



**Stress Factors and Coping Mechanisms in Health Social Workers'
Workplaces: An Exploratory Study in Saudi Arabian Western Province Hospitals**

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Abstract

There is a growing body of literature that recognises the increasingly complex challenges faced by health social workers (HSWs) in their workplaces, due to the nature of the social work profession. To date, however, there has been limited research concerning work-related stress in the context of social work within health communities in Saudi Arabia. Therefore, this study aims to fill a gap in the existing literature in the domain of social work field by focusing on the Saudi HSWs' experiences in the workplace. This study attempts to explore the incidence of work-related stress in public hospitals in Saudi Arabia (Makkah and Jeddah cities) from the perspective of HSWs. The specific objective is to identify those factors contributing to stress in the workplace, as well as the strategies that HSWs employ to overcome stress, and the influence of HSWs' demographic background on work-related stress. The methodological approach taken in this study utilises Constructivist Grounded Theory Methodology (CGTM), with two phases for data collection (semi-structured interviews followed by a survey). The data obtained from HSWs suggests various factors are associated with the dominance of a conservative culture within the Saudi society, as well as other factors linked to gender. Moreover, the HSWs identified various strategies related to their spiritual beliefs and personal skills, in addition to the emotional and instrumental support as well as central supervision they receive. The findings also indicted a notable difference based on gender and length of fieldwork experience, in terms of both work-related stress factors and coping strategies. Based on these findings, a working framework for health social work practice in public hospitals in SA has been suggested in an attempt to enhance our understanding of those aspects that might contribute to work-related stress among HSWs within Saudi hospitals. It is anticipated that the outcomes presented in this research will make a specific contribution to the literature by focusing on the experience of work-related stress from HSWs' viewpoint, increasing understanding of health and social work practices within the Saudi context.

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Chapter One: Introduction

Overview

This chapter provides a brief outline of the status of the social work profession in Saudi society, before moving on to discuss the impact of status on practitioners within the health sector. It then clarifies the rationale and value of the study, explaining how it contributes to the existing literature, underlining the researcher's personal interest in the topic, and presenting the study aims. The chapter concludes by defining the key terms used in the study, and by providing an overview of the content of the thesis.

The goal of this thesis is to explore the experience of work-related stress from the perspective of health social workers (HSWs) in Saudi Arabia (SA), by discovering those factors that might be contributing to stress in their workplace. The study also explores the possible strategies that HSWs might employ to mitigate stressful experiences within the Saudi context, considering the association between HSWs' demographic characteristics and stress factors, as well as techniques and approaches they might implement to cope with job stress. The constructivist grounded theory methodology (CGTM) provides the methodological framework, and two phases of data collection took place.

No previous empirical research on this topic exists in the Saudi context; hence, it is anticipated that this study will bridge some of the knowledge gaps concerning this issue.

Two principal research questions were generated for this purpose:

RQ1. What are the key factors contributing to the occurrence of work-related stress in HSWs workplaces in SA?

The first research question prompted the emergence of the following sub-questions:

- Are there any factors that could expose HSWs to stress in their workplaces in SA?
- Is there any impact from HSWs' demographic characteristics on factors contributing to work-related stress?

RQ2. How do HSWs in SA cope with current experiences of work-related stress?

This led to the following sub-questions:

- Are there any strategies that could enable HSWs to overcome work-related stress in SA?
- Is there any impact from HSWs' demographic characteristics on the coping strategies selected?

The key issues

Before exploring work-related stress in HSWs' workplaces in Saudi society, it is important to highlight the key general points associated with the role of social work within the Saudi community. The emergence of social work practice as an independent profession in SA is new relative to its emergence in Western countries (Yalli and Cooper, 2008). Saudi policy makers have generally aimed to import and adapt principles of social work practice from the American and British literature into the Saudi social care system (Al-Saud, 1996). However, the cultural differences affecting communities in developing countries, such as SA, mean that transferring the principles and findings derived in these contexts is complex and difficult, if not impossible (Al-Qurni, 2003).

The lack of awareness about social work as a profession amongst Saudi citizens should also be considered when discussing the status of social work in SA (Albrithen and Yalli, 2015). According to Alahidb (2012), who is one of the most important pioneers of social work in SA, reactionary thinking and lack of understanding within Saudi society serves as a notable barrier to HSWs attaining recognition. For example, social media is an important tool utilised in a wide range of contexts within Saudi society, particularly by government ministries, to promote information sharing about services (Askool, 2012; Albahlal, 2019), leads certain Saudi clients to define a social worker as a person that is only responsible for assisting clients financially. This perspective not only influences the perceptions among some Saudi citizens regarding the importance of the social workers' role, but also reflects on public confidence concerning the ability of social workers to help, which might additionally underestimate their value (Al-Brathin and Yalli, 2012).

In the health social work domain, despite attention from Saudi policy makers towards developing a model of social work practice, significant limitations endure (Albrithen and Yalli, 2012). These can be observed in the findings frequently obtained from the few studies

conducted between 1990 and 2016 in SA designed to investigate the challenges HSWs face when practicing within Saudi hospitals. For example, Al-Shammari and Khoja undertook a survey study in 1992 to assess the roles of social workers in hospitals in Riyadh, the capital city of SA. Their study identified issues relating to inadequate theoretical preparations for HSWs pre-and post-graduation. Moreover, the participants frequently referenced a lack of adequate facilities to enable them to practice their roles, including access to communication devices and private rooms in which to meet clients, as well as the absence of clear job descriptions for social workers in primary health care settings (Al-Shammari and Khoja, 1992).

Regardless of the cultural changes experienced within Saudi society, the limitations observed by Al-Shammari and Khoja (1992) twenty- nine years ago continue to top the list of obstacles encountered by HSWs in Saudi hospitals today. In 2012, Albrithen and Yalli conducted research to explore the experiences of HSWs in the Saudi hospitals' context in greater detail. They identified several concerns that appeared to relate principally to organisational limitations, including a lack of resources within workplaces, leadership settings and inter-professional teamwork. Interestingly, some aspects that have been identified as characterising the current situation for HSWs in SA were also present twenty-eight years ago in Western societies such as the USA. For example, Rose (1993) summarised the limitations faced by social workers in the medical domain at that time as follows:

Unease and instability permeate today's hospitals. Closings, downsizing, mergers, affiliations, and other restrictions are commonplace. Social work department personnel budgets have been devastated by severe cuts, social workers are being replaced by non-professional staff, specialization is decreasing, decentralization is increasing, and other disciplines are appropriating key social work functions. A luxury most cannot afford, clinical supervision is minimal or non-existent; indeed, the clinical contribution of social work in hospitals seems devalued. (p. 243)

Several possible explanations for the endurance of workplace challenges in Saudi hospitals is that recommendations set out in previous research by the Saudi scientific community have not been implemented at the practice level, and nor has a specific theoretical model for social work practice applicable to the Saudi community been produced (Albrithen and Yalli, 2015).

