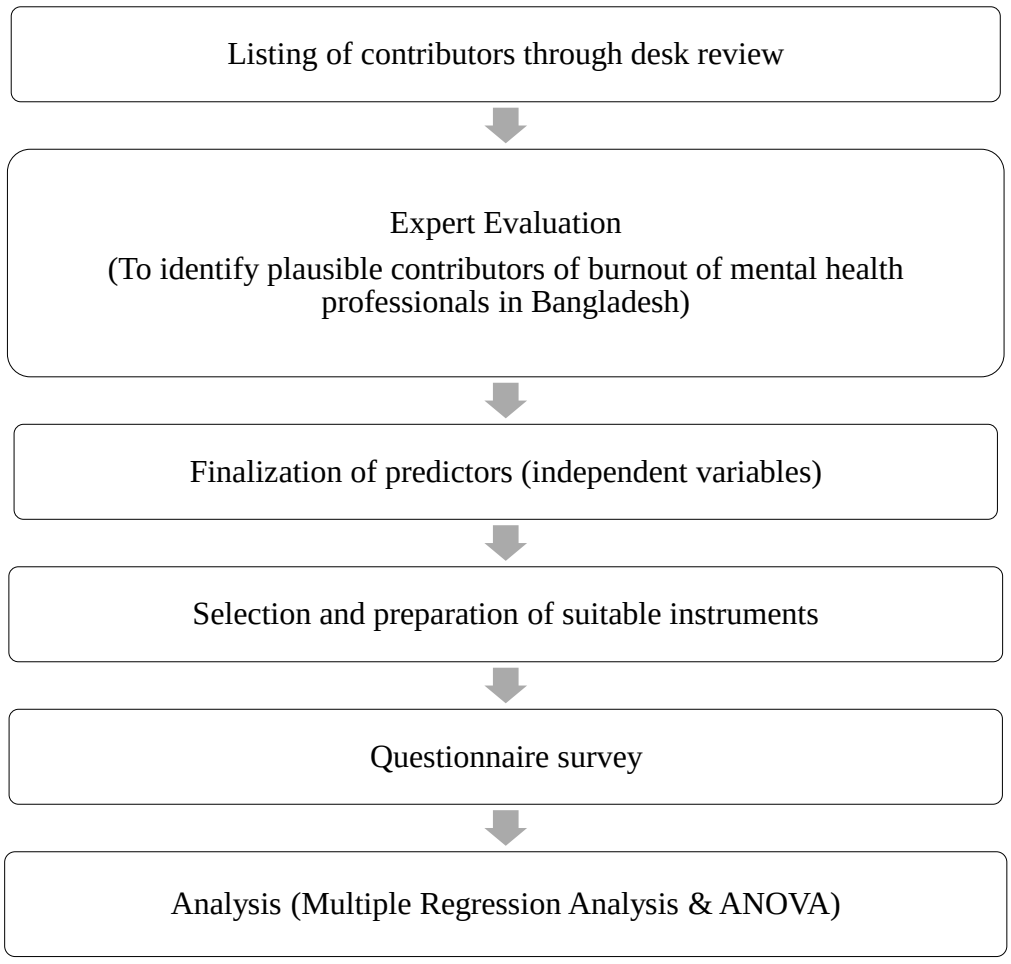
METHOD

Method

This research used a cross-sectional survey design to test and identify predictors of burnout among Bangladeshi Mental health professionals. However, a small formative qualitative exploration in the form expert opinion was used to narrow down the list of already known contributors suggested in the available literature before those could be put into testing. Design of the study has been presented in a flowchart in Figure 2.1.

Figure 2.1

Design of the Study



2.1. Participants

Practicing mental health professionals from four different background namely psychiatry, clinical psychology, counseling psychology, and educational psychology were invited to participate in this study. Only Bangladeshi professionals working in Bangladesh were considered eligible for this study.

The number of qualified mental health practitioners in Bangladesh is quite low considering the huge population in need. Recent reports indicates that there are only 305 psychiatrists, 405 clinical psychologists (including assistant clinical psychologists with masters), 143 counselling (including assistant counseling psychologists with masters), and 146 educational psychologists (including assistant educational psychologists with masters) in Bangladesh (Mozumder, 2024). Due to the limited number of professionals available in Bangladesh, the researchers attempted to invite as many participants possible to ensure confirmatory analysis. Two hundred and ninety-two professionals took part in this study.

2.1.1. Inclusion and Exclusion Criteria

Multiple mental health professional groups had been recruited for the present study where inclusion and exclusion criteria have been mentioned in Table 2.1.

Table 2.1

Inclusion and Exclusion Criteria of the Participants

Participant Group	Inclusion Criteria	Exclusion Criteria
Psychiatry	Having higher degree (MD/ MCPS/ FCPS/ MPhil/PhD) in Psychiatry.	Not residing and not practicing in Bangladesh.
Clinical Psychology	Having Masters (MS/MSc) degree in Clinical Psychology.	Not residing and not practicing in Bangladesh.

Participant Group	Inclusion Criteria	Exclusion Criteria
Counseling Psychology	Having Masters (MS/MSc) degree in Counseling Psychology.	Not residing and not practicing in Bangladesh.
Educational Psychology	Having Masters (MS/MSc) degree in Educational Psychology.	Not residing and not practicing in Bangladesh.

2.1.2. Participant Characteristics

Majority of the participants were from clinical psychology background (N=113) followed by educational psychology (N= 94), counseling psychology (N = 60) and psychiatry (N= 25) (see Table 2.2). Most of the participants were female (59.9%) and married (63.4%). Among the respondents approximately 73% professional's educational qualification was Master's degree. Details of the sociodemographic characteristics of the participants are presented in Table 2.2.

Table 2.2

Demographic Information of the Participants

Variable with levels	Number (%)
Gender	
Female	175 (59.9)
Male	117 (40.1)
Marital Status	
Unmarried	107 (36.6)
Married	185 (63.4)
Professional Background	
Clinical Psychology	113 (38.7)

Variable with levels	Number (%)
Counseling Psychology	60 (20.5)
Educational Psychology	94 (32.2)
Psychiatry	25 (8.6)
Educational Qualification	
Masters	213 (72.9)
MPhil Part 1	24 (8.2)
MPhil	29 (9.9)
PhD	2 (0.7)
MD	15 (5.1)
FCPS	8 (2.7)
MCPS	1 (0.3)

2.2. Contributors of Burnout Among Mental Health Professionals in Bangladesh

To explore the putative contributors of burnout among mental health professionals in Bangladesh, the known predictors of burnout from international context were listed through literature review and presented to a panel of mental health professionals for their opinion. The panel of experts narrowed down the list based on their subjective but professional experience and provided opinions about which of these factors could be the possible contributors of burnout in Bangladesh. Predictors listed through desk review (see Table 1.1) were not country-specific and the predictors of burnout of mental health professionals are known to vary across country and context. It was, therefore, anticipated that an expert evaluation could be an effective way to identify putative contributors of burnout for Bangladeshi mental health professionals.

Consultation with a Panel of Experts

Eight mental health professionals were consulted for their expert opinion on the suitability of the listed predictors (identified from the literature review) for Bangladesh context. The expert panel involved multiple professionals including psychiatrists, clinical psychologists, educational and counseling psychologists, and child development practitioners who have extensive experience in working with psychologists of different fields (see Appendix A for the list of experts).

A short Bangla questionnaire was prepared for expert evaluation (see Appendix C). It was an online fillable Google form consisting of two sections. Section one included an explanatory statement and consent (see Appendix B). Section two included twenty-one items on the known predictors from global studies in which they had to respond to Likert-type option. Response options were completely agree, somewhat agree, not sure, somewhat disagree, and completely disagree. In addition, there was an open question for adding other factors that experts think contribute to burnout of mental health professionals of Bangladesh. They had to choose to what extent they thought that particular factor could contribute to burnout of mental health professionals in Bangladesh. The score for completely agrees, somewhat agree, not sure, somewhat disagree, and completely disagree were 4,3,2,1, and 0, respectively.

Suggested Contributors

Average score of responses from the experts were calculated and thirteen factors were found to have a score above the cutoff score of 3 (out of 4) as presented in Table 2.3.

Table 2.3

Plausible Contributors Agreed upon by the Experts

Suggested contributors	Scores
Family issues	3.13
Sense of autonomy at work	3.25
Perceived capacity to influence decision	3.25
Coping mechanism	3.63
Inequality at workplace	3.38
Personality traits	3.13
Case load	3.13
Coworker support	3.13
Lack of supervision	3.5
Team/staff cohesion	3.38
Role Clarity	3.13
Stressful involvement at work	3.13
Aggression at workplace	3.25

Apart from the 13 contributors listed in Table 2.2, multiple experts (at least three) suggested to add continuous professional development (CPD), salary satisfaction, and self-care as possible contributors and therefore these three were also included in the putative contributors making the total number of contributors to 16.

2.3. Instruments

Copenhagen burnout Inventory (Kristensen et. al, 2005**)** was used to assess burnout of the participants. A series of already available instruments and a few custom-built instruments were used to measure the predictors. Although experts identified inequality as

putative contributor, due to the unavailability of tool, the research team decided to use a closely aligned construct, injustice, in this study. The following section described the tools used in the study. All the instruments used in this research are presented in the Appendix (see Appendix D to I).

2.3.1. Socio-demographic Information Questionnaire

A custom-built questionnaire containing socio-demographic details including age, gender, marital status, professional background, education, work setting, and experiences was used. This seven-item questionnaire was essential to understand the representativeness of the selected participants.

2.3.2. Copenhagen Burnout Inventory (CBI; Kristensen et al., 2005)

The Bangla form of the Copenhagen Burnout Inventory (CBI) was used in the present study. CBI was developed by Kristensen et al. (2005) and has been used in different countries to assess burnout. CBI is a self-rating tool having 19 items. The Copenhagen burnout inventory consists of three subscales namely personal burnout, work-related burnout, and client-related burnout. The CBI use summative-average scoring system. Personal burnout subscale has six items, and the response options are always (100), often (75), sometimes (50), seldom (25), and never/almost never (0). Work-related burnout subscale has seven items. Response options for the first four items are response options are always (100), often (75), sometimes (50), seldom (25), never/almost never (0). For the last three items, response options are to a very high degree (100), to a high degree (75), somewhat (50), to a low degree (25), to a very low degree (0). One item required reverse scoring. The client-related burnout subscale has six items. For this, response options for the first four items are to a very high degree (100), to a high degree (75), somewhat (50), to a low degree (25), to a very low degree (0, and the response options for last to items are always (100), often (75), sometimes (50), seldom (25), never/almost never (0). The CBI has high

internal reliability (.85-.87) as well as face validity, criterion-related (convergent validity, divergent validity), concurrent and predictive validity (Kristensen et al., 2005). The Bangla form of the Copenhagen Burnout Inventory was translated by Gayen & Mozumder (2011) and later modified (linguistic) by Islam and Mozumder (2020; personal communication). It was collected through personal communication.

