

A comparative study of stress, burnout, quality of life and coping among mental health professionals

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ABSTRACT

Background: Mental health professionals (MHPs) have particular vulnerabilities to stress. This study aimed to examine stress, burnout, quality of life, and coping in 50 MHPs in India. **Methods:** It was a cross-sectional, online questionnaire-based study. The Copenhagen Burnout Inventory, Perceived Stress Scale, WHO Quality of Life-BREF, and Coping Scale were used for the assessment of burnout, perceived stress, quality of life, and coping. **Results:** Results indicated that burnout and perceived stress levels were significantly high across all groups of mental health professionals, with notable differences in work burnout between Psychiatrists and Psychiatric Social Workers ($p = 0.018$), as well as between Psychiatrists and Clinical Psychologists ($p = 0.024$). There was a significant negative correlation between all domains of QOL and burnout and perceived stress. A significant negative correlation was also noted between coping skills, burnout and perceived stress. Age, years of employment, and satisfaction with income were negatively correlated with burnout and stress. Unmarried MHPs had higher burnout levels. **Conclusion:** Mental health professionals, particularly Psychiatric Social Workers and Clinical Psychologists, are at a heightened risk of burnout, which is significantly correlated with lower quality of life. Factors related to burnout included younger age, fewer years of employment, low income, and less income satisfaction.

Keywords: Burnout, mental health professional, stress, coping, quality of life

INTRODUCTION

Burnout is a syndrome characterized by psychological problems resulting from chronic work-related stress.^[1] There is growing evidence to indicate that mental health professionals have particular vulnerabilities to stress, which, if not appropriately dealt with, can lead to chronic stress and burnout.^[2] Overriding common factors leading to burnout in these professionals is their constant dealing with the emotional pain of others, their inability to draw demarcation lines in their professional interactions, as well as their non-reciprocated constant attentiveness to patients' problems and needs.^[3] Burnout has been found to be associated with job dissatisfaction, low organizational commitment, absenteeism, intention to leave the job, and turnover.

Considerable evidence indicates that burnout negatively affects the physical and mental well-being of individual workers, the welfare and functioning of the team and organization, and is associated with reduced productivity and impaired quality of patient care.^[4]

Factors particular to the mental health field have been proposed to make workers in this field more vulnerable to burnout.^[5] These factors include stigma of the profession, demanding therapeutic relationships, threats of violence from patients and patient suicide.^[6] Few studies have empirically examined the association between burnout and wellbeing.^[7] However, the idea of "burnout consequences" may not accurately assess the direction of

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How to Cite the Article: Saraogi M, Arahamthabailu P, Shenoy S. A comparative study of stress, burnout, quality of life and coping among mental health professionals. Indian J Psychiatr Soc Work 2024;15(1):4-10.

Access the Article Online

DOI:

10.29120/IJPSW.2024.v15.i1.596

Quick Response Code



Website:

<http://pswjournal.org/index.php/ijpsw>



relationships or causality. For example, staff who are already going through high levels of physical health related problems may feel added work pressure and report higher levels of emotional exhaustion due to their pre-existing health problems. On the other hand, factors like underlying depression or anxiety could manifest in both high levels of burnout and greater preoccupation with physical health problems. Moreover, the associated problems may moderate burnout through varied, complex and multivariate pathways.^[8] To keep up with the challenges in the healthcare delivery system and to maintain the quality of care rendered and client satisfaction with the care received, it is essential to know how satisfied healthcare workers are with their QOL and job and what characteristics influence their quality of life. Among public-sector psychiatrists, female gender, longer hours of work, and more consultations per week were associated with a higher score on the work-related dimension.^[9]

A review highlighted that mental health issues among physicians are a significant and often underestimated factor in public health policy. The well-being of physicians is frequently overlooked as a crucial quality indicator of healthcare systems.^[10] Preventing and treating burnout, its negative effects on care and patients' health outcomes, can improve the quality of care in mental health units.^[11] In the Indian population, burnout was noted in 46% of psychiatrists as per an online questionnaire-based survey.^[12] In another study done on medical professionals including residents, some form of burnout was present in up to 90% of the respondents.^[13] Though the stress and burnout levels have been assessed, their relationship with different domains of quality of life and the levels of coping in this aspect has not been explored by Indian mental health professionals.