In relation to the profile of the Saudi community, a more recent survey raised significant points associated with HSWs' demographic characteristics (e.g. gender). Albrithen and Yalli (2012)

claimed that approximately two-thirds of the HSWs surveyed were men. In support of this, the annual report issued by the Saudi Ministry of Health (MoH) in (2017) stated the total number of HSWs of both genders in Saudi Arabia working in Social Work Departments (SWDs) within Saudi hospitals is 1999, 1249 of whom are males and 750 of whom are females. This reflects the limitations affecting the participation of women in the Saudi workforce (Hamdan, 2012). Moreover, the data indicates that the majority of female HSWs are either single or divorced. This might reflect the negative perceptions of many Saudi husbands with regard to their wives working in mixed settings, such as hospitals. Indeed, whilst working as a teaching assistant, the author of the current study witnessed many instances of students wanting to leave the social work department because their husbands were refusing to allow them to train in hospitals, and preferred that their wives study another discipline.

Furthermore, Albrithen and Yalli (2012) similarly referred to another factor present among health social work practitioners in Saudi Arabia, namely the existence of individuals who graduated from a non-social work discipline choosing to practice HSW, despite potentially lacking the necessary skills to perform their tasks effectively within a hospital environment.

Social work is considered a highly stressful job in any country, due to workers being involved in intricate social situations, leading many writers to identify the area of social work practice as a highly stressful domain (Lloyd, King, and Chenoweth, 2002; Coyle, Edwards, Hannigan, and Fothergill, 2005; Collins, 2008; Coffey, Dugdill, and Tattersall, 2009; Savaya, 2014; Fantus, Greenberg, Muskat, and Katz, 2017), even without the added complexities linked to Saudi culture. Accordingly, this study aims to gain a more in-depth understanding of the experiences of HSWs, by investigating job stress factors and the coping mechanisms that HSWs might experience in a Western province of SA. It addresses and explores the association between HSWs' demographic characteristics, stress factors and coping strategies.

Research rationale

Having a clear purpose and rationale is a prerequisite when conducting empirical work, as noted by Rojon and Saunders (2012), because it allows researchers to connect existing theoretical evidence with practical applications in the same context. Frequently, a research rationale reflects the curiosity of a particular researcher in terms of acquiring more information about a specific issue to represent personal experience or particular arguments about the theme

of a study. In this study, two factors inspired the choice of this topic as a PhD project; i.e. the personal background of the researcher in the workplace as an administrative employee who graduated from a Social Work speciality, and the problematic status of health social work practice during the period the researcher was training in hospital for her undergraduate social work degree.

In 2006, the researcher was appointed as a social worker in a Medicine College at Umm Al-Qura University after graduating as a social worker from the Social Work Department at the same University in the same year. Although working with doctors and students in the medical field increased her awareness of health issues, the researcher encountered a number of boundaries that inhibited her engagement in the workplace. These included performing tasks that were purely administrative, and far removed from what she had studied at university. This led to awkward and disappointing situations, as she was required to perform roles with no previous training or experience. Nevertheless, the researcher chose to endeavour to expand her knowledge of the administration and her colleagues concerning the importance of social work; however, this was met with a lack of sufficient emotional and financial support. The aforementioned reasons negatively exposed the researcher to a significant quantity of pressure in the workplace, resulting in her resignation at the end of 2007.

Moreover, the researcher was fascinated by health and social care, particularly when training in hospitals at undergraduate level. The issues that HSWs dealt with, despite very little theoretical preparation for social work practice in the medical field by Saudi universities at that time (2002 to 2006) prompted enthusiasm to learn more about this area. Interestingly, the researcher observed variability in the tasks that HSWs undertook according to the kind of cases they were dealing with, as each case demanded a different type of support. For example, with patients in the dialysis unit, HSWs mostly engage in supportive roles that include providing entertainment (e.g. watching TV during dialysis sessions). Meanwhile, in other instances (e.g. chronic illnesses) HSWs undertook comprehensive assessments to identify patients' needs, and to work in conjunction with patients' families and support systems to facilitate patients' access to medical equipment at home where necessary, as well as to organise follow up treatment plans. However, in cases of child abuse, HSWs are required to provide counselling and psycho-social support, also requiring assistance from other governmental organisations (e.g. police office) to facilitate their investigations.

Thus, reflecting on the personal experiences of the researcher, in addition to the lack of research investigating issues linked to work-related stress in Saudi workplaces, the aim of this study is to explore the experience of work-related stress in the field of health social work. The particular focus is on discovering what contributes to job stress in HSWs' workplaces, as well as strategies that might help to minimise stress. In addition, it aims to explore the relation between HSWs' demographic characteristics, work-related stress, and coping mechanisms; since very little is known about job stress currently, particularly in the complex area of health social work.

Significance of the study

The lack of literature concerning the social work domain characterises the majority of Muslim and Arabic communities, as few relevant studies have been undertaken in such societies (Hodge, 2005; Ashencaen Crabtree, 2008). Empirical work might have been long neglected in such communities, due to various international and local factors. At the international level, successive political events, such as the terrorist attacks of 11 September 2001 on the World Trade Centre in the USA, might be expected to increase the lack of interest in undertaking research studies in Muslim societies. In the wake of these shameful acts of terrorism, perceived associations between terrorism and Islam have to some extent affected the opinions of researchers in Western societies with regard to Muslim communities (Hodge, 2005; Amer and Bagasra, 2013).

Locally, it has been suggested that the scarcity of research could be partially linked to the absence of a clear philosophy for conducting scientific research in some Arabic contexts (Almansour, 2016; Elsayed and Sabtan, 2018). Crucially, financial shortages and research policies could also explain why researchers in Muslim and Arabic societies are failing to conduct empirical work. Indeed, the majority of Arabic universities do not allocate specific budgets to research, and the processes for applying for research grants are convoluted (Almansour, 2016). Consequently, Arabic communities tend to seek out and import solutions to resolve social problems from abroad, rather than conducting research that fulfils national needs (Yalli and Cooper, 2008; Albrithen and Yalli, 2012; Almansour, 2016).