2.3.3. Ten Item Personality Inventory (TIPI; Gosling et al., 2003)

The Bangla Ten Item Personality Inventory (TIPI-B) was used to assess the personality factors of the participants. The original Ten Item Personality Inventory (TIPI) was developed by Gosling et al. (2003). TIPI-B is a ten-item self-report questionnaire. It has five domains such as extraversion (item no. 1, 6), agreeableness (item no. 2, 7), conscientiousness (item no. 3, 8), neuroticism (item no. 4,9), and openness (item no. 5, 10). Ten Item Personality Inventory (TIPI-B) is a short measure of personality adapted by Islam (2009). It is a five-point Likert scale where 1 = not applicable at all, 2 = not applicable, 3 = uncertain, 4 = applicable, and 5 = completely applicable. Item numbers 2,4,6,8, and 10 have reverse scoring. TIPI has significant positive correlation (r = .954) (Islam, 2009). Moreover, TIPI-B has acceptable content validity, convergent validity, discriminant validity, and test-retest reliability (Islam, 2009).

2.3.4. Coping Scale (Folkman and Lazarus, 1980)

The Translated and adapted version of the coping Scale (Huque, 2004) was originally developed by Folkman and Lazarus (1980). This scale is used to measure the coping behavior of the participants. The Coping scale is a 22-item self-report measure of coping strategies. The measure has four-point Likert-type response options where 1 = I usually do not do this at all, 2 = I usually do this sometimes, 3 = I do this most of the time, 4 = I do this always. The item no 1, 2, 3, 4, 5, 6, 12, 13, 16, 17, 18, 21, 22 measures adaptive coping strategies and item no. 7, 8, 9, 10, 11, 14, 15, 19, 20 measures adaptive coping

strategies. Maximum and minimum scores for the scale are 88 and 22. The adaptive coping score ranges from the lowest 13 to the highest 52. On the other hand, the non-adaptive coping score ranged from the lowest 9 to the highest 36. The highest score indicates the participants frequently adopted coping strategies, whereas the lowest score indicates that participants rarely used coping strategies. The reliability of this scale was found to be highly significant (r=0.86, <0.01), and the test-retest reliability for each subscale was also significant (r=0.80, <0.01) (Huque, 2004).

2.3.5. Steel Injustice Inventory (Steel, 2020; Personal Communication)

The Steel injustice inventory is a recently developed instrument for measuring injustice with four items. For assessing sense of inequality, two items from the Steel Injustice Inventory (Steel, 2020) were used. Among the four items, two items measure sense of inequality of one's personal life and other two items measure sense of inequality in workplace. Response options for item number 2 and 4 are yes/ no. Response options for item number 2 and 4 are not at all, very few, sometimes, often, always.

2.3.6. Composite Questionnaire to Assess Multiple Contributors

Due to absence of available instruments, a composite questionnaire was derived to assess the remaining contributors namely caseload, salary satisfaction, supervision, coworker support, family issues, workplace decision-making, sense of autonomy at work, stressful involvement at work, role clarity, aggression at the workplace, team cohesion, self-care, and continuous professional development. For each of the constructs one to three items were used based on the type and complexities of constructs.

2.3.7. Consent Form

An informed consent form with a short description of the study's procedure and explanation of risks & potential benefits of this study was added to the google questionnaire (see Appendix K).

2.4. Procedures

Data was collected both in-person and electronically from March, 2022 to April, 2022. At first, eligible participants were approached through personal contact. Based on verbal consent they were sent the link to the survey questionnaire though email or social media. The participant received detailed instructions though the anonymized survey link. They provided implied consent indicated by responding 'YES' to the questing asking for their willingness participate. Based on preference of the participants, a few interviews were completed through paper and pencil version.

2.5. Ethical Consideration

The study received ethical approval from the ethics committee of the Department of Clinical Psychology (Project number: MP220203) before the start of data collection (see Appendix J).

For this study, ethical issues were carefully ensured. For making a rational decision about participating, required information was provided to the participants. Participants did have freedom of choice whether to participate in this study. An option was added to acknowledge that they understood the study and agreed to participate. Interested participants could proceed after filling out the informed consent form. The researcher offered them to answer further queries if they had any. Participation in this study was not associated with any kind of health or psychological risk, inconvenience or discomfort that went beyond what is normally experienced in day-to-day living, either short-term or long-term. Since there was no control group, there was no instance of anyone being deprived of benefits.

2.6. Data Preparation

Statistical Package for Social Sciences (SPSS) (V. 20, IBM Corp. 2011) was used for quantitative data analysis. After importing data to IBM SPSS data cleaning was done and dummy variables were prepared. Scale score was calculated according to the scoring principle of each scale. Two variables namely professional background and work settings were dummy coded. Professional background was dummy coded into four separate variables i.e. being psychiatrist, being clinical psychologist, being counseling psychologist, and being educational psychologist. Work setting was coded into engagement in private practice, working in educational institution, working in medical settings, working in refugee settings, working in other settings, working in multiple settings. Total thirty-five variables including suggested contributors & demographic variables were entered to predict personal, work, and client-related burnout.

Preliminary analyses were performed before final analysis to check for the assumptions in carrying out regression analysis.

2.6.1. Absence of Multicollinearity

Intercorrelation matrix as well as tolerance and VIF were checked to rule out multicollinearity. The correlation matrix found no incredibly high correlation (.90). It was found that the tolerance was more than 0.01, and the VIF was less than 10, which indicated no multicollinearity among the predictors.

2.6.2. Influential Cases

Outliers and influential cases were checked as they can affect regression coefficients. Visual inspection of the scatterplot was carried out as the first check to detect outlier. The scatterplot indicated no outlier. Additional assessment using Mahalonobis distance and Cook's distance were also explored. Mahalanobis distance ranged from 6.028 to 57.867 were below the critical value of chi-square (χ^2=66.6 at df = 35, $p < .001$) (see. Li et al.,

2019) indicating absence of any overly influential cases. Cook's distance value ranged from minimum 0.000 to 0.179 with a mean of 0.004. This was below the cutoff for concern (> 1; Field, 2009). These analyses indicated absence of overly influential case in the data and multiple regression can be carried out with the data.

2.6.3. Homoscedasticity

Visual analysis of the scatterplot and histogram indicated no concern regarding heteroscedasticity. The P-P plot looked diagonal which also indicated that the residuals are normally distributed. So, assumptions of homoscedasticity had been met.

2.6.4. Independence of Errors

To assess the independence of error assumptions, Durbin -Watson test was used and the value fall between the acceptable range (between 1 and 3; Field, 2009). The result suggests that the residuals were uncorrelated with one another.

Chapter 3

RESULTS

Results

Listing putative contributors of burnout for mental health professionals in Bangladesh was done through expert consultation (see section 2.2). Sixteen factors were voted and suggested by the experts, and then these factors along with the demographic features were put into the test. Multiple regression was carried out to identify the significant contributors of burnout among mental health professionals in Bangladesh. One way analysis of variance (ANOVA) was performed to compare levels of burnout among different mental health professionals.

3.1. Predictors of Burnout Among Mental Health Professionals

Multiple regression analyses were used to investigate whether the independent variables significantly predict burnout of mental health professionals. To get a parsimonious model, stepwise regression using backward method in SPSS was performed to minimize suppressor effect (Field, 2009). Three different analyses were performed to identify the predictors of personal burnout, work-related burnout, and client-related burnout.

3.1.1. Predictors of Personal Burnout

Results indicated a model with twelve factors as predictors of personal burnout, ($F_{12, 279} = 32.73$, $p < .001$; $R^2 = .585$) which explained 58.5% variance of personal burnout of mental health professionals in Bangladesh (Table 3.1).

Of these twelve factors, five had significant positive relationship with personal burnout. These were satisfied with salary ($\beta = .147$, $p < .01$), perception of injustice ($\beta = .172$, $p < .001$), family issues ($\beta = .156$, $p < .001$) stressful work ($\beta = .117$, $p < .01$) and workplace aggression ($\beta = .235$, $p < .001$). These factors are associated with increased personal burnout.

On the other hand, working in educational institution (β = -.109, p < .05), self-care (β = -.136, p < .01), extraversion (β = -.127, p < .01), neuroticism (β = -.211, p < .001), nonadaptive coping (β = -.191, p < .001), and being a psychiatrist (β = -.112, p < .01) had significant negative relationship with personal burnout which indicates that these factors associated with decreased personal burnout.

Table 3.1

Predictors of Personal Burnout of Mental Health Professionals

Predictors	B	SE	β	95% CI	
				LL	UL
(Constant)	64.134	10.210		44.036	84.231
Engagement in private practice	3.719	1.997	.081	-.212	7.651
Working in educational institution	-4.787	1.850	-.109*	-8.428	-1.145
Satisfied with salary	4.370	1.338	.147**	1.737	7.004
Perception of injustice	7.491	2.007	.172***	3.540	11.442
Family issues	4.234	1.134	.156***	2.003	6.466
Stressful work	2.801	1.056	.117**	.722	4.881
Self-care	-3.868	1.225	-.136**	-6.279	-1.456
Workplace aggression	5.608	1.126	.235***	3.391	7.824
Extraversion	-3.228	1.027	-.127**	-5.249	-1.206
Neuroticism	-6.106	1.197	-.211***	-8.462	-3.751
Nonadaptive coping	-.935	.232	-.191***	-1.391	-.478
Being a psychiatrist	-8.417	3.177	-.112**	-14.671	-2.162
R^2	.585				
Adjusted R^2	.567				
F (df1, df2)	32.73**(12, 279)				

Note. CI = Confidence interval; SE= Standard Error; LL= Lower limit; UL = Upper limit

* p < .05, ** p <.01, ***p <.001.

Workplace aggression (β = .235, p < .001), neuroticism (β = -.211, p < .001) and nonadaptive coping (β = -.191, p < .001) were the strongest predictors of personal burnout among mental health professionals in Bangladesh.

3.1.2. Predictors of Work-related Burnout

Results indicated a model with fourteen factors as predictors of work-related burnout, ($F_{14, 277}$ = 24.933, p < .001; R^2 = .558) which explained 55.8% variance of work-related burnout of mental health professionals in Bangladesh (see Table 3.2).

Of these fourteen factors, four had significant positive relationship with work-related burnout. These were perception of injustice (β = .137, p < .01), family issues (β = .112, p < .05) stressful work (β = .225, p < .001) and workplace aggression (β = .208, p < .001). These factors are associated with increased work-related burnout. On the other hand, working in medical settings (β = -.139, p < .01), length of experience (β = -.101, p < .05), role clarity (β = -.124, p < .01), engagement in CPD (β = -.164, p < .001), extraversion (β = -.131, p < .01), neuroticism (β = -.205, p < .001), openness (β = -.108, p < .05), nonadaptive coping ((β = -.163, p < .001), being a counseling psychologist (β = -.106, p < .05) and being an educational psychologist (β = -.140, p < .05) had significant negative relationship with work-related burnout which indicates that these factors associated with decreased work-related burnout.