The present study aimed to examine stress, burnout, quality of life, and the level of coping among mental health professionals: Psychiatrists, Psychiatric Social Workers (PSWs), and Clinical Psychologists (CPs) in India.

MATERIAL AND METHODS

The research objectives were to determine the levels of stress and burnout in mental health professionals, assess their quality of life, and establish their levels of coping. This cross-

sectional questionnaire-based study involved three groups of mental health professionals as defined by the Mental Health Care Act, 2017 in India. The study included Psychiatrists, Psychiatric Social Workers and Clinical Psychologists who had been practising for at least one year in medical colleges, private practice, or research.

The study was initiated after receiving approval from the Department Scientific Committee and Institutional Ethics Committee of Kasturba Medical College, Manipal Academy of Higher Education. Mental health professionals practising for at least one year in India were recruited using the Indian Psychiatric Society (IPS) Directory. They were contacted via phone and email using the convenience sampling method. A total of 77 responses were collected over six months, from October 2019 to March 2020. Informed consent was obtained from the respondents, and data were collected through an online survey. Only complete questionnaires were considered for the final analysis.

Socio-demographic details collected included age, gender, marital status, family type, monthly income, and the number of children under five years old. Work-related details included designation, place of work, type of work, years of employment, hours of work per day and week, number of patients seen weekly, and satisfaction with their monthly income.

Four tools were used for data collection: the Copenhagen Burnout Inventory (CBI), the Perceived Stress Scale, the WHO Quality of Life-BREF, and the Coping Scale. These were conducted using an online questionnaire, aiming to generate a minimum of 50 responses from each specialization.

The Copenhagen Burnout Inventory (CBI) scale consists of three independent subscales measuring personal-related (6 items), work-related (7 items), and patient-related (6 items) dimensions. Twelve of the items use a five-point Likert scale to measure frequency, ranging from 'never/almost never' (0) to 'always' (4). The remaining seven items measure intensity, ranging from 'a very low degree' (0) to 'a very high degree' (4). CBI scores were calculated for each dimension for each respondent. These three scales have demonstrated good reliability and criterion-related validity.^[14]

Perceived Stress Scale (PSS) is one of the most widely used instruments for assessing the perception of stress and is designed to measure the degree to which situations in one's life are appraised as stressful. It takes into account how uncontrollable, unpredictable and overloaded participants find their lives and it also has a number of direct queries about the current levels of experienced stress. It has been found to have adequate reliability and validity across multiple studies involving various streams of both professionals and non-professionals.^[15]

World Health Organization Quality-of-Life Scale (WHOQOL-BREF) is a self-administered, psychometrically sound cross-cultural instrument developed in 15 centres across both developing and developed countries. It evaluates subjective QOL in the past 2 weeks in four domains: physical health, psychological health, social relationship, and environment. It also has two items for assessing overall QOL and general health. The 26 items are scored 1–5 to give domain scores, the total score ranges between 26 and 130, with a higher score indicating a better QOL. The scale has demonstrated good discriminant validity, concurrent validity, internal consistency and test-retest reliability.^[16]

Coping Scale: This coping questionnaire assesses cognitive, emotional, and behavioural methods of dealing with problems. Each answer category has a value from 4 to 1. The total score

is the sum or mean of all the items. Higher category has a value from 4 to 1. The total score is the sum or mean of all the items. Higher scores are meant to indicate higher levels of coping. The Cronbach's Alpha value for internal consistency is 0.91.^[16]

Permission for using the verified tools was also taken from the respective authors. Respondents were given the space to withdraw from the interview at any given time and confidentiality of all information was ensured and maintained.

Statistical analysis was performed using SPSS version 15 (Statistical Package for the Social Sciences). Descriptive statistics included means and standard deviations for continuous variables and frequencies and percentages for categorical variables. To compare socio-demographic and clinical variables among the three groups, Chi-square/Fisher's exact tests, ANOVA, and Kruskal-Wallis tests were employed. Tukey's/Mann-Whitney's test for post hoc analysis was conducted to determine specific group differences. Additionally, Pearson's correlation tests were used to identify associations with variables.