Due to the relative newness of social work practice within Saudi society, at both the educational and practical level, limited attention has been directed towards conducting academic research in this area. Notably, policy makers seem to focus more on setting up guidelines for social work education to produce qualified practitioners to efficiently address emerging social problems

(Yalli and Cooper, 2008; Soliman, 2013; and Almaizar and Abdelhamed, 2018). Although a small number of existing studies, conducted in Western and Asian communities and involving Islamic and Arabic ethnic minorities have delivered valuable information about social work practice with Muslim clients (e.g. Hodge, 2005; Crabtree, Parker, Azman, and Carlo, 2014); further cultural aspects of purely Muslim and Arabic societies, particularly SA remain to be revealed. Thus, and given that research engagement could contribute to the formation of social policies in any country (Albrithen and Yalli, 2012; Elsayed and Sabtan, 2018), there is an urgent need for additional exploratory studies. Such studies might help not only to enrich the theoretical foundation of the profession, but also to develop evidence-based practices that ensure better services and improve the efficiency of social workers on the ground (Albrithen and Yalli, 2012; Almaizar and Abdelhamed, 2018).

Accordingly, the period from 1999 witnessed a gradual increase in research being undertaken by academic member of Saudi universities in the field of social work. By 2016, the body of published research comprised eighty-five such studies in different areas related to social work practice; including elderly, women, people with special needs, addiction, youth, and family's issues (Almaizar and Abdelhamed, 2018). In the health care domain, there are also several studies that have examined issues relating to social work practice within the health field in SA (e.g. Al-Shammari and Khoja, 1992; Yalli and Cooper, 2008; Albrithen and Yalli, 2012, and Albrithen and Yalli, 2015). Whilst some research has been carried out regarding the challenges that social workers might encounter in health care workplaces, no single study exists exploring the experience of work-related stress from HSWs' perspectives.

Having mentioned this, the current study focuses on the experience of work-related stress, by exploring what is currently occurring in HSWs' workplaces. The CGTM facilitated an in-depth examination, rather than only assessing level of stress among practitioners. Alternatively, the research aims to enhance our understanding of the possible factors that may have contributed to work-related stress, and how HSWs manage their existing stress. It also relates the experiences and perspectives of informants, namely HSWs with different demographic profiles. Moreover, it offers us an opportunity to explore how HSWs have perceived the experience of stress from different points of views.

The research might also offer valuable information in terms of accumulated facts obtained from empirical research generated by working with Saudi health social work professionals; ideally, these might be expected to lead to the construction of appropriate support systems for health

care practitioners. The results, suggestions, and recommendations posed in this study might benefit Saudi policy makers, administrators, health care planners, and practitioners. It will also provide them with empirical evidence to assist them in understanding the context that would influence the professionalising process of HSWs in SA, along with possible solutions to improve the current situation.

Finally, it is anticipated that the findings of this PhD thesis will provide additional guidance to enhance the future of social work practice in the health domain; as well as encourage further research to expand our knowledge of issues related to social work and practitioners. This will not only offer a solid basis for developing framework, but could also increase recognition of the value of HSWs among Saudi citizens, by clarifying the importance of HSWs roles within medical teams, contributing to an efficient and healthy environment for HSWs in their workplaces.

Research Contribution

It is intended that the outcomes presented in this research will make a useful contribution to the literature by focusing on the experience of work-related stress from HSWs' perspectives, furthering our understanding of health social practice within the Saudi context. The results will also augment the existing body of knowledge, and update the existing knowledge surrounding health social work, particularly in terms of job stress.

The outcomes of this study will serve as a foundation for future work concerning the development of an environment in Saudi healthcare workplaces, as well as offering a foundation for further work in other countries with a similar profile to SA in terms of the history and development of social work practice, and the religious and cultural context affecting HSWs work. This follows a recognition for the need to reshape social and health services (Almalki, FitzGerald, and Clark, 2011; Albrithen and Yalli, 2012; Albrithen and Yalli, 2015). Hence, this study will address the gap in the literature and generate findings that government policy makers, health administrators, and HSWs in such countries would find highly relevant to mitigating their own challenges and opportunities.

While it cannot be guaranteed that the research findings will dramatically change Saudi HSWs' workplaces, the likely beneficiaries of this study would be policy makers and leaders at both

ministerial and central level, as well as some interested health care administrators, willing to develop regulations for social work practice in health setting. They will be familiar with all the related factors affecting HSWs and their wellbeing, and could utilise the knowledge gained to inform possible strategies to contribute to improving the agenda for social work practice, making a positive contribution to the quality of provided service, and the wellbeing of health care practitioners (Albrithen and Yalli, 2012; Albrithen and Yalli, 2015).

In addition, by reviewing the current international social work literature, vital issues related to the experience of work-related stress will be defined and gaps are identified, adding to the construction of a viable broad theoretical framework. By employing an interpretive perspective, this study seeks to address methodological gaps by engaging with two methods for data collection. This covers a wide range of elements related to the issue under examination.

Finally, this study involved only public sector health care organisations, namely hospitals supervised by the MoH, as private health organisations were not included. Nonetheless, the private sector might be expected to learn from the situation in other sectors as a means to improve the workplace environment.

The author of the current study also believes that further research needs to be undertaken in the future in the context of the private sector considering the uniqueness of SA's circumstances, to establish what resources are available to confront the challenges faced by HSWs. This will play a major role in improving the experiences of health social work providers and users in SA.

Definition of Terms

As this is an academic study, it is essential to clarify the meanings of the key terms identified from international perspectives and relative to the Saudi context, to ensure clarity and a shared understanding. The following specific terms are used extensively in this study.

Work-Related Stress: According to the European Agency for Safety and Health at Work (2000), scholars agree that the term 'workplace stress' is considered undefinable and unmeasurable. Moreover, Blaug, Kenyon, and Lekhi (2007) believes the meaning of work-related stress can vary from one situation to another, and between one workplace environment and another. They further emphasised the role of culture in determining the criteria for work-related stress, since aspects of the workplace that may be considered stressors in some societies

might not be so in others. The National Institute of Occupational Safety and Health (NIOSH) (1999, as cited in Palmer, Cooper, and Thomas, 2004), defined work-related stress as:

The harmful physical and emotional responses that occur when the requirements of the job do not match the capabilities, resources, [and] needs of the workers. (p. 2)

In this study, although the scholars have differentiated between the meaning of both stress and pressure in terms of their sequence of occurrence, the term ‘pressure’ is used when communicating with the participants because the majority of Saudi citizens believe that admitting to stress has implications for one’s mental health. However, the intentional meaning of work-related stress in this study is virtually identical to the definition above.