Table 3.2

Predictors of Work-Related Burnout of Mental Health Professionals

Predictors	B	SE	β	95% CI	
				LL	UL
(Constant)	82.289	9.009		64.554	100.023
Working in medical setting	-5.963	1.963	-.139**	-9.827	-2.099
Perception of injustice	5.279	1.873	.137**	1.593	8.966

Predictors	B	SE	β	95% CI	
				LL	UL
Length of experience	-.474	.214	-.101*	-.894	-.053
Family issues	2.694	1.055	.112*	.618	4.771
Stressful work	4.765	.949	.225***	2.896	6.633
Role clarity	-2.603	.907	-.124**	-4.388	-.818
Engagement in CPD	-3.901	1.053	-.164***	-5.974	-1.829
Workplace aggression	4.392	1.027	.208***	2.371	6.413
Extraversion	-2.960	1.008	-.131**	-4.944	-.975
Neuroticism	-5.226	1.127	-.205***	-7.445	-3.008
Openness	-3.022	1.261	-.108*	-5.504	-.540
Nonadaptive coping	-.705	.200	-.163***	-1.098	-.311
Being a counseling psychologist	-4.852	2.346	-.106*	-9.470	-.233
Being an educational psychologist	-5.571	2.248	-.140*	-9.996	-1.146
R^2	.558				
Adjusted R^2	.535				
F (df1, df2)	24.933**(14, 277)				

Note. CPD = Continuing professional development; CI = Confidence interval; SE= Standard Error; LL= Lower limit; UL = Upper limit

* $p < .05$, ** $p < .01$, ***$p < .001$.

Stressful work ($\beta = .225$, $p < .001$), workplace aggression ($\beta = .208$, $p < .001$) and neuroticism ($\beta = -.205$, $p < .001$) were the strongest predictors of work-related burnout among mental health professionals in Bangladesh.

3.1.3. Predictors of Client-related Burnout

Results indicated a model with eleven factors as predictors of client-related burnout, ($F_{11, 280}$= 24.927, p < .001; R^2= .495) which explained 49.5% variance of client-related burnout of mental health professionals in Bangladesh (Table 3.3).

Of these eleven factors, five had significant positive relationship with client-related burnout. These were engagement in private practice (β = .122, p < .01), satisfied with salary (β = .140, p < .01), empowerment in workplace decision making (β = .136, p < .01), stressful work (β = .172, p < .001), workplace aggression (β = .255, p < .001). These factors are associated with increased client-related burnout. On the other hand, length of experience (β = -.121, p < .05), role clarity (β = -.175, p < .001), extraversion (β = -.139, p < .01), neuroticism (β = -.195, p < .001) and adaptive coping (β = -.197, p < .001) had significant negative relationship with client-related burnout which indicates that these factors associated with decreased client-related burnout.

Table 3.3

Predictors of Client-related Burnout of Mental Health Professionals

Predictors	B	SE	β	95% CI	
				LL	UL
(Constant)	57.657	8.007		41.895	73.419
Engagement in private practice	4.797	1.827	.122**	1.201	8.392
Satisfied with salary	3.569	1.249	.140**	1.110	6.028
Perception of injustice	3.598	1.889	.096	-.120	7.315
Length of experience	-.552	.217	-.121*	-.979	-.125
Empowerment in workplace decision making	2.031	.699	.136**	.655	3.407
Stressful work	3.528	.961	.172***	1.637	5.419
Role clarity	-3.568	.935	-.175***	-5.409	-1.726

Predictors	B	SE	β	95% CI	
				LL	UL
Workplace aggression	5.218	1.040	.255***	3.170	7.265
Extraversion	-3.041	.948	-.139**	-4.906	-1.176
Neuroticism	-4.822	1.097	-.195***	-6.981	-2.663
Adaptive coping	-.764	.177	-.197***	-1.113	-.414
R^2	.495				
Adjusted R^2	.475				
F (df1, df2)	24.927** (11, 280)				

Note. CI = Confidence interval; SE= Standard Error; LL= Lower limit; UL = Upper limit

* p <.05, ** p <.01, ***p <.001.

Workplace aggression (β = .255, p < .001), neuroticism (β = -.195, p < .001), adaptive coping (β = -.197, p < .001) were the strongest predictors of client-related burnout among mental health professionals in Bangladesh.

3.2. Comparing Burnout Among Different Groups of Mental Health Professionals

One-way ANOVA was performed to investigate whether there is any difference in burnout scores of different groups of mental health professionals in Bangladesh. Results of one-way ANOVA revealed that there was statistically significant difference in the mean of personal burnout ($F_{3, 288}$ = 21.508, p < .001), work-related burnout ($F_{3, 288}$ = 8.780, p < .001) & client-related burnout ($F_{3, 288}$ = 13.559, p < .001) scores of different professional groups (see Table 3.4).

Table 3.4

Means, Standard Deviations, and One-Way Analyses of Variance in Personal Burnout, Work-related Burnout and Client-related Burnout

Measures	Clinical Psychology M (*SD*)	Counseling Psychology M (*SD*)	Educational Psychology M (*SD*)	Psychiatry M (*SD*)	F (3, 288)
Personal Burnout	41.22 (18.88)	25.76 (19.94)	21.05 (18.59)	36.67 (20.02)	21.508***
Work-related Burnout	34.23 (20.02)	24.17 (16.50)	22.30 (13.94)	30.14 (23.42)	8.780***
Client-related Burnout	25.60 (18.04)	16.04 (15.87)	13.16 (14.46)	30.67 (22.47)	13.559***

Note. SD = Standard Deviation

****p* <.001.

Results showed that clinical psychology and psychiatry professionals scored higher in all three domains of burnout scores. Post-hoc tests were carried out to identify the group that contributed to the differences between the four professional groups in each category of burnout.

3.2.1. Differences in Personal Burnout

Multiple comparisons of the mean of personal burnout score using Tukey HSD revealed significant differences among the four professional groups. More specifically, personal burnout scores of clinical psychology professionals were significantly higher than counseling psychology professionals (mean difference = 15.460, p <.001) and educational psychology professionals (mean difference = 20.169, p <.001*)*. On the other hand, no significant mean difference was found between clinical psychology and psychiatry professionals (p > .05). For counseling psychology professionals mean difference of burnout

score was found nonsignificant with educational psychology and psychiatry professionals ($p > .05$). For educational psychology professionals, mean score of personal burnout was significantly lower than psychiatry professionals (mean difference = -15.612, $p < .01$). Detailed results are presented in Table 3.5.

Table 3.5

Mean Differences of Personal Burnout in Different Professional Groups

Professional Background (I)	Professional Background (J)	Mean Difference (I-J)	SE	95% CI	
				LL	UL
Clinical Psychology	Counseling Psychology	15.460*	3.052	7.57	23.35
	Educational Psychology	20.169*	2.667	13.28	27.06
	Psychiatry	4.558	4.222	-6.35	15.47
Counseling Psychology	Clinical Psychology	-15.460*	3.052	-23.35	-7.57
	Educational Psychology	4.709	3.157	-3.45	12.87
	Psychiatry	-10.903	4.548	-22.65	.85
Educational Psychologist	Clinical Psychologist	-20.169*	2.667	-27.06	-13.28
	Counseling Psychology	-4.709	3.157	-12.87	3.45
	Psychiatry	-15.612*	4.299	-26.72	-4.50
Psychiatry	Clinical Psychology	-4.558	4.222	-15.47	6.35
	Counseling Psychology	10.903	4.548	-.85	22.65
	Educational Psychology	15.612*	4.299	4.50	26.72

Note. CI = Confidence Interval; SE= Standard Error; LL= Lower limit; UL = Upper limit

3.2.2. Differences in Work-related Burnout

Multiple comparisons of the mean of work-related burnout score using Tukey HSD revealed significant differences among the four professional groups. Work-related burnout score of clinical psychology professionals were significantly higher than counseling psychology professionals (mean difference = 10.062, $p < .01$) and educational psychology

professionals (mean difference = 11.926, p <.001*)*. On the other hand, mean difference with psychiatry professionals and other three professional groups were found statistically nonsignificant (p > .05). Mean difference of counseling and educational psychology group was also found nonsignificant (p > .05). Detailed results are presented in Table 3.6.

Table 3.6

Mean Differences of Work-related Burnout in Different Professional Groups

Professional Background (I)	Professional Background (J)	Mean Difference (I-J)	SE	95% CI	
				LL	UL
Clinical Psychology	Counseling Psychology	10.062*	2.858	2.68	17.45
	Educational Psychology	11.926*	2.498	5.47	18.38
	Psychiatrist	4.086	3.954	-6.13	14.30
Counseling Psychology	Clinical Psychology	-10.062*	2.858	-17.45	-2.68
	Educational Psychology	1.864	2.956	-5.78	9.50
	Psychiatry	-5.976	4.259	-16.98	5.03
Educational Psychology	Clinical Psychology	-11.926*	2.498	-18.38	-5.47
	Counseling Psychology	-1.864	2.956	-9.50	5.78
	Psychiatry	-7.840	4.026	-18.24	2.56
Psychiatry	Clinical Psychology	-4.086	3.954	-14.30	6.13
	Counseling Psychology	5.976	4.259	-5.03	16.98
	Educational Psychology	7.840	4.026	-2.56	18.24

Note. CI = Confidence interval; SE= Standard Error; LL= Lower limit; UL = Upper limit

3.2.3. Differences in Client-related Burnout

Multiple comparisons of the mean of client-related burnout score using Tukey HSD revealed significant differences among the four professional groups. Client-related burnout score of clinical psychology professionals were significantly higher than counseling psychology professionals (mean difference = 9.548, p <.01) and educational psychology

professionals (mean difference = 12.425, p <.001*)*. For psychiatry professionals mean of client-related burnout score were also found significantly higher than counseling psychology professionals (mean difference = 14.625, p <.01) and educational psychology professionals (mean difference = 17.502, p <.001). Detail results are presented in Table 3.7.

Table 3.7

Mean Differences of Client-related Burnout in Different Professional Groups

Professional Background (I)	Professional Background (J)	Mean Difference (I-J)	SE	95% CI	
				LL	UL
Clinical Psychology	Counseling Psychology	9.548*	2.710	2.55	16.55
	Educational Psychology	12.425*	2.368	6.31	18.54
	Psychiatry	-5.077	3.749	-14.77	4.61
Counseling Psychology	Clinical Psychology	-9.548*	2.710	-16.55	-2.55
	Educational Psychology	2.877	2.803	-4.37	10.12
	Psychiatry	-14.625*	4.038	-25.06	-4.19
Educational Psychology	Clinical Psychology	-12.425*	2.368	-18.54	-6.31
	Counseling Psychology	-2.877	2.803	-10.12	4.37
	Psychiatry	-17.502*	3.817	-27.37	-7.64
Psychiatry	Clinical Psychology	5.077	3.749	-4.61	14.77
	Counseling Psychology	14.625*	4.038	4.19	25.06
	Educational Psychology	17.502*	3.817	7.64	27.37

Note. CI = Confidence interval; SE= Standard Error; LL= Lower limit; UL = Upper limit

Chapter 4

DISCUSSION

Discussion

The present research aimed at investigating contextually relevant predictors of burnout among mental health professionals. Sixteen putative factors were selected as possible contributors of burnout among mental health professionals in Bangladesh through a serial process of desk review and expert evaluation. A sample of 292 mental health professionals from four groups, namely psychiatrists, clinical psychologists, counseling psychologists, and educational psychologists, were recruited in this study. Analyses were conducted as per the three specific objectives of the study, which were, exploration of putative contributors of burnout, identification of significant predictors of burnout in Bangladesh, and comparison of burnout among different mental health professionals in Bangladesh.

4.1. Putative Contributors of Burnout for Mental Health Professionals in Bangladesh

In the context of limited data on burnout among mental health professionals in Bangladesh, the analysis of findings from published literature across the globe provided a base to start with. However, the awareness of contextual variation of contributors required some validation of these factors for the Bangladesh context. The expert evaluation process provided this validation in a subjective form. Sixteen factors identified through their suggestion, and were therefore used as the putative contributors of burnout. These 16 factors were then measured and put into testing to identify the most significant predictors of burnout among mental health professionals in Bangladesh.