The study was conducted in accordance to the latest declaration of Helsinki. Informed consent forms were obtained from all the participants and the project was approved by the Department Scientific Committee and Institutional Ethics Committee.

RESULTS

Comparison of socio-demographic variables

Table 1: Socio-demographic details of the three groups

Variables	Variables Category	Psychiatrists n = 50	PSW n = 14	CP n = 13	Chi-Square/ Fisher's exact test/ ANOVA	p value
		f(%)	f(%)	f(%)		
Gender	Male	21 (42)	6 (42.9)	2 (15.4)	3.3	0.21
	Female	29 (58)	8 (57.1)	11(84.6)		
Marital status	Single	8 (16)	7 (50)	7 (53.8)	12.52	0.02*
	Married	40 (80)	7 (50)	6 (46.2)		
	Widowed/Separated	2 (4)	0	0		
Income	Below Rs.20000	1 (2)	2 (14.3)	1 (7.7)	21.94	<0.001***
	Rs.20000-40000	4 (8)	5 (35.7)	4 (30.8)		
	Rs.40000-60000	3 (6)	3 (21.4)	3 (23.1)		
	Above Rs.60000	42 (84)	4 (28.6)	5 (38.5)		
Type of family	Living alone	7 (14)	1 (7.1)	1 (7.7)	6.38	0.14
	Nuclear	29 (58)	9 (64.3)	12 (92.3)		
	Joint	14 (28)	4 (28.6)	0		
Age	Mean \pm SD	43.1 + 12.6	35.1 + 6.2	34.2 + 10.2	4.63	0.01*
Years of employment	Mean \pm SD	13.6 + 12.9	8.1 + 6.7	8.3 + 8.6	1.97	0.14

*p value < 0.05 ; ** p value < 0.01 ; *** p-value <0.001

Table 2: Comparison of burnout and stress

Variables	Level	Psychiatrists n = 50 f(%)	PSW n = 14 f(%)	CP n = 13 f(%)	Kruskal Wallis test F(p)
Personal burnout	Present	17 (34)	8 (57.1)	8 (61.5)	4.5 (0.1)
	Absent	33 (66)	6 (42.9)	5 (38.5)	
Work burnout	Present	6 (12)	7 (50)	5 (38.5)	10.6 (0.005)**
	Absent	44 (88)	7 (50)	8 (61.5)	
Client burnout	Present	7 (14)	3 (21.4)	3 (23.1)	0.84 (0.74)
	Absent	43 (86)	11 (78.6)	10 (76.9)	
Perceived stress	Mild	15 (30)	3 (21.4)	2 (15.4)	1.1 (0.55)
	Moderate	32 (64)	10(71.4)	10(76.9)	
	Severe	3 (6)	1 (7.2)	1 (7.7)	

** p value < 0.01

Table 3: Comparison of burnout, perceived stress, QOL and coping levels

Variables	Psychiatrists n = 50 Mean ± SD	PSW n = 14 Mean ± SD	CP n = 13 Mean ± SD	One-way ANOVA (F)	p-value
Personal Burnout	39.6 ± 20	51.7 ± 27.2	53.8 ± 15.2	3.5	0.035*
Work Burnout	27.4 ± 18.3	44.6 ± 26.5	44.5 ± 20.4	6.16	0.003**
Client Burnout	23.6 ± 23.1	30 ± 22.7	29.1 ± 19.7	0.61	0.54
Perceived stress	15.7 ± 7.1	18.2 ± 6.3	18.6 ± 7.8	1.25	0.29
Physical QOL	14.7 ± 1.7	14 ± 2.2	14.3 ± 1.8	0.86	0.42
Psychological QOL	14.8 ± 2.7	13.8 ± 3	15 ± 2.5	0.77	0.46
Social QOL	15.3 ± 3.2	13.7 ± 3.4	15.3 ± 2.7	1.31	0.27
Environment QOL	15.8 ± 1.8	13.6 ± 2.2	15 ± 2.2	6.55	0.002**
Coping skills	38 ± 6.1	39 ± 5.5	40.77 ± 5.8	1.13	0.32