Coping Mechanisms: The term coping is used by Lazarus and Folkman (1984) to refer to: “constantly changing cognitive and behavioural effort to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person” (p. 479, cited in Baqutayan, 2015). Parallel to the incidence of work-related stress, coping mechanisms can be influenced by several factors, including individual differences, and cultures of communities and religion. In this work, the term coping mechanism refers to strategies that HSWs employ in order to reduce the effects of stressful experiences they might encounter in their workplaces (Saudi hospitals). This might include either emotion or problem focused techniques, present within or outside HSWs’ workplaces.

Health Social Workers (HSWs): HSWs working within medical care centres are professionals who graduated with either social work, sociology or psychology degrees. They typically assist patients and their families to understand and manage particular illnesses that have emotional dimensions post-diagnosis, and offer counselling that support the decision making process. HSWs are considered essential members of the medical profession, since they work collaboratively with doctors, nurses, and other health professionals (e.g. psychologists). Social workers in the medical domain are responsible for alerting other professional care providers to the social and emotional characteristics of an illness that a patient is suffering from, in addition to assisting patients and their family members to identify the social, financial and psychological problems potentially associated with changes in their health. In this research, the term HSWs refers to Saudi social workers working in state hospitals in SA (National Association of Social Workers, 2011).

Workplaces: According to a definition provided by the Work Health and Safety Act (2016) in the UK, the workplace is a location where work is performed to support a business or a mission, and includes any place an employee goes to complete tasks relating to a job. Thus, a workplace can be a vehicle, aircraft, offices, factories, schools or hospitals. For the purposes of this research, the term workplace is used to refer to state hospitals in the cities of Makkah and Jeddah in SA. State hospitals are run by the MoH, and number six hospitals in Jeddah city (Al-Amal Hospital; King Fahad Hospital; King Abdulaziz Hospital; Al-Thagher Hospital; King Sa’aud Hospital; Maternity and Children Hospital). In Makkah city, six hospitals are also involved to present the mentioned workplaces within this study including Al-Noor Hospital; King Abdul-Aziz Hospital; Hera’a Hospital; Ajjad Hospital; King Faisal Hospital and Maternity and Children Hospital).

The Organisation of the Study

This dissertation is comprised of ten chapters, including the current introductory chapter; each chapter includes the following information.

Chapter One: Introduction: This chapter has introduced and outlined the study, and summarised the key terms and content present in the thesis.

Chapter Two: presents the background to the research context (SA), considering several topics, including the dominance of culture and religion in all aspects of life, in addition to the development of female graduates in education and their participation in Saudi workplaces. Most importantly, the status of social work generally, and HSW in particular, is discussed in depth, alongside the responsibilities set out by various public organisations to support the roles of HSWs in the Saudi community.

Chapter Three: has been divided into seven parts. The first part deals with those strategies used to identify the relevant international empirical work that informs the aims of the current study. The second section sheds light on the process of conceptualising stress, along with the developments associated with using stress as a research term. The third part concerns the prevalence of stress across different occupations, accessing international perspectives regarding typical factors that contribute to the occurrence of stress, particularly in health care field work in the fourth part of this thesis. The fifth section covers the previous empirical work

and identifies work-related stress factors in the health and social work domain. Following this, literature focusing on the strategies used in the health and social work fields to address stress are presented in the sixth section, Finally, the last part of the chapter addresses the aims of the study and the research questions.

Chapter Four: describes the methodology applied in this study and the associated research approach (paradigm), as well as the strategy chosen for data collection that has been divided into two phases: qualitative methods, followed by quantitative methods. It will also cover the development of the questionnaire in the quantitative phase and the formulation of the questions in the interview schedule. This chapter presents the sampling process for both stages of data collection, in addition to the data analysis techniques. Moreover, it outlines the possible influence of the researcher's insider position, as well as the strategies used to examine the validity and reliability of the data obtained. In the final part of this chapter, the potential limitations of the chosen methodology are also identified.

Chapter Five: presents an analysis of the data obtained from the interviews in the main phase of this study (the qualitative findings). This part of the thesis is concerned with the main themes to emerge in relation to the Factors that might lead to job stress for HSWs.

Chapter Six: concerns the coping strategies that may be applied by the participants to cope with work-related stress. There are nine themes associated with the contributing coping mechanisms.

Chapter Seven: includes the second phase outcomes (the quantitative findings). The data obtained from the returned questionnaires is analysed here, including stress factors and coping strategies. In addition, the impact of HSWs' demographic characteristics on both stress factors and the chosen coping strategies are examined. The reliability test is also presented in this chapter.

Chapter Eight: provides an in-depth discussion of the results obtained in the present study. Moreover, the findings are also compared with the data presented in the international literature that concerns the experience of stress in health care professionals' workplaces, including (HSWs).

Chapter Nine: the conclusions of the study are presented in this final chapter, alongside recommendations proposed to improve the workplace environments of HSWs, according to the

research evidence. In addition, the implications for further research are also set out in this chapter.

Summary

This chapter has provided basic information concerning the aims of this study, beginning by explaining the research issues, and followed by clarification of the importance of conducting this study in the research field. Subsequently, the main motivations that led the researcher to undertake this study were revealed. In addition, the goals the project aims to achieve were identified, as were the key words and terminology used in this study. Finally, the organisation of the thesis by chapter was detailed. The following chapter affords a clear explanation of the Saudi context in relation to different considerations.