4.2. Significant Predictors of Burnout Among Mental Health Professionals in Bangladesh

The Copenhagen Burnout Inventory (Kristensen et al., 2005) used in this research provided us with an opportunity to assess burnout from three aspects, namely personal, work related and client related burnout. Burnout predictors for mental health professionals were identified for each of the three areas of burnout.

The significant predictors found in this research are consistent with the findings from burnout research. As already known, from the conceptualization of burnout, stressful work context has been a significant predictor of all the three types of burnout (personal-, work-, and client- related burnout). This is a robust finding reported in other researches as well (Evans et al., 2006). Job stress has been suggested as a factor that leads to emotional exhaustion and, consequently, a potential for turnover (Acker, 2012).

In addition, workplace aggression was also found to increase all three domains of burnout. This finding is consistent with other studies. For instance, organizational environment has been found to predict burnout (Beatrice, 2020; Green et al., 2014). Additionally, workplace aggression (Gascon et al., 2013; Merecz et al., 2009) and aggressive administrative environment (Kumar et al., 2011) were reported to have significant contributions in developing burnout. Moreover, perception of injustice was found to significantly increase personal and work-related burnout. Maslach & Leiter (2016) demonstrated injustice or perceived unfairness as contributory factors of burnout. There was also a higher association of burnout with perceived unfairness (Lasalvia et al., 2009).

Professionals' work setting has been found to be significantly associated with burnout. Working in educational institution found to be associated with decreased personal burnout while working with medical settings was associated with decreased work-related burnout, and engagement in private practice was associated with increased client-related

burnout. Existing findings about professionals' work setting are consistent with current study (Johnson et al., 2018; Lakioti et al., 2020). Research also revealed that work settings had significant correlation with burnout for professional psychologists (Rupert & Kent, 2007). Lack of control over work, demanding work, organizational structure, contact with colleagues were associated with work setting that differentiate burnout levels of different professionals (Sorgaard et al., 2007).

Moreover, personality of the professionals has also been found as responsible factors of burnout. personality factors namely extraversion and neuroticism were found to contribute in decreasing all the three types of burnout, while openness was contributing only to work related burnout. Role of personality factors in burnout also been reported by other researches including, Zaninotto et al., (2018), which is also consistent with the present findigns. According to them, personality traits might be related to coping strategies which can protect from burnout (Zaninotto et al., 2018). Extrovert people tend to have higher assertiveness, confidence, and sociability (McCrae & Costa, 1987). Thus, they tend to have positive emotion and positive view of their self-efficacy, which can protect them from burnout (Judge & Ilies, 2002). On the other hand, individuals with neuroticism may attempt to cope with negative feelings and anxiety with maladaptive strategies like denial or delay (Carver & Connor-Smith, 2010; McCrae & Costa, 1997), which may be useful even for the shorter term. In addition, individuals with openness are more curious intellectually and open-minded which protect from experiencing discomfort and burnout (Zimmerman, 2008).

Professionals who generally use nonadaptive coping to deal with difficulties and stressful situation in their everyday life has been found to be associated with a lower level of personal and work-related burnout while use of adaptive coping has been found to be associated with lower level of client- related burnout. Consistent with the present findings, use of specific coping strategies was reported to be one of the major contributors of burnout

in other studies (Rodriguez & Carlotto, 2017; Thompson et al., 2014). In addition, Hannigan et al. (2000) reported that higher burnout was associated with lower adaptive coping strategies which is consistent with the findings of predictors of client-related burnout, and inconsistent with the predictors of personal and work-related burnout.

Also, professionals having both the clear knowledge about what is expected from their role, and proper understanding of their work has been found to be less vulnerable to work- and client-related burnout. Consistent with present findings, role clarity was reported to be associated with higher personal accomplishment (Green at al., 2014) and lower level of emotional exhaustion, and depersonalization (Lee & Ashforth, 1996). In addition, high levels of role conflict can contribute to burnout (Lee & Ashforth, 1996; Maslach et al., 2001) as higher role conflict can contribute to stressful climate in organization (Glisson et al., 2008).

Furthermore, length of experience was also found to be negatively associated with work- and client-related burnout which indicates that more experienced professionals are less likely to experience work- and client-related burnout. Experienced professionals develop mechanisms that may help them to manage burnout and increase resiliency through their career (Clarke, 2008). On the contrary, Sofology et al. (2019) found higher emotional exhaustion among experienced professionals. However, strong association between working experience and emotional exhaustion was also found in other studies (Leiter & Maslach, 2009; Ray et al., 2013).

Besides, findings from the present study indicate that mental health professionals who are satisfied with their salary are more vulnerable to develop personal and client-related burnout which is contradictory with existing knowledge of burnout. Salary dissatisfaction was reported to be associated with increased emotional exhaustion (Acker, 2008).

Further, professional background was also found to have significant contribution to burnout. Findings suggests that being a psychiatrist in Bangladesh is associated with lower level of personal burnout where higher levels of burnout were found in other studies (Ballenger et al. 2011). On the other hand, counseling and educational psychologists of Bangladesh are at lower risk of developing work-related burnout. This result is consistent with previous studies that demonstrated lower level of burnout on depersonalization aspects in psychologists (Billings et al., 2003; Nelson et al., 2009; Prosser et al., 1997).

Along with personal and work-related factors, professionals who have stressful family issues, find them difficult to manage, and these hinders their work are more susceptible to develop personal and work-related burnout. Findings from Gayen & Mozumder (2011) support the present findings of the impact of family issues on burnout. Other studies also indicated work-family conflict as a major contributor of burnout (Gallavan & Newman, 2013).

Findings also suggest that mental health professionals of Bangladesh who feel the importance of self-care and maintain self-care are less susceptible to develop personal burnout which is a consistent with existing knowledge on burnout (Emery et al., 2009). Moreover, professionals who have both the scope of participation on continuing professional development (CPD) program for improving their knowledge and skills, and regularly participate are prone to develop less work-related burnout. Continuing professional development boost skills and knowledge of professionals that help professionals to deal with the demands of profession (Gayen & Mozumder, 2011).

However, Professionals who have the scope of providing opinion to administrative decisions and whose opinion is treated as valuable to their workplace tend to suffer from higher level of client-related burnout which is inconsistent with existing knowledge of burnout (Evans et al., 2006).

From the above findings, it can be stated that burnout results from the interaction of personal, interpersonal, and workplace-related factors. It is the interplay of multiple factors.

4.3. Comparison of Burnout Among Different Professionals

Burnout experiences of the four professional groups significantly vary on different aspects of burnout, namely personal, work, and client-related burnout.

4.3.1. Differences in Personal Burnout

Personal burnout is significantly higher in clinical psychology and psychiatry professionals. Indication of high burnout among psychiatrists is consistent with existing knowledge (Ballenger-Browning et al., 2011; Bycov et al., 2022; Sarma, 2018; Volpe et al., 2014). Supervisory or administrative responsibilities and direct client care (Ballenger-Browning et al., 2011), stressors associated with psychiatrists' personal life and work (Fothergill et al., 2004), personality traits (Kumar et al., 2005; Naisberg-Fennig et al., 1991) were reported to predispose burnout in psychiatry profession. In addition, psychiatrists are expected to deal effectively and quickly clients with a lot of risks (Holloway, 1997). Also, findings of clinical psychology professionals' burnout are consistent with Gayen & Mozumder (2011) and Das & Mozumder (2023). Compared to others, the psychiatry and clinical psychology professionals in Bangladesh deals mostly with severe and high-distress cases in hospital and clinic settings. They usually go through a lot of pressure linked with unrealistic expectations of recovery of mental health problems of clients (Constantino et al., 2011; Goldfried, 2013; Larsen et al., 2014). As already mentioned, such stressful work can make professionals more vulnerable to burnout. This is consistent with the observation of Maslach et al. (2001) that burnout levels higher among health care professionals dealing intensively with clients in a regular basis.

Clinical psychology professionals experience higher level of personal burnout than counseling psychology and educational psychology professionals. In the same way,

personal burnout was significantly higher among psychiatry professionals compared to educational psychology professionals. However, no significant difference was found between clinical psychology and psychiatry professionals and also for counseling psychology professionals with educational psychology and psychiatry professionals. Lower level of burnout in counseling and educational psychology professionals is consistent with existing knowledge of burnout (Billings et al., 2003; Nelson et al., 2009; Prosser et al., 1997).

These findings are indicative of similar experiences between the professionals of clinical psychology with psychiatry and the counseling psychology with educational psychology professionals.

4.3.2. Differences in Work-related Burnout

Like personal burnout, work-related burnout was also higher in clinical psychology and psychiatry professionals. This finding is consistent with existing knowledge of burnout (Ballenger-Browning et al. 2011; Bycov et al., 2022; Das & Mozumder, 2023; Gayen & Mozumder, 2011; Sarma, 2018; Volpe et al., 2014).

Clinical psychology professionals are more susceptible to burnout compared to counseling psychology and educational psychology professionals. On the other hand, difference of psychiatry professionals with other three professional groups were found statistically nonsignificant. Difference between counseling and educational psychology professional group was also found nonsignificant. These findings indicate distinct experiences of clinical psychologists in case of work-related burnout.

4.3.3. Differences in Client-related Burnout

Psychiatry and clinical psychology professionals of Bangladesh are also more vulnerable to client-related burnout like personal and work-related burnout (Ballenger-

Browning et al. 2011; Bycov et al., 2022; Das & Mozumder, 2023; Gayen & Mozumder, 2011; Sarma, 2018; Volpe et al., 2014).

However, psychiatry and clinical psychology professionals scored significantly higher than both the counseling psychology and educational psychology professionals. On the other hand, difference between psychiatry and clinical psychology professional's client-related burnout score was nonsignificant. Moreover, difference between counseling psychology professionals and educational psychology professional's client-related burnout score was also nonsignificant. These findings indicate that professionals of psychiatry and clinical psychology share similar experience in client-related burnout compared to the other two groups.

4.4. Strengths and Limitations of the Study

This study explored predictors of burnout of mental health professionals in Bangladesh. One of its major strengths is that the study included different mental health professional groups where most of the previous study conducted in different countries mainly focused on the burnout of clinical and psychiatric professionals. Moreover, the study used mixed methods for obtaining the research objectives which has strengthened the present findings.

The present study is subject to certain limitations in terms of achieving its intended objectives. Specifically, the study aimed to recruit an equal number of participants from different mental health professions, including psychiatrists, clinical psychologists, counseling psychologists, and educational psychologists. The limited number of different mental health professionals in Bangladesh made it impossible to ensure equal number of participants from each professional group (see Mozumder, 2024). Additionally, the study encountered difficulty in obtaining an adequate number of participants from the psychiatry profession due to lack of accessibility due to dispersion of the professionals across the

country. After multiple attempts, estimated sample size couldn't be attained due to multiple practical constrains. As we mentioned rate of psychiatrists are extremely low in terms of population of the country. The existing number of psychiatrists in Bangladesh are also too much occupied in terms of service delivery that falls under practical considerations to the present sample size (Bartlett et al., 2001; Memon et al., 2020).

4.5. Directions of the Future Research

This study only identified the key contributors of burnout, however, exploratory process studies may now be designed and initiated based on the findings to generate a deeper understanding on how these factors contribute to specific areas of burnout and to specific professional groups. Further research needs to be conducted to translate the present study findings into intervention strategies and treatment programs.