*p value < 0.05 ; ** p value < 0.01

Table 4: Factors affecting stress and burnout[#]

	Personal Burnout	Work burnout	Client burnout	Perceived stress	Dissatisfaction with income
Physical QOL	-0.66***	-0.57 ***	-0.38 ***	-0.56 ***	-0.35**
Psy QOL	-0.67***	-0.63***	-0.58***	-0.74***	-0.17
Social QOL	-0.47***	-0.5***	-0.52***	-0.56***	-0.28*
Env QOL	-0.58***	-0.57 ***	-0.43***	-0.4***	-0.41***
Coping skills	-0.14	-0.15	-0.32**	-0.33**	0.05
Age	-0.3 *	-0.4 ***	-0.28 *	-0.37 **	0.23*
Gender	0.26*	0.15	0.16	0.04	0.12
Marital status	-0.07	0.22	0.09	-0.14	-0.01
Dissatisfaction with income	0.33 **	0.29 **	0.2	0.26*	-----
Years of employment	-0.27*	-0.35**	-0.22*	-0.32**	0.27*

*p value < 0.05 ; ** p value < 0.01 ; *** p-value < 0.001 # Pearson's correlation test

The total number of respondents was 77, out of which 50 were Psychiatrists (Group 1), 14 were Psychiatric Social Workers (Group 2) and 13 were Clinical Psychologists (Group 3). The socio-demographic details have been described in Table 1. The three groups did not differ significantly with respect to gender distribution (p = 0.21), type of family (p = 0.14), and years

of employment (p = 0.14). However, they did differ significantly with respect to marital status (p = 0.02). Post hoc analysis using Mann-Whitney's test showed that Group 1 differed significantly from both Group 2 (p = 0.008) and Group 3 (p = 0.005), but there was no significant difference between Group 2 and Group 3 (p = 0.84).

There was also a significant difference in income among the three groups ($p < 0.001$). Post hoc analysis using Mann-Whitney's test indicated that Psychiatrists' incomes were significantly higher than those of the Psychiatric Social Work group ($p < 0.001$) and the Clinical Psychologist group ($p = 0.001$).

Burnout, perceived stress, quality of life and coping skills

The mean scores of personal burnout, work burnout, and client burnout are presented in Table 2. ANOVA tests revealed significant differences in personal burnout ($p = 0.03$) and work burnout ($p = 0.003$) among the three groups. Tukey's post hoc analysis indicated significant differences in work burnout between group 1 and group 2 ($p = 0.018$) and between group 1 and group 3 ($p = 0.024$).

The mean scores of perceived stress and coping skills for the three groups are listed in Table 3, with no significant differences observed among the groups.

Quality of life, assessed using the WHOQOL-BREF with mean scores for physical, psychological, social, and environmental domains, is also presented in Table 3. The groups differed significantly only in environmental QOL ($p = 0.002$). Tukey's post hoc analysis demonstrated a significant difference between group 1 and group 2 ($p = 0.002$).

Factors affecting stress and burnout

A significant negative correlation was found between all domains of quality of life (QOL) and both burnout and perceived stress. A significant negative correlation was also noted between the perceived stress scores and the four domains of QOL. A significant negative correlation was noted between coping skills and client burnout as well as with perceived stress. Age was negatively correlated with all types of burnout and stress. Gender had a significant correlation only in personal burnout. Dissatisfaction with income was positively correlated with personal burnout, work burnout, and perceived stress but not with client burnout.

The number of years of employment had a negative correlation with all types of burnout and with perceived stress. Marital status did not seem to have a correlation with stress, and personal and client burnout but it did have an

impact on work burnout ($p=0.01$) as single MHPs were more prone to work burnout.

DISCUSSION

The striking feature of this study is the relatively higher burnout scores in the PSW and the CP groups in comparison with the psychiatrists' group. This finding is in accordance with a few earlier studies,^{[17] [18]} where PSWs had more burnout as the mean scores on all the burnout scales were higher than in the other groups. In this study, the perceived stress scores were similar in all three groups. However, burnout was higher in the PSW and CP groups though the level of coping skills was also similar in all three groups.