Chapter Two: Research Context

Overview

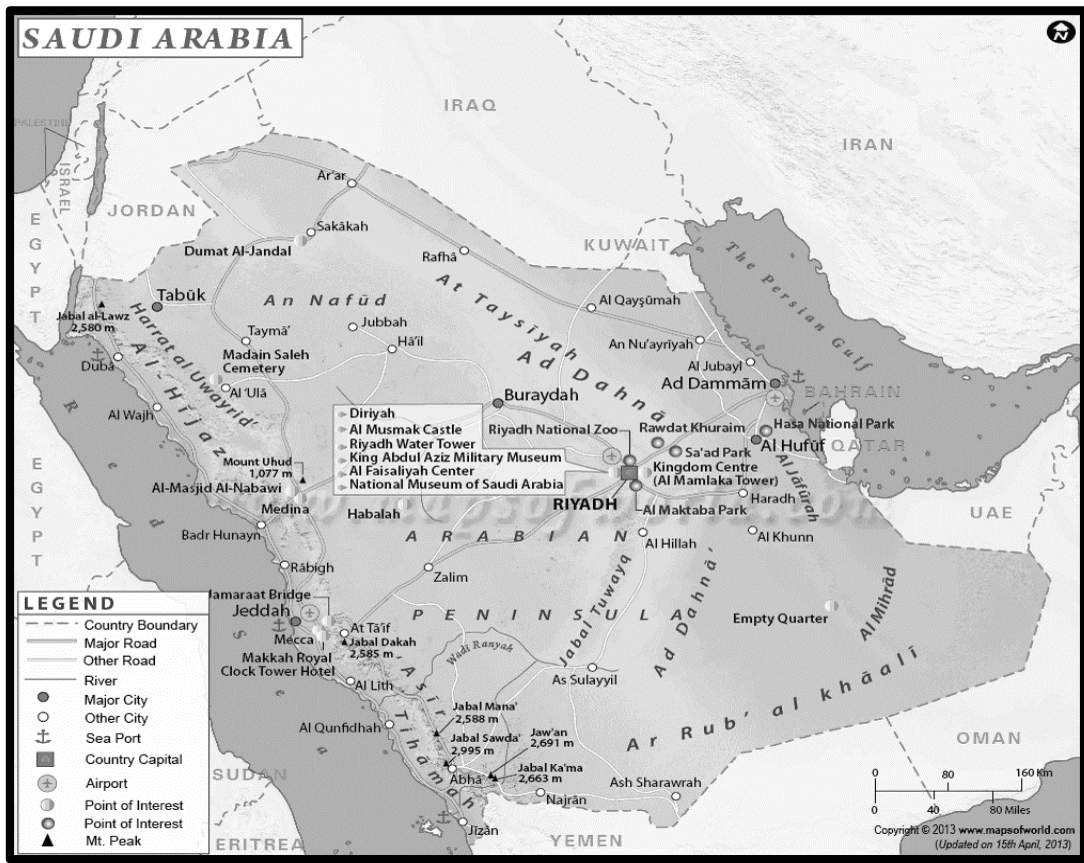
The aim of this study is to explore the experience of work-related stress in Health Social Workers (HSWs) workplaces in Saudi Arabia (SA). Thus, the first part of this chapter provides a brief summary introducing SA as the study context. Saudi society is internationally recognised as unique in terms of the economic, religious, and cultural conditions that influence all aspects of life there enormously. The second part describes, in detail, the various bodies and organisations that present major areas of interest within this study. Thirdly, the status of social work in SA is discussed, in addition to additional factors that might potentially affect the perceptions of HSWs working in the Saudi health sector.

Background to SA

This part provides readers with general information relating to the geographical location of SA and the demographic characteristics of Saudi society. It also recounts the processes of historical development in the country; explaining changes there have significantly affected the lifestyle of Saudi citizens and society more generally with regard to the labour sectors, in particular the field of healthcare. This will make it possible to explore the challenges that HSWs might face in their workplaces.

SA is located in Southwestern Asia, and is the second largest nation in Arab state. As shown in Figure (1), SA borders seven other countries: Jordan, Iraq and Kuwait in the north, Yemen and Oman to the south, and the United Arab Emirate and Qatar to the east; in addition to three bodies of water: The Gulf of Aqaba and the Red Sea to the west and the Persian Gulf to the east. Due to its location the Saudi labour force includes many professionals from neighbouring countries, and there is a notable lack of qualified Saudi practitioners in certain sectors (e.g. doctors, teachers and social workers) (Maps of the World, 2015).

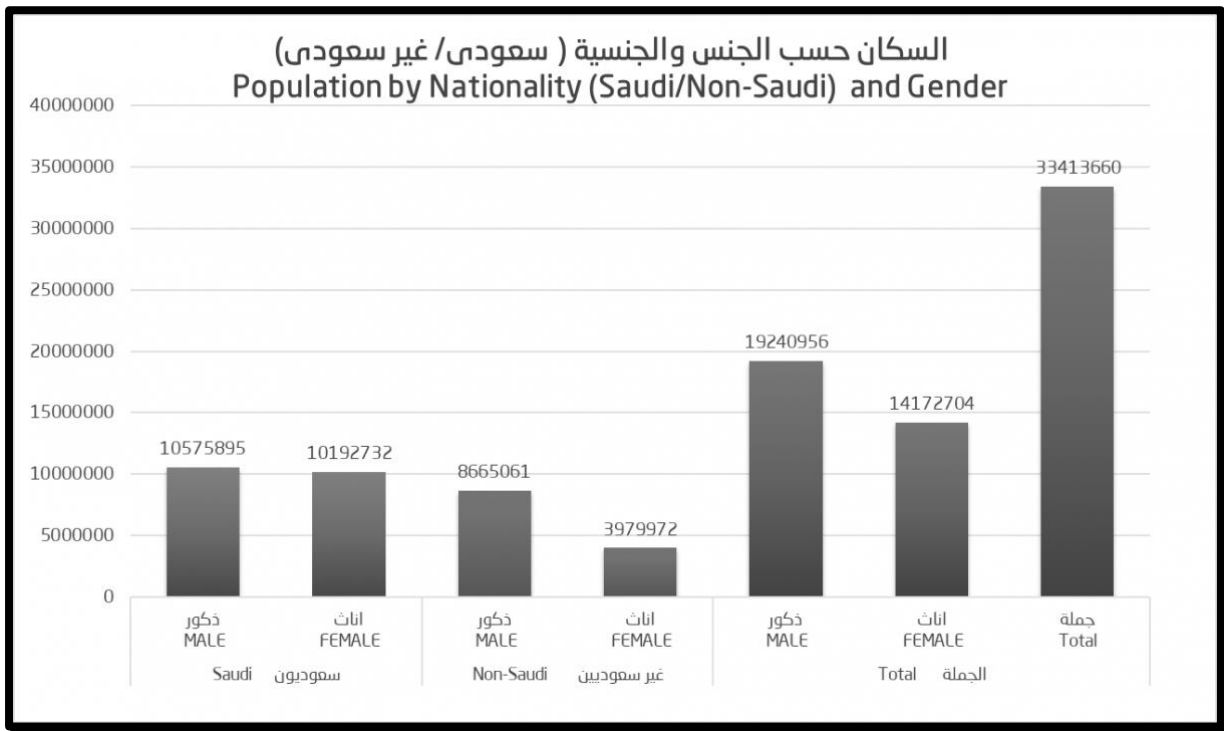
Figure 1: Map of SA



Source: Maps of the World (2015)