Given the key predictors of burnout uncovered, future research should focus on qualitative research and study different professional groups separately. Finding the causes of the relationship between greater burnout and factors such as empowerment in making decisions at work and salary satisfaction can be the focus of qualitative study. Additionally, organizations can look at the causes and mechanisms of stressful work environments and conduct intervention research to create new strategies for eliminating workplace-related burnout issues. Moreover, research on investigating intervention program and treatment strategies can be initiated for specific areas of burnout.

This research revealed some interesting findings related to predictors of burnout which contradicts our general understanding of burnout as well as existing literature on burnout. These includes satisfied with salary and empowerment in workplace decision making are associated with increased burnout. Further research is need to understand the underlying reason behind this.

4.6. Implications and Recommendation

This research identified predictors of burnout for mental health professionals in Bangladesh which was an essential element in developing intervention strategies to prevent burnout. The findings may be useful to multiple stakeholders including the policy makers, service providing organizations, academic institutions, professional organizations and the individual service providers.

Policy makers may use these findings to decide strategies to prevent burnout and ensure the quality of mental health service delivery. Professional organizations such as Bangladesh Association of Psychiatrists, Bangladesh Clinical Psychology Society, Bangladesh Educational and Counselling Psychology Society have mandate to ensure high-quality care and protection of their members from harm. These findings can be especially useful for them to devise long-term strategies and policy papers to guard their members from the loss of quality from burnout.

Academic institutions that produce mental health professionals can also utilize the study findings in designing curricula and training strategies. Creating awareness at an early stage of development of future professionals can be extremely useful for protecting them from burnout.

The findings identified some organizational factors (e.g., stressful work, workplace aggression, inequality, role clarity, empowerment in workplace decision-making) associated with burnout. This finding can facilitate organizations to develop preventive measures for burnout for their employees in the mental health field. Organizations can arrange employee training to improve role clarity and workplace decision-making. They can take necessary steps to ensure a supportive and equitable environment for all. By taking preventive measures, they can improve the organizational climate and ensure employee and client wellbeing. Additionally, knowledge on the predictors (personality traits, coping strategies,

family issues) as risk factors may help individual practitioners to remain aware and take initiatives to address these aspects to protect them from burnout and thus improve wellbeing. Thus, they can early detect the issues and take preventive measures for themselves.

Furthermore, this study provides insight into how mental health professionals' burnout varies across different groups of professionals.

The number of mental health specialists is insufficient in Bangladesh. In the limited scope of service, burnout causes additional loss of service and quality. Taking action against burnout should, therefore, be a major area of concern among the relevant stakeholders. It is important to initiate strategies to create awareness among the professionals.

Initiating a taskforce to develop concrete policy papers and strategies needs to be considered who may use the findings to address personal level and organizational level contributors of burnout identified in this study.

Chapter 5

CONCLUSIONS

Conclusions

The findings of this research have shed light on predictors that can lead mental health professionals to burnout that interfere with their work as well as personal life. Findings revealed that burnout is more likely to occur in all the three domain- personal, work- and client- related when there are stressful work environment and workplace aggression. On the other hand, personality traits such as extraversion, neuroticism was associated with lower level of burnout in all three domains. Furthermore, a decrease in personal and work-related burnout was linked to nonadaptive coping, but a drop-in client-related burnout was linked to adaptive coping.

Additionally, it has been found that mental health professional, that is clinical psychologist are particularly susceptible to personal, work- and client-related burnout. It was also found that psychiatrists are more likely to experience burnout than the other two groups of mental health professionals.

The findings of this study yield opportunity for future research in the area of burnout of mental health professionals of Bangladesh. These findings open up new avenues for investigation into Bangladeshi mental health professionals' burnout.

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APPENDICES

Appendix A

List of Experts

1. Dr. S. M. Yasir Arafat, Psychiatrist & Assistant Professor, Enam Medical College and Hospital
2. Fayaza Ahmed, Senior Instructor- Child Psychology & Psychotherapist, Hospital Services Management, DGHS
3. Tarun Kanti Gayen, Clinical Psychologist & Part-Time Faculty, Department of Clinical Psychology, University of Dhaka
4. Dr. Kamal Uddin Ahamed Chowdhury, Clinical Psychologist, Professor, Department of Clinical Psychology, University of Dhaka
5. Dr. Mahjabeen Haque, Professor, Department of Educational and Counselling Psychology, University of Dhaka
6. Ruma Khondaker, Clinical Psychologist, MHPSS Specialist
7. Chayon Kumar Das, Clinical Psychologist, Monno Medical College Hospital
8. Md. Taifur Islam, Manager & Senior Psychologist, BRAC Institute of Educational Development, BRAC University.

Appendix B

Consent form for experts

আমি খাদিজা বেগম, ঢাকা বিশ্ববিদ্যালয়ের ক্লিনিক্যাল সাইকোলজি বিভাগের একজন এমফিল গবেষক। আমার গবেষণার বিষয় "Predictors of Burnout among Mental Health Professionals". এই গবেষণাটি ঢাকা বিশ্ববিদ্যালয়ের ক্লিনিক্যাল সাইকোলজি বিভাগের অধ্যাপক মুহাম্মদ কামরুজ্জামান মজুমদার ও সহযোগী অধ্যাপক এস এম আবুল কালাম আজাদ এর তত্ত্বাবধানে করছি।

এই গবেষণার অংশ হিসেবে বাংলাদেশসহ আন্তর্জাতিক প্রকাশিত গবেষণায় প্রাপ্ত মানসিক স্বাস্থ্য সেবায় নিয়োজিত পেশাজীবিদের বার্ণআউট এর সাথে সম্পর্কিত গুরুত্বপূর্ণ ফ্যাক্টরগুলোর তালিকা করেছি। এই তালিকা থেকে কোন বিষয়গুলো বাংলাদেশের মানসিক স্বাস্থ্যসেবায় নিয়োজিত পেশাজীবির (সাইকিয়াট্রিস্ট, এসিসট্যান্ট কাউন্সেলিং সাইকোলজিস্ট, কাউন্সেলিং সাইকোলজিস্ট, এসিসট্যান্ট এডুকেশনাল সাইকোলজিস্ট, এডুকেশনাল সাইকোলজিস্ট, এসিসট্যান্ট ক্লিনিক্যাল সাইকোলজিস্ট, ক্লিনিক্যাল সাইকোলজিস্ট) বার্ণআউট এর ক্ষেত্রে সম্পর্কিত তা জানার জন্য বিশেষজ্ঞের মূল্যায়ন (Expert evaluation) করছি। বিশেষজ্ঞের মূল্যায়নের ভিত্তিতে গবেষণার পরবর্তী ধাপ পরিচালনা করা হবে।

এই গবেষণা বাংলাদেশের মানসিক স্বাস্থ্যসেবায় নিয়োজিত পেশাজীবিদের বার্ণআউট প্রতিরোধ করা এবং ব্যবস্থাপনা পরিকল্পনার ক্ষেত্রে গুরুত্বপূর্ন ভূমিকা রাখতে পারে। এই গবেষণায় অংশগ্রহণের জন্য আপনার ১৫-২০ মিনিট সময় প্রয়োজন হতে পারে। আপনার তথ্যের গোপনীয়তা রক্ষা করা হবে এবং এই তথ্য শুধুমাত্র গবেষণার কাজে ব্যবহার করা হবে। এই গবেষণায় অংশগ্রহণের মাধ্যমে আপনার কোন ক্ষতির সম্ভাবনা নেই। এই গবেষণায় অংশগ্রহণ সম্পূর্ণ স্বেচ্ছামূলক। ফর্মটি সাবমিট করার পূর্ব পর্যন্ত আপনি যেকোন সময় বাধ্যবাধকতা ছাড়াই গবেষণা থেকে নিজেকে বিরত রাখতে পারবেন।

গবেষণা সম্পর্কিত আর কোন প্রশ্ন থাকলে আমার সাথে যোগাযোগ করতে পারেন ০১৭৯৫৩০৬৬৮৪ নাম্বারে অথবা ইমেইল (khadizadipu@gmail.com) করতে পারেন।

Appendix C

Expert evaluation form

আপনার মতে বাংলাদেশের মানসিক স্বাস্থ্য সেবায় নিয়োজিত পেশাজীবির (সাইকিয়াট্রিস্ট, কাউন্সেলিং সাইকোলজিস্ট, এডুকেশনাল সাইকোলজিস্ট, ক্লিনিক্যাল সাইকোলজিস্ট) বার্ণআউট এর ক্ষেত্রে কোন বিষয়গুলো গুরুত্বপূর্ণ ভূমিকা রাখে অনুগ্রহ করে চিহ্নিত করুন। যদি আপনি মনে করেন নিম্নে উল্লেখিত বিষয়গুলো ছাড়াও বিশেষ কোন ফ্যাক্টর বা কারণ বাংলাদেশের মানসিক স্বাস্থ্যসেবায় নিয়োজিত পেশাজীবির বার্ণআউট এর ক্ষেত্রে উল্লেখযোগ্য ভূমিকা রাখে তবে ফর্মের শেষে অন্যান্য তালিকায় যুক্ত করুন।

১। "কাজের অভিজ্ঞতার ব্যাপ্তিকাল (Years of experience)" বাংলাদেশের মানসিক স্বাস্থ্যসেবায় নিয়োজিত পেশাজীবির বার্ণআউট এর সাথে সম্পর্কিত।

- সম্পূর্ণ একমত (৪)
- কিছুটা একমত (৩)
- নিশ্চিত নই (২)
- কিছুটা দ্বিমত (১)
- সম্পূর্ণ দ্বিমত (০)

২। "পারিবারিক চাপ (Family issues)" বাংলাদেশের মানসিক স্বাস্থ্য সেবায় নিয়োজিত পেশাজীবির বার্ণআউট এর সাথে সম্পর্কিত।

- সম্পূর্ণ একমত (৪)
- কিছুটা একমত (৩)
- নিশ্চিত নই (২)
- কিছুটা দ্বিমত (১)
- সম্পূর্ণ দ্বিমত (০)

৩। "শিক্ষাগত যোগ্যতা (Length of education)" বাংলাদেশের মানসিক স্বাস্থ্য সেবায় নিয়োজিত পেশাজীবির বার্ণআউট এর সাথে সম্পর্কিত।

- সম্পূর্ণ একমত (৪)
- কিছুটা একমত (৩)
- নিশ্চিত নই (২)
- কিছুটা দ্বিমত (১)
- সম্পূর্ণ দ্বিমত (০)

৪। "কাজের ক্ষেত্রে কোন ভূমিকায় রয়েছেন (Type of role- administrative/ teaching/ supervisor etc.)" বাংলাদেশের মানসিক স্বাস্থ্য সেবায় নিয়োজিত পেশাজীবির বার্ণআউট এর সাথে সম্পর্কিত।

- সম্পূর্ণ একমত (৪)
- কিছুটা একমত (৩)

- নিশ্চিত নই (২)
- কিছুটা দ্বিমত (১)
- সম্পূর্ণ দ্বিমত (০)