Some factors that may have played a role in the higher levels of burnout could be relatively lower income and higher levels of dissatisfaction with income which were also significantly different among the three groups. Other factors could include high job demands, not feeling valued for work that was done, more community-based work etc. Feelings about the way social work is perceived within mental health services could also be the reason for higher burnout.

Lower age and lesser number of years were also associated with more chance of burnout, suggesting possible adjustment difficulties and recent onset of responsibilities. This finding is similar to a finding in a meta-analysis which mentioned that the age and years of work experience reduced the chance of burnout. As mental health professionals grow older, they become better at dealing with their clients and providing treatment services, contributing to a higher level of personal accomplishment.^[19]

In this sample, there was no association between the number of hours per day/week or factors like having a working spouse or children aged less than 5 years and burnout. However, there was an association with gender and burnout with females being more prone to personal burnout, but not work or client burnout. Possible reasons could be increased domestic responsibilities and more demands on working women. A meta-analysis on gender differences in burnout stated that women are still responsible for the majority of the household chores and because they are still considered as the primary child and elderly caregivers, they experience more family-

related demands, such as role juggling and role conflict.^[20] This is especially true in the Indian context.

Another striking finding of this study is the strong association between burnout and quality of life. All four domains of QOL had a highly significant negative correlation with all three types of burnout. This has been seen in other studies too.^{[21] [22]} Heavy psychological burden and stress can cause physical, mental, and emotional health problems, thereby reducing the QOL.^[22]

Poor QOL in all domains is a cause of concern as mental health professionals need to take good care of themselves. Poor QOL may reflect in poorer work performance or quitting the job or MHPs developing mental health problems themselves. It could also mean future sickness absences, sleep problems, use of painkillers, intention to quit etc. Lower levels of coping were negatively correlated with client burnout and perceived stress. Coping skills did appear to help people with higher perceived stress but did not appear to be effective in those with personal and work burnout. The reason for this could be that burnout occurs in mostly those with ineffective coping skills^[23] and it is difficult to employ coping skills after the burnout has set in.

Limitations of this study include factors like small sample size, which limits the generalization of results and cross-sectional design of the study. The causal direction could not be determined, especially between burnout and QOL which might have been assessed in a longitudinal study, especially in younger MHPS. Response bias also cannot be ruled out as people with higher levels of burnout might not have responded to the survey.

CONCLUSION

Mental health professionals are at risk of burnout in all domains like personal, work and client burnout. Amongst MHPS, PSWs and CPs appear to have a higher risk of burnout than psychiatrists. Burnout is also significantly associated with poorer quality of life in personal, psychological, social and environmental domains. Younger MHPs with fewer years of employment, suggesting early career MHPS are more vulnerable to burnout. Female MHPs are more prone to personal burnout compared to their male counterparts.

Work burnout was also more commonly seen in unmarried professionals. Perceived stress is also significantly high in all the MHPs (more so, in those living alone) and is associated with poorer quality of life. While coping skills appear to help in those with perceived stress, especially among the psychiatrists, it wasn't really helpful in those who had developed burnout. Other factors that increased the likelihood of all types of burnout included less income and less satisfaction with income.

Future research could include longitudinal assessments into factors leading to burnout, especially in younger mental health professionals and its impact on job satisfaction and work performance, especially in vulnerable groups. Studies that look into the interventions to prevent or overcome burnout are also essential.

Ethical clearance: Taken from Kasturba Medical College, Manipal Academy of Higher Education (IEC 532 – 2019)

Source of funding: This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

Conflict of interest: None

Author's contribution: MS, SS and PA have contributed to the conception of the study. MS has done the data collection and data entry. SS and PA have done the data analysis. All the authors have contributed to the manuscript writing, and revising and have read and approved the submission of the manuscript.

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Received on: 16-06-2024

Revised on: 17-06-2024

Accepted on: 25-06-2024

Published on: 01-07-20