According to the Saudi General Authority for Statistics (SGAfS) (2018), the total population in SA numbered 33,431,660 at the end of 2018. The number of Saudi citizens is currently 20.7 million, accounting for 67% of the country’s total population; this means 12.6 million (33%) non-Saudi citizens who live within the Saudi community (SGAfS, 2018). The population is distributed across thirteen provinces that form the Kingdom of Saudi Arabia. However, population density is most concentrated in the capital city (Al-Riyadh), in the middle region, and the holy capital (Makkah) in the Western region. This can be attributed to the attractive political and economic statuses associated with Al-Riyadh. In addition, Makkah, where this study took place, is a holy place for Muslims around the world, meaning that it is crowded with pilgrims who come for Hajj and Umrah throughout the year. After finishing Al-Hajj or Umrah, some pilgrims decide not to return home, preferring to stay illegally in SA for business reasons (see Figure 2).

Figure 2: Population of SA in 2018



Source: SGaFS (2018)

Cultural features in the Saudi community

In SA, the Islamic religion exerts a major influence on all aspects of citizens' lives, including educational, political, economic, social, and health. In addition, conservative cultures and traditions that are prevalent within the Saudi community also play a major role, alongside religion, in shaping individuals' attitudes (Almasabi, 2013). However, although the majority of these standards and traditions are derived from Islamic teachings, in many cases Saudi people follow Islamic teaching to meet their cultural obligations rather than as an act of faith (Al-Shahri, 2002; Doumato, 2003; Andersson and Togelius, 2011; Hamdan, 2012). For example, while Islam bans smoking for people of all ages and both genders, it is also more culturally unacceptable for young people and females to smoke than males (Abdalla, Al-Kaabba, Saeed, Abdulrahman, and Raat, 2007). A further issue relates to how culture rather than religion dictates the colour of the Hijab that Saudi women should wear. Although there is no fixed evidence in the Qur'an or the Hadith that women must wear black Hijabs, most Saudi husbands do not permit their wives to wear coloured scarves or Abayas for reasons of tradition (Hamdan, 2012).

A conservative¹ culture also prevails in most Saudi workplaces, especially those employing individuals and serving clients from different educational and socioeconomic backgrounds. For instance, in healthcare, professionals are typically very cautious about taking histories from most patients because some questions (e.g., those associated with sexual activities) are perceived as very sensitive and offensive (Al-Shahri, 2002; Al Mutair, Plummer, O'Brien, and Clerehan, 2014). Moreover, it is highly preferred by the majority of the Saudi population to have a doctor who is the same gender as the patient, in order to maintain chastity (Al-Shahri, 2002; Mufti, 2000; Halligan, 2006). On this point, it is important to note a very recent incident that occurred (in April 2016) at the biggest medical centre in the capital city of SA (Riyadh), when a jealous husband shot a male obstetrician. The doctor had helped a pregnant woman deliver her baby as a member of a medical team that consisted of female nurses. Following the delivery, the husband requested that the doctor meet him in the hospital's garden to share a coffee to extend his appreciation and thanks for his assistance. However, he shot the doctor, who was then transferred in a serious medical condition to the intensive care unit at the same hospital (Jack Moore, 2016). This deplorable act reflects the endurance of traditional restrictions on male female mixing, despite the presence of some foreign cultures introduced by people of different nationalities within Saudi society.

Furthermore, modest and reactionary thinking characterises the majority of Saudi people when interpreting illnesses (Al-Shahri, 2002; Yalli and Cooper, 2008; Albrithen and Yalli, 2012; Koenig, Al Zaben, Sehlo, Khalifa, Al Ahwal, Qureshi, and Al-Habeeb, 2014). Despite the role of faith in causing a Saudi patient and his\her family to believe in predestination and the will of Allah, when illness occurs approaches to dealing with physical (organic) disease vary. Traditional medical practices still exist, especially among illiterate people and those in rural areas, where they prefer to use natural substances (e.g. herbs) or practise dietary treatments and cupping for treatment (Al-Shahri, 2002; Almasabi, 2013). In addition, similar to the many other countries where Islamic and Arabic ethnic minorities live (including Europe), Middle Eastern spiritual treatments are widely used by Saudi citizens to treat disease (Khalifa, Hardie, Latif, Jamil, and Walker, 2011). Some Saudis believe there is a spiritual rather than a physical cause for most chronic illnesses. This belief derives from Islamic teachings; for example, in certain

¹ The cultural setting of Saudi Arabia is greatly influenced by Arab and Islamic culture. Society is in general is deeply religious, conservative, traditional, and family-oriented. Many attitudes and traditions are centuries-old, derived from the early days of Arab civilization and Islamic heritage.

cases verses from the Holy Qur'an are read over a patient to reduce the impact of evil eyes², and Jinni³ (Al-Shahri, 2002; Khalifa, Hardie, Latif, Jamil, and Dawn- Marie Walker, 2011; Koenig et al., 2014; Shaheen Al Ahwal, Al Zaben, Sehlo, Khalifa, and Koenig, 2016).

Similar to the many countries that impose Islamic religious law, mental illnesses remain poorly understood by the majority of Saudis, due to the stigma associated with mental disease in Saudi society (Qureshi, Van der Molen, Schmidt, Al Habeeb, and Magzoub, 2009; Attum, Waheed and Shamoan, 2019). Therefore, despite positive improvements in the attitudes of educated Saudis with regard to the social and psychological effects of certain illnesses, the majority of patients continue to manage conditions in traditional and conservative ways that neglect the impact of emotional and psychological difficulties on increasing organic illnesses. For instance, Koenig et al. (2014) emphasised a strong association between depression and chronic headaches and joint pain. However, the prevailing impression amongst Saudi citizens is that any mental disorders are a result of spiritual causes, such as Jinni and the evil eye. In some cases, patients and their families refuse the interventions of trained medical professionals other than doctors and nurses even when ideal for their treatment plan (e.g. psychologists and social workers) (Al-Krenawi and Graham, 2000; Yalli and Albrithen, 2011).