৫। "কর্মক্ষেত্রে ব্যক্তিস্বাধীনতা রয়েছে এবং সিদ্ধান্ত নেওয়ার ক্ষেত্রে প্রভাবিত করার ক্ষমতা রয়েছে এমন অনুভূতি (Job control- sense of autonomy at work and perceived capacity to influence decisions)" বাংলাদেশের মানসিক স্বাস্থ্য সেবায় নিয়োজিত পেশাজীবির বার্ণআউট এর সাথে সম্পর্কিত।

- সম্পূর্ণ একমত (৪)
- কিছুটা একমত (৩)
- নিশ্চিত নই (২)
- কিছুটা দ্বিমত (১)
- সম্পূর্ণ দ্বিমত (০)

৬। "সমস্যা সমাধান ও প্রতিবন্ধকতা মোকাবেলার প্রক্রিয়া (Coping mechanism)" বাংলাদেশের মানসিক স্বাস্থ্য সেবায় নিয়োজিত পেশাজীবির বার্ণআউট এর সাথে সম্পর্কিত।

- সম্পূর্ণ একমত (৪)
- কিছুটা একমত (৩)
- নিশ্চিত নই (২)
- কিছুটা দ্বিমত (১)
- সম্পূর্ণ দ্বিমত (০)

৭। "কর্মক্ষেত্রে বৈষম্যের শিকার হওয়ার অনুভূতি" বাংলাদেশের মানসিক স্বাস্থ্যসেবায় নিয়োজিত পেশাজীবির বার্ণআউট এর সাথে সম্পর্কিত।

- সম্পূর্ণ একমত (৪)
- কিছুটা একমত (৩)
- নিশ্চিত নই (২)
- কিছুটা দ্বিমত (১)
- সম্পূর্ণ দ্বিমত (০)

৮। "ব্যক্তিত্বের বৈশিষ্ট্য" বাংলাদেশের মানসিক স্বাস্থ্যসেবায় নিয়োজিত পেশাজীবির বার্ণআউট এর সাথে সম্পর্কিত।

- সম্পূর্ণ একমত (৪)
- কিছুটা একমত (৩)
- নিশ্চিত নই (২)
- কিছুটা দ্বিমত (১)
- সম্পূর্ণ দ্বিমত (০)

৯। "ক্লায়েন্টের ধরণ (যেমনঃ পার্সোনালিটি ডিসঅর্ডার/ সাইকোটিক ডিসঅর্ডার/ এংজাইটি ডিসঅর্ডার ইত্যাদি)" অনুসারে বাংলাদেশের মানসিক স্বাস্থ্যসেবায় নিয়োজিত পেশাজীবির বার্ণআউট এর মাত্রার পার্থক্য হয়।

- সম্পূর্ণ একমত (৪)

- কিছুটা একমত (৩)
- নিশ্চিত নই (২)
- কিছুটা দ্বিমত (১)
- সম্পূর্ণ দ্বিমত (০)

১০। " ক্লায়েন্টের সংখ্যা (Case load)" বাংলাদেশের মানসিক স্বাস্থ্যসেবায় নিয়োজিত পেশাজীবির বার্ণআউট এর সাথে সম্পর্কিত।

- সম্পূর্ণ একমত (৪)
- কিছুটা একমত (৩)
- নিশ্চিত নই (২)
- কিছুটা দ্বিমত (১)
- সম্পূর্ণ দ্বিমত (০)

১১। "কোন মাধ্যমে ক্লায়েন্টকে সেবা দিচ্ছেন (সরাসরি/ অনলাইন)" তা বাংলাদেশের মানসিক স্বাস্থ্যসেবায় নিয়োজিত পেশাজীবির বার্ণআউট এর সাথে সম্পর্কিত।

- সম্পূর্ণ একমত (৪)
- কিছুটা একমত (৩)
- নিশ্চিত নই (২)
- কিছুটা দ্বিমত (১)
- সম্পূর্ণ দ্বিমত (০)

১২। "কাজের জায়গার ধরণ (কমিউনিটি/ প্রাইভেট সেবা/ হাসপাতাল ইত্যাদি)" বাংলাদেশের মানসিক স্বাস্থ্যসেবায় নিয়োজিত পেশাজীবির বার্ণআউট এর সাথে সম্পর্কিত।

- সম্পূর্ণ একমত (৪)
- কিছুটা একমত (৩)
- নিশ্চিত নই (২)
- কিছুটা দ্বিমত (১)
- সম্পূর্ণ দ্বিমত (০)

১৩। "প্রফেশনাল ব্যাকগ্রাউন্ড (সাইকিয়াট্রিস্ট/ সাইকোলজিস্ট)" বাংলাদেশের মানসিক স্বাস্থ্যসেবায় নিয়োজিত পেশাজীবির বার্ণআউট এর সাথে সম্পর্কিত।

- সম্পূর্ণ একমত (৪)
- কিছুটা একমত (৩)
- নিশ্চিত নই (২)
- কিছুটা দ্বিমত (১)
- সম্পূর্ণ দ্বিমত (০)

১৪। "কর্মক্ষেত্রে সহকর্মীদের সহযোগীতা পাওয়া না পাওয়ার বিষয়টি" বাংলাদেশের মানসিক স্বাস্থ্যসেবায় নিয়োজিত পেশাজীবির বার্ণআউট এর সাথে সম্পর্কিত।

- সম্পূর্ণ একমত (৪)
- কিছুটা একমত (৩)

- নিশ্চিত নই (২)
- কিছুটা দ্বিমত (১)
- সম্পূর্ণ দ্বিমত (০)

১৫। "সুপারভিশন না পাওয়া" বাংলাদেশের মানসিক স্বাস্থ্যসেবায় নিয়োজিত পেশাজীবির বার্ণআউট এর সাথে সম্পর্কিত।

- সম্পূর্ণ একমত (৪)
- কিছুটা একমত (৩)
- নিশ্চিত নই (২)
- কিছুটা দ্বিমত (১)
- সম্পূর্ণ দ্বিমত (০)

১৬। "পর্যাপ্ত সুপারভিশন পাচ্ছিনা এমন অনুভূতি (Perceived inadequacy of clinical supervision)" বাংলাদেশের মানসিক স্বাস্থ্যসেবায় নিয়োজিত পেশাজীবির বার্ণআউট এর সাথে সম্পর্কিত।

- সম্পূর্ণ একমত (৪)
- কিছুটা একমত (৩)
- নিশ্চিত নই (২)
- কিছুটা দ্বিমত (১)
- সম্পূর্ণ দ্বিমত (০)

১৭। "দলগত সংহতি (Team / staff cohesion)" বাংলাদেশের মানসিক স্বাস্থ্যসেবায় নিয়োজিত পেশাজীবির বার্ণআউট এর সাথে সম্পর্কিত।

- সম্পূর্ণ একমত (৪)
- কিছুটা একমত (৩)
- নিশ্চিত নই (২)
- কিছুটা দ্বিমত (১)
- সম্পূর্ণ দ্বিমত (০)

১৮। "কাজ সম্পর্কে স্পষ্ট ধারণা থাকা না থাকার (Role clarity)" বিষয়টি বাংলাদেশের মানসিক স্বাস্থ্যসেবায় নিয়োজিত পেশাজীবির বার্ণআউট এর সাথে সম্পর্কিত।

- সম্পূর্ণ একমত (৪)
- কিছুটা একমত (৩)
- নিশ্চিত নই (২)
- কিছুটা দ্বিমত (১)
- সম্পূর্ণ দ্বিমত (০)

১৯। "কাজের ভূমিকা নিয়ে দ্বন্দ থাকা না থাকার (Role conflict)" বিষয়টি বাংলাদেশের মানসিক স্বাস্থ্যসেবায় নিয়োজিত পেশাজীবির বার্ণআউট এর সাথে সম্পর্কিত।

- সম্পূর্ণ একমত (৪)
- কিছুটা একমত (৩)
- নিশ্চিত নই (২)

- কিছুটা দ্বিমত (১)
- সম্পূর্ণ দ্বিমত (০)

২০। "কর্মক্ষেত্রে চাপ" বাংলাদেশের মানসিক স্বাস্থ্যসেবায় নিয়োজিত পেশাজীবির বার্ণআউট এর সাথে সম্পর্কিত।

- সম্পূর্ণ একমত (৪)
- কিছুটা একমত (৩)
- নিশ্চিত নই (২)
- কিছুটা দ্বিমত (১)
- সম্পূর্ণ দ্বিমত (০)

২১। "কর্মক্ষেত্রে আক্রমণাত্মক পরিবেশ (যেমনঃ হুমকি, মৌখিক বা শারীরিক আক্রমণ ইত্যাদি)" বাংলাদেশের মানসিক স্বাস্থ্যসেবায় নিয়োজিত পেশাজীবির বার্ণআউট এর সাথে সম্পর্কিত।

- সম্পূর্ণ একমত (৪)
- কিছুটা একমত (৩)
- নিশ্চিত নই (২)
- কিছুটা দ্বিমত (১)
- সম্পূর্ণ দ্বিমত (০)

২২। অন্যান্য ফ্যাক্টর যা বাংলাদেশের মানসিক স্বাস্থ্যসেবায় নিয়োজিত পেশাজীবির বার্ণআউট এ ভূমিকা রাখে কিন্ত উল্লেখ করা হয়নি বলে আপনার মনে হয় (যতগুলো ইচ্ছে লিখুন)।

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Appendix D

Socio-demographic Information Questionnaire

অংশগ্রহণকারীর তথ্য

1. প্রফেশনাল ব্যাকগ্রাউন্ড
    - সাইকিয়াট্রি
    - এডুকেশনাল সাইকোলজি
    - কাউন্সেলিং সাইকোলজি
    - ক্লিনিক্যাল সাইকোলজি
2. সর্বোচ্চ শিক্ষাগত যোগ্যতা .....
3. বয়স ....
4. লিঙ্গ
    - নারী
    - পুরুষ
5. বর্তমান বৈবাহিক অবস্থা
    - বিবাহিত
    - অবিবাহিত
6. কাজের ক্ষেত্র (একের অধিক চিহ্নিত করতে পারেন)
    - প্রাইভেট প্র্যাক্টিস
    - শিক্ষা প্রতিষ্ঠান
    - হাসপাতাল বা মেডিকেল সেটিং
    - শরণার্থী সেবামূলক প্রতিষ্ঠান
    - অন্যান্য
7. আপনি কত সাল থেকে মানসিক স্বাস্থ্য সেবা প্রদান করছেন? .....