Gender differentiation

Despite the remarkable improvement in Saudi women's economic and political participation during the last two decades (Hamdan, 2005; 2012; Alhareth Yahya Al, Yasra, Al Alhareth, and Al Dighrir, 2015), women working remains an area of confusion among the majority of conservative Muslim societies. The majority of the literature on this topic attributes this to the religious and cultural ideologies that prevail in these communities (Moghadam, 1988; Sidani, 2005). Prior to the advent of Islam, female participation in political and commercial contexts did take place. 'Khadija' and 'Aisha', the wives of the Prophet Muhammad, had a high level of autonomy and enjoyed the right to work. Meanwhile some women in other tribes in the region had a very limited degree of autonomy (Alhareth et al., 2015; Hamdan, 2012).

² There is a belief among some Muslims that some people can use the 'evil eye', which relates to the power of envy to inflict harm on others either mentally or physically (Khalifa et al., 2011, p. 70).

³ Jinn are creatures who conceal themselves from humans, so they see us but cannot be seen. The belief that Jinn are capable of causing physical and mental harm to humans (i.e., through possession or causing ill health and misfortune) is widely accepted among Muslims (Khalifa et al., 2011, p. 70).

Although AlSaleh (2012) argued that Saudi women, much like women in any other country, play a major role in raising and caring for their families, gender inequality endures in most other aspects of life. In some Saudi families, this inequality is upheld as early as the embryonic stage, as it is apparent that some tribes prefer having sons to daughters. Despite the scientific reality that a baby's gender is not influenced by the woman, in most Saudi cities it is perceived that the best gift a woman can give her husband and family is to deliver a boy. This is because sons protect the family name and have a career, in addition to being custodians of their families' values, while a girl often leaves her family following marriage and starts another family with her husband and his family (Hamdan, 2012).

In the education sector, differentiation takes place between males and females in SA. Despite the fact that Islamic teachings do not oppose female education, females were not welcome to enter schools, especially in the public sector, because some religious scholars argued that education could spoil females' morals. Moreover, girls who gained an education were considered less desirable marriage prospects than those who did not attend schools. The majority of parents merely educated their daughters in the skills required to prepare them to be good mothers and wives. Therefore, while males who graduated from high school were encouraged to join colleges and universities to obtain a degree, it was preferred that girls obtain husbands instead (Hamdan, 2005; 2012).

Several economic and political events (such as the 1990-1991 Gulf War) led Saudi women to begin seeking their rights as members of the public community as set out in Islamic instructions. At that time, some Western countries were actively defending SA and other Gulf countries, bringing females into contact with many Western principles, including advocating for women rights. Nevertheless, female integration into society remains a contentious area debated by both religious scholars and the state (Yamani, 2000). Indeed, in the education sector, some Saudi universities exclude women from studying medicine, law, aviation, engineering and geology; especially in the public sector, because these specialities expose Saudi women to gender mixing in the workplace, which some religious scholars interpret as being contrary to Islamic law (Hamdan, 2012; Van Geel, 2016).

Moreover, the religious conservative perspective also appears to fiercely resist female involvement in the workforce, even though Sharia law accords women this right if her male guardian allows (Alharbi, 2015). However, some political and religious restrictions continue to outweigh women's opportunities to access jobs. Arguably:

One of the problems that persist with regard to feminine employment is the political leaders who, while acting under the guise of progressiveness, still follows traditional law and seem to go back-and-forth with regards to policies surrounding the laws. (Alharbi, 2015, p. 21)

This statement emphasises the sway held by religious and traditions perspectives as a mechanism for determining the majority of the Saudi women's issues. For instance, women holding of leadership positions is a contentious matter within Saudi workplaces, particularly in the public sector, and in cases where male members of staff are not granted seniority (Hamdan, 2012; Aharbi, 2015).

Under the rule of King Abdullah in SA, Saudi women began to be granted more freedom and were able to participate in building a modern, civilised culture that ensures women a powerful voice (Alharbi, 2015). However, multiple physical and religious factors continue to impose high levels of gender inequality. At this point, it is important to mention a very recent incident that reflects the reactionary thinking of some religious Saudi men. A landmark bill, the first of its type in Saudi history was passed by the King of Saudi Arabia (Royal Decree (A\91)) enabling the participation of 30 Saudi women on the Shura Council (Parliament), representing 20% of members. Although this decision was informed by Islamic teachings, some religious men have objected to it and consequently protested at the Royal Court. Al-Sharif (2012) described this protest as born from out-dated customs and traditions, rather than a genuine fear of breaching Islamic teachings (Al-Madina Newspaper).

An issue currently causing significant conflict is the granting of Saudi women the right to drive. The issue attracted the interest of the international media when the law changed in 2018, but the idea is wholly unacceptable to conservatives. Prior to that time, Saudi women were not permitted to drive, and if arrested while driving a car would be sent to jail because the Saudi government did not publish driving licences for females at that time. Although the reason for this rule is unclear from the lens of another culture (e.g. Western society), it may relate to the judgment of Saudi religious men. They justified banning women from driving in SA by arguing that a woman could be raped or sexually harassed by males if her car were to be broken into in the middle of the street (RajKhan, 2014).

Accordingly, the ban on women driving within the Saudi society provoked a major social dilemma (RajKhan, 2014), affecting not only women, but also their males relative (i.e. husbands, brothers and fathers), who are otherwise responsible for transporting female family

members while potentially meeting other commitments outside the home. This resulted in the male as breadwinner according to Saudi tradition being obligated to hire a driver and buy an extra car, which while affordable for some families is very expensive for others (Alfasi, 2018).

The Saudi government recognised the importance of extending to females the right to drive, in what is considered a huge step toward Saudi women's empowerment. On the 27th of September 2017, the King issued a Royal Decree (M\85), providing the first legal instrument allowing Saudi females to hold a driving licence (Alfasi, 2018). However, surprisingly the Counsel of Shura did not act until May 2018. The likely cause for this postponement might reflect the ongoing conflict amongst religious scholars within the Saudi community regarding the empowering of Saudi women in different fields, and their protection from harassment (Alharbi, 2015). Despite women being allowed to drive in theory, still many practical obstacles remain in place, which might require many years ahead to normalise (Alfasi, 2018).