Appendix E

COPENHAGEN BURNOUT INVENTORY

১ = সবসময় বা অতি উচ্চ পরিমাণে
২ = প্রায়ই বা উচ্চ পরিমাণে
৩ = মাঝে মাঝে বা কিছুটা
৪ = কদাচিৎ বা অল্প পরিমাণে
৫ = কখনোই না বা খুব অল্প পরিমাণে

1. আপনি কত ঘন ঘন ক্লান্তি বোধ করেন? *	**১**	**২**	**৩**	**৪**	**৫**
2. আপনি কত ঘন ঘন পরিশ্রান্ত হন? *	১	২	৩	৪	৫
3. আপনি কত ঘন ঘন অবসাদগ্রস্ত হন? *	১	২	৩	৪	৫
4. আপনি কত ঘন ঘন ভাবেন ঃ "আমি আর নিতে পারছি না"? *	১	২	৩	৪	৫
5. আপনি কত ঘন ঘন নিঃশোষিত বোধ করেন? *	১	২	৩	৪	৫
6. আপনি কত ঘন ঘন দুর্বল এবং রোগাক্রান্ত বোধ করেন? *	১	২	৩	৪	৫
7. আপনি কি কর্মদিবস শেষে নিঃশোষিত বোধ করেন? *	১	২	৩	৪	৫
8. "কর্মক্ষেত্রে আরো একটি দিন" এই ভাবনায় সকালে আপনি অবসন্ন বোধ করেন? *	১	২	৩	৪	৫
9. আপনি কি অনুভব করেন যে প্রতিটি কর্মঘন্টাই আপনার জন্য ক্লান্তিকর? *	১	২	৩	৪	৫
10. অবসর সময়ে পরিবার-পরিজন এবং বন্ধু-বান্ধবদের সাথে কাটানোর জন্য যথেষ্ট উদ্দীপনা আপনার থাকে কিনা? *	১	২	৩	৪	৫
11. আপনার কাজ কি আপনাকে আবেগীয়ভাবে অবসাদগ্রস্ত করে তোলে? *	১	২	৩	৪	৫
12. আপনার কাজ কি আপনাকে হতাশ করে? *	১	২	৩	৪	৫
13. আপনি কি আপনার কাজের জন্য মনোঃদহন (Burn-out) বোধ করেন? *	১	২	৩	৪	৫
14. সেবা গ্রহীতাদের (অথবা সহকর্মী, ছাত্র, প্রশিক্ষণার্থী বা কাজ সম্পর্কিত যে কোন ব্যক্তি) সাথে কাজ করতে কি আপনি দুরূহ বোধ করেন? *	১	২	৩	৪	৫
15. সেবাগ্রহীতাদের (অথবা সহকর্মী, ছাত্র, প্রশিক্ষণার্থী বা কাজ সম্পর্কিত যে কোন ব্যক্তি) সাথে কাজ করা কি আপনার শক্তিকে নিঃশেষিত করে? *	১	২	৩	৪	৫
16. সেবাগ্রহীতাদের (অথবা সহকর্মী, ছাত্র, প্রশিক্ষণার্থী, কাজ সম্পর্কিত যে কোন ব্যক্তি) সাথে কাজ করতে আপনি কি হতাশা বোধ করেন? *	১	২	৩	৪	৫
17. আপনি কি অনুভব করেন যে যখন আপনি সেবাগ্রহীতাদের (অথবা সহকর্মী, ছাত্র, প্রশিক্ষণার্থী বা কাজ সম্পর্কিত যে কোন ব্যক্তি) সাথে কাজ করেন তখন যা পান তার চেয়ে বেশি দেন? *	১	২	৩	৪	৫
18. আপনি কি সেবাগ্রহীতাদের (অথবা সহকর্মী, ছাত্র, প্রশিক্ষণার্থী বা কাজ সম্পর্কিত যে কোন ব্যক্তি) সাথে কাজ করতে করতে ক্লান্ত? *	১	২	৩	৪	৫
19. আপনি কি মাঝেমাঝে ভাবনায় পড়ে যান যে আরো কতকাল সেবা গ্রহিতাদের (অথবা সহকর্মী, ছাত্র, প্রশিক্ষণার্থী বা কাজ সম্পর্কিত যে কোন ব্যক্তি) সাথে কাজ চালিয়ে যেতে সক্ষম হবেন? *	১	২	৩	৪	৫

Appendix F

Ten Item Personality Inventory

প্রশ্নগুচ্ছ

নিম্নে মানুষের **১০ জোড়া ব্যক্তিত্ব বৈশিষ্ট্য** দেয়া আছে । প্রতি জোড়া বৈশিষ্ট্য আপনার ক্ষেত্রে কতখানি প্রযোজ্য তা ৫টি উত্তরের মধ্যে যেটিতে প্রযোজ্য তার পাশে টিক চিহ্ন (√) দিয়ে প্রকাশ করুন। যদিও প্রতি জোড়া চারিত্রিক বৈশিষ্ট্যগুলোর মধ্যে একটি বৈশিষ্ট্য অপরটির চেয়ে আপনার ক্ষেত্রে কম বা বেশি প্রযোজ্য হতে পারে। ৫টি উত্তরঃ

১= একেবারেই প্রযোজ্য নয়
২= প্রযোজ্য নয়
৩= অনিশ্চিত
৪= প্রযোজ্য
৫= সম্পূর্ণ প্রযোজ্য

আমি নিজেকে যেভাবে দেখি:

জোড়া বৈশিষ্ট্য					
১। মিশুক, চটপটে	১	২	৩	৪	৫
২। জটিল, ঝগড়াটে	১	২	৩	৪	৫
৩। নির্ভরযোগ্য, আত্মনিয়ন্ত্রক	১	২	৩	৪	৫
৪। দুশ্চিন্তাগ্রস্থ, সহজে বিপর্যস্থ	১	২	৩	৪	৫
৫। নতুন অভিজ্ঞতায় আগ্রহী, সৃষ্টিশীল	১	২	৩	৪	৫
৬। গম্ভীর, চুপচাপ	১	২	৩	৪	৫
৭। দরদী, আন্তরিক	১	২	৩	৪	৫
৮। অগোছালো, উদাসীন	১	২	৩	৪	৫
৯। শান্ত, ধীরস্থির	১	২	৩	৪	৫
১০। গতানুগতিক, সৃষ্টিশীল নই	১	২	৩	৪	৫

Appendix G

Coping Scale

অভিযোজন প্রশ্নমালা

জীবনের কঠিন ও চাপমূলক পরিস্থিতির সাথে খাপ খাইয়ে নেয়ার জন্য মানুষ বিভিন্ন উপায় অবলম্বন করে। এই প্রশ্নমালায় আমরা জানতে চাই আপনি এই ধরনের চাপের সম্মুখে কি করেন অথবা তখন আপনার অনুভূতি কেমন হয়। এখানে ঠিক অথবা ভুল উত্তর নাই। তাই যে উত্তরটি সবচেয়ে বেশী আপনার জন্য প্রযোজ্য সেটি বেছে নিন। অন্যরা এই পরিস্থিতিতে কি করে তা চিন্তা করবেন না । আপনি নিজে সাধারনতঃ কি করেন নীচের চারটি উত্তরের মধ্যে থেকে একটিতে টিক (√) চিহ্ন দিন।

১=আমি সাধারনতঃ এটা করিনা
২=আমি সাধারনতঃএটা মাঝে মাঝে করি
৩=আমি সাধারনত ঃ এটা বেশীর ভাগ সময় করি
৪=আমি সাধারনত ঃ এটা সবসময় করি

১	আমি এই পরিস্থিতিতে সমস্যার সমাধান করতে চেষ্টা করি	১	২	৩	৪
২	নিজেকে বোঝাতে চেষ্টা করি যে পরিস্থিতি যতটা খারাপ ভাবছি সব কিছু ততটা খারাপ নয়	১	২	৩	৪
৩	এমন পরিস্থিতিতে আমি গালিগালাজ/বিরক্তি প্রকাশ করি	১	২	৩	৪
৪	যা ঘটেছে তার মধ্যে আমি ভাল কিছু খুজে বের করতে চেষ্টা করি	১	২	৩	৪
৫	আমি আমার আবেগ /অনুভুতিগুলো প্রকাশ করি	১	২	৩	৪
৬	আমার কেমন লাগে তা অন্যদের সাথে আলোচনা করি	১	২	৩	৪
৭	আমি সমস্যা সমন্ধে চিন্তা বা কিছু করা পরিহার করি	১	২	৩	৪
৮	আমি আশা করি অলৌকিক কিছু ঘটবে	১	২	৩	৪
৯	মানুষকে এড়িয়ে চলি	১	২	৩	৪
১০	বেশী করে গান অথবা রেডিও শুনি	১	২	৩	৪
১১	আমি নিজেকে দোষী মনে করি	১	২	৩	৪
১২	এই পরিস্থিতিতে কি করা যায় সে রকম একটা কৌশল বের করতে চেষ্টা করি	১	২	৩	৪
১৩	অন্যদের সাথে মারামারি করি	১	২	৩	৪
১৪	আমি তখন আল্লাহর উপর বিশ্বাস রাখি	১	২	৩	৪
১৫	আমি সব কিছু মেনে নেই অথবা এই সমস্যা নিয়ে বেঁচে থাকার চিন্তা করি	১	২	৩	৪
১৬	অতিরিক্তি কিছু কাজ করে সমস্যা এড়িয়ে যাই	১	২	৩	৪
১৭	অন্যের জিনিস পত্রের ক্ষতি করি	১	২	৩	৪
১৮	এই পরিস্থিতিতে কি করতে হবে তা এমন একজনের কাছ থেকে উপদেশ নেই	১	২	৩	৪
১৯	যাতে করে কম চিন্তা করতে হয় তাই সিনেমা দেখতে যাই অথবা টিভি দেখি	১	২	৩	৪
২০	আমি আল্লাহর সাহায্য প্রার্থনা করি	১	২	৩	৪
২১	যে এমন পরিস্থিতিতে আমাকে সাহায্য করবে এমন কারও সাথে কথা বলি	১	২	৩	৪
২২	অন্যেরা এমন পরিস্থিতিতে কি করেছে তা জিজ্ঞাসা করি	১	২	৩	৪

Huque, P(2004) Coping Scale, The Dhaka University Journal of Psychology, vol.32

Appendix H
Steel Injustice Inventory

স্টিল অবিচার ইনভেন্টরিঃ

মাঝে মাঝে আমাদের জীবনে এমন কিছু অভিজ্ঞতার সম্মুখীন হতে হয় যা অবিচার বা অন্যায় মনে হয়।
এই অন্যায়গুলো হয়তো আপনার সাথে বা আপনার পরিচিত কারো সাথে হয়েছে যার প্রভাব আপনার মধ্যে পড়েছিল বা এখনো পড়ছে। এই অন্যায় বা অবিচারগুলো কোন ব্যক্তি, দল অথবা সংস্থার দ্বারা সংঘটিত হতে পারে। এই অংশে আমরা আপনি অতীতে বা বর্তমানে এই ধরনের কোন অভিজ্ঞতার সম্মুখীন হয়েছেন কিনা সে বিষয়ে জানতে চাইব।

1. আপনি কি অবিচারের সম্মুখীন হয়েছেন? যদি 'না' হয় তবে পরের অংশে (কর্মক্ষেত্রে অবিচার -3 তে চলে যান)

- হ্যাঁ
- না

2. আপনি যদি কোন অবিচারের সম্মুখীন হয়ে থাকেন তবে, গত একমাসে সেটা নিয়ে কতবার বিরক্ত বোধ করেছেন?

- একদমই না
- খুবই কম
- মাঝে মাঝে
- প্রায়ই
- সবসময়

কখনো কখনো মানুষ তাঁর কর্মক্ষেত্রেও অবিচার বা অন্যায়ের সম্মুখীন হয়। এই অভিজ্ঞতাগুলো আপনার বা আপনার পরিচিত কারোও হতে পারে|

3. আপনি কি কর্মক্ষেত্রে কোন অবিচারের সম্মুখীন হয়েছেন?

- হ্যাঁ
- না

4 আপনি যদি কর্মক্ষেত্রে কোন অবিচারের সম্মুখীন হয়ে থাকেন তবে, গত একমাসে সেটা নিয়ে কতবার বিরক্ত বোধ করেছেন?

- একদমই না
- খুবই কম
- মাঝে মাঝে
- প্রায়ই
- সবসময়

Appendix I

Composite Questionnaire

১. আপনি কি মনে করেন আপনার প্রাপ্ত পারিশ্রমিক কাজের তুলনায় পর্যাপ্ত?

- হ্যাঁ
- না
- প্রযোজ্য নয়

২. আপনার ক্লিনিক্যাল সুপারভিশন নেওয়ার সুযোগ রয়েছে কিনা?

- কখনোই না
- খুবই কম
- মাঝেমাঝে
- বেশিরভাগ সময়
- সবসময়

৩. আপনি ক্লিনিক্যাল সুপারভিশন গ্রহণ করেন কিনা?

- কখনোই না
- খুবই কম
- মাঝেমাঝে
- বেশিরভাগ সময়
- সবসময়

৪. আপনার সহকর্মীরা সহযোগীতামূলক মনোভাব সম্পন্ন কিনা?

- একদমই নয়
- কিছুটা
- মোটামুটি
- বেশি
- অনেক বেশি

৫. আপনার সহকর্মীদের কাছ থেকে আপনি কতটা সহযোগীতা পান?

- কখনোই না
- খুবই কম
- মাঝেমাঝে
- বেশিরভাগ সময়
- সবসময়

৬. আপনার পারিবারিক বিষয়গুলো কতোটা চাপমূলক?

- একদমই নয়
- কিছুটা
- মোটামুটি
- বেশি

- অনেক বেশি

৭. পারিবারিক বিষয়গুলো এতটাই চাপমূলক যে এগুলো সামলাতে আপনি হিমসিম খান?

- কখনোই না
- খুবই কম
- মাঝেমাঝে
- বেশিরভাগ সময়
- সবসময়

৮. পারিবারিক বিষয়গুলো আপনার কাজকে কতটা বাধাগ্রস্ত করে?

- একদমই নয়
- কিছুটা
- মোটামুটি
- বেশি
- অনেক বেশি

৯. কর্মক্ষেত্রে নীতিনির্ধারণী সিদ্ধান্ত গ্রহণে আপনার মত প্রকাশের সুযোগ রয়েছে কিনা?

- কখনোই না
- খুবই কম
- মাঝেমাঝে
- বেশিরভাগ সময়
- সবসময়
- প্রযোজ্য নয়

১০. কর্মক্ষেত্রে নীতিনির্ধারণী সিদ্ধান্ত গ্রহণে আপনার মতামতকে কতটা গুরুত্ব দেওয়া হয় ?

- একদমই না
- কিছুটা
- মোটামুটি
- যথেষ্ট
- অনেক বেশি
- প্রযোজ্য নয়

১১. আপনি কিভাবে কাজ করবেন সে বিষয়ে আপনার কতটুকু স্বাধীনতা রয়েছে?

- একদমই না
- কিছুটা
- মোটামুটি
- বেশি
- অনেক বেশি

১২. নিজের কাজের পরিমাণ নির্ধারণে আপনার স্বাধীনতা রয়েছে কিনা?

- একদমই না
- খুবই কম

- মাঝেমাঝে
- বেশিরভাগ সময়
- সবসময়

১৩. আপনার কর্মক্ষেত্রের পরিস্থিতি কতটা চাপমূলক চাপমূলক?

- একদমই নয়
- কিছুটা
- মোটামুটি
- বেশি
- অনেক বেশি

১৪. কর্মক্ষেত্রের পরিস্থিতি এতটাই চাপমূলক যে এগুলো সামলাতে আমি হিমসিম খাই

- কখনোই না
- খুবই কম
- মাঝেমাঝে
- বেশিরভাগ সময়
- সবসময়

১৫. কর্মক্ষেত্রে আমার কাছ থেকে কি কি প্রত্যাশিত তা সম্পর্কে আমার পরিষ্কার ধারণা আছে?

- একদমই নয়
- কিছুটা
- মাঝামাঝি
- বেশি
- অনেক বেশি

১৬. কর্মক্ষেত্রে আমার কাজগুলো কি কি তা আমি স্পষ্টভাবে জানি ?

- একদমই নয়
- কিছুটা
- মোটামুটি
- বেশি
- অনেক বেশি

১৭. আপনার কর্মক্ষেত্রের পরিবেশ কতটা আক্রমণাত্মক বলে মনে হয়?

- একদমই নয়
- কিছুটা
- মোটামুটি
- বেশি
- অনেক বেশি

১৮. আপনি নিজে কখনো কর্মক্ষেত্রে শারিরিক বা মৌখিকভাবে আক্রমণের শিকার হয়েছেন কি?

- কখনোই না
- খুবই কম

- মাঝেমাঝে
- বেশিরভাগ সময়
- সবসময়

১৯. আপনার কর্মক্ষেত্রে সহকর্মীদের মধ্যে কতটা সংহতি (Cohesion) রয়েছে?

- একদমই নয়
- কিছুটা
- মোটামুটি
- বেশি
- অনেক বেশি

২০. আমি বুঝি যে আমার নিজের যত্ন নেওয়াটা খুবই গুরুত্বপূর্ণ

- একদমই না
- কিছুটা
- মোটামুটি
- বেশি
- অনেক বেশি

২১. আমি নিজের যত্ন নিই

- একদমই নয়
- কিছুটা
- মোটামুটি
- বেশি
- অনেক বেশি

২২. আমার দক্ষতা ও জ্ঞান উন্নয়নের জন্য নিয়মিত 'চলমান প্রফেশানাল ডেভেলপমেন্ট (CPD)' কার্যক্রম (প্রশিক্ষণ, কর্মশালা, কোর্স ইত্যাদি) এ অংশগ্রহণের সুযোগ রয়েছে

- একদমই নয়
- কিছুটা
- মাঝে মাঝে
- বেশি
- অনেক বেশি

২৩. আমার দক্ষতা ও জ্ঞান উন্নয়নের জন্য 'চলমান প্রফেশানাল ডেভেলপমেন্ট (CPD)' কার্যক্রম (প্রশিক্ষণ, কর্মশালা, কোর্স ইত্যাদি) এ অংশগ্রহণ করি

- কখনোই না
- খুবই কম
- মাঝেমাঝে
- বেশিরভাগ সময়
- সবসময়

২৪. সাপ্তাহিক আনুমানিক ক্লায়েন্ট সংখ্যা.....

Appendix J

Ethical Clearance Certificate

চিকিৎসা মনোবিজ্ঞান বিভাগ
ঢাকা বিশ্ববিদ্যালয়
কলা ভবন (৫ম তলা)
ঢাকা – ১০০০, বাংলাদেশ

DEPARTMENT OF CLINICAL PSYCHOLOGY
UNIVERSITY OF DHAKA
Arts Building (4th Floor)
Dhaka 1000, Bangladesh

Tel: 9661900-73, Ext. 7801, Fax: 880-2-9667222, E-mail: clinpsy@du.ac.bd

Date: September 01, 2022

Certificate of Ethical Approval

Project Number : **MP220203**

Project Title : **Predictors of Burnout among Mental Health Professionals**

Investigators : **Khadiza Begum and Dr. M Kamruzzaman Mozumder & S M Abul Kalam Azad**

Approval Period : **01 September 2022 to 15 February 2024**

Terms of Approval

1. Any changes made to the details submitted for ethical approval should be notified and sought approval by the investigator(s) to the Department of Clinical Psychology Ethics Committee before incorporating the change.
2. The investigator(s) should inform the committee immediately in case of occurrence of any adverse unexpected events that hampers wellbeing of the participants or affect the ethical acceptability of the research.
3. The research project is subject to monitoring or audit by the Department of Clinical Psychology Ethics Committee.
4. The committee can cancel approval if ethical conduction of the research is found to be compromised.
5. If the research cannot be completed within the approved period, the investigator must submit application for an extension.
6. The investigator must submit a research completion report.

. . . . . .

Chairperson
Ethics Committee
Department of Clinical Psychology
University of Dhaka

Appendix K

Consent Form for the Participants

প্রিয় অংশগ্রহণকারী

আমি খাদিজা বেগম, ঢাকা বিশ্ববিদ্যালয়ের ক্লিনিক্যাল সাইকোলজি বিভাগের একজন এমফিল গবেষক। উক্ত গবেষণায় অংশ নেওয়ার জন্য আপনাকে বিনীতভাবে অনুরোধ করছি।

গবেষণার বিস্তারিত বিবরণ

গবেষণার বিষয়ঃ "Predictors of Burnout among Mental Health Professionals". এই গবেষণা বাংলাদেশের মানসিক স্বাস্থ্যসেবায় নিয়োজিত পেশাজীবিদের বার্ণআউট প্রতিরোধ করা এবং ব্যবস্থাপনা পরিকল্পনার ক্ষেত্রে গুরুত্বপূর্ন ভূমিকা রাখতে পারে।

আপনাকে যা করতে হবেঃ এখানে বার্ণ আউট এবং এর সাথে সম্পর্কিত ফ্যাক্টরগুলোর কয়েকটি প্রশ্নমালা রয়েছে। প্রতিটি বিবৃতির জন্য যে উত্তরটি আপনার জন্য সবচেয়ে বেশি গ্রহণযোগ্য মনে হয় সেটি চিহ্নিত করুন।

ঝুঁকি এবং গোপনীয়তাঃ এই গবেষণায় অংশগ্রহণ সম্পূর্ণ ঝুঁকিমুক্ত। অংশগ্রহণকারীর নাম, পরিচয়, ঠিকানা বা সনাক্ত করা যায় এমন তথ্য সংগ্রহ করা হবেনা।গবেষণায় অংশগ্রহণের কারণে আপনার কোন ক্ষতি হওয়ার সম্ভাবনা নেই। বর্তমান গবেষণাটি ক্লিনিক্যাল সাইকোলজি বিভাগের একজন সহযোগী অধ্যাপকের তত্ত্বাবধানে করা হচ্ছে। এই গবেষণায় অংশগ্রহণের জন্য আপনার ১০-১৫ মিনিট সময় প্রয়োজন হতে পারে। আপনার তথ্যের গোপনীয়তা রক্ষা করা হবে এবং এই তথ্য শুধুমাত্র গবেষণার কাজে ব্যবহার করা হবে। এই গবেষণায় অংশগ্রহণের মাধ্যমে আপনার কোন ক্ষতির সম্ভাবনা নেই।

অংশগ্রহণকারী হিসেবে আপনার অধিকারঃ এই গবেষণায় অংশগ্রহণ সম্পূর্ণ স্বেচ্ছামূলক। ফর্মটি সাবমিট করার পূর্ব পর্যন্ত আপনি যেকোন সময় বাধ্যবাধকতা ছাড়াই গবেষণা থেকে নিজেকে বিরত রাখতে পারবেন।

এই গবেষণাটি ক্লিনিক্যাল সাইকোলজি বিভাগের এথিকস কমিটি দ্বারা অনুমোদিত। গবেষণা সম্পর্কিত আর কোন প্রশ্ন থাকলে আমার সাথে যোগাযোগ করতে পারেন ০১৭৯৫৩০৬৬৮৪ নাম্বারে অথবা ইমেইল (khadizadipu@gmail.com) করতে পারেন।

গবেষণায় অংশগ্রহণের সম্মতি

- হ্যাঁ, আমি এই গবেষণায় অংশগ্রহণে সম্মতি দিচ্ছি
- না, আমি এই গবেষণায় অংশগ্রহণ করতে আগ্রহী নই