Very recently, in his weekly speech for 'Aljuma'a' prays, a Saudi religious man discussed the issue of females attending medical college and discussed their future working in places where gender mixing occurs. He described female doctors using extremely rude phrases, contravening the laws expressed in Islamic teachings. Although the Saudi Grand Mufti has stated that this individual does not represent conservative Saudi society and must be jailed, this incident, and the others described reflect the negative perception of some Saudi males with regard to women work in mixed settings such as hospitals (Alriyadh, 2016). Although this statement does not appear to represent current Saudi male perceptions about the involvement of females in medical field, it is noteworthy; particularly in a community largely directed according to religious and conservative norms (Hamdan, 2012; Van Geel, 2016).

Drawing together all the factors mentioned above, it is apparent that gender discrimination remains the central concern of officials in Saudi society when discussing Saudi women's rights. Between conservative and more liberal-minded opinions, Saudi women's roles remain relatively unclear in different fields including educational and working domains. Prevalent culture, traditions and norms seem to be the primary causes of the discrimination taking place in most aspects of Saudi life, including the workplace (Van Geel, 2016).

The development of SA

The regions of SA went through several historical changes before its unification by King Abdul Aziz Al-Saud in 1932. Much like any emerging country, SA adopted agriculture and farming as its main economic resources, also exporting dates. At that time, trading was generated by pilgrims who visited Makkah and Al-Madinah to perform Hajj and Umrah and sell goods during rituals. Initially, the Saudi economy and social frameworks lacked the required infrastructure to maintain efficiency and improvements as a new state (Henderson, 2011; UNDP, 2012; Samargandi, Fidrmuc, and Ghosh, 2014).

Following the discovery of oil in 1936, and its commercial production by 1938, modernisation started to take place. By 1945, SA was one of the original 51 United Nations members, and was in possession of significant oil revenues. This position can be considered a first step towards the emergence of a systematised SA, and a cabinet system was later established in 1958, followed by the First Governmental Development Plan issued in 1970. During this time, Saudi society began to move away from simple agriculture and small-scale trading towards a complex and organised community that hugely influenced individual's lifestyle (Samargandi et al., 2014). Most Saudi people (of both genders) attended school, with the majority taking a government jobs after graduation. There was also increasingly improved medical awareness, that contributed to reducing the prevalence of diseases and epidemics (Hamdan, 2012; UNDP, 2012; Van Geel, 2016).

Notably, this rapid transition into a modern state due to economic wealth resulted in several challenges for Saudi citizens (Albrithen, 2014). According to Al-Sughair (2015),

Development in economic conditions, along with other factors such as education, the availability of technological capabilities, migration from rural and Bedouin to urban areas, travel and being in contact with other societies all have affected the SA family system.

For example, while a female's participation in the labour force contributed to increasing a family's income, it also prevented her from being fully engaged with her domestic responsibilities towards her husband and children, which in some cases led to divorce (Hamdan, 2012). This is evident in a recent statistical report issued by the Saudi Ministry of Justice (MoJ), which indicates there were 4688 active divorce cases in January 2019. Approximately half of these were registered in Makkah and Riyadh regions (2268 cases),

where females typically enjoy more freedom and have greater opportunities to join the work force (MoJ, 2019).

An additional change, resulting from modernisation, was that the structure of most Saudi families became more independent, which had both desirable and undesirable impacts on Saudi families (Al-Sharfi, 2017). Many sociologists in SA agreed that urbanisation is significantly linked to individualism, because traditional communities enjoy more cooperative ties when compared to civilised societies (Yalli and Al-Brithen, 2011). Changes in the lifestyle of Saudi families weakened traditional family ties (Yalli and Al-Brithen, 2011; Sacarellos, Wright, Almosaed, Moghrabi, Bashatah, and Morgan, 2016; Al-Sharfi, 2017). Moreover, this was also reflected in the way that individuals within the nuclear family dealt with each other (Sacarellos et al., 2016). Al-Sharfi (2017) suggested that the emergence of an independent family (i.e. nuclear family structure) tended to expose couples to a number of social and psychological problems that were not present before. This then significantly affected family cohesion⁴ and adaptability⁵ (Connolly, Al-Ghamdi, Kobeisy, Alqurashi, Schwartz, and Beaver, 2017; Alzhrany, 2018).

Arguably, it is an increasing reality that due to the financial challenges faced by nuclear Saudi families, women (including wives and mothers) are being encouraged, and sometimes required, to find a job to meet their family's needs; e.g. contributing to renting or buying a house, and paying for schooling for their children (Alzhrany, 2018). Consequently, females are spending more time outside their homes by necessity, which has influenced their commitment to their children and domestic responsibilities, conflicting with the traditions and norms of Saudi culture. Consequently, many families now rely on housemaids and outside assistance to care for their children (Al-Sharfi, 2017; Alzhrany, 2018). Although it should not be assumed that this would be the situation in all cases, it has been suggested that both marital relationships and parent-offspring relationships are now being significantly influenced by the physical absence of parents, especially mothers (Sacarellos et al., 2016; Al-Sharfi, 2017; Alzhrany, 2018).

The challenges of nuclear families and both parents working appear to be affecting Saudi family's functionality, resulting in several socio-economic and emotional problems for the elderly, children and adolescents. For instance, Connolly et al. (2017) identified multiple forms

⁴ Family cohesion is defined "as the emotional bonding that family members have towards one another" (Alzhrany, 2018, p. 11).

⁵ Family adaptability is defined "as the ability of marital or family system to change its power structure, role relationships, and relationships rules in response to situational and developmental stress" (Alzhrany, 2018, p. 11).

of delinquency present among Saudi youths; including smoking, skipping school, running away from home, damaging other people's property, getting into fights, stealing, taking vehicles without permission, and breaking into a buildings. At the other end of the spectrum are the elderly, who lack emotional and physical support due to being excluded from the nuclear family group (Salamah, 2018). Increasingly, elderly people are experiencing emotional and psychological difficulties; e.g. feeling associated with being socially isolated, such as depression (Ghazwani and Al-Musa, 2013).

In addition, modernisation and economic growth appear to influence health-related behaviours among Saudi citizens (Aldossary, While, and Barriball, 2008). Khaliq (2012), for example, reported a recent significant increase in cigarette smoking, at a rate of 37% of males and 6% of females aged over 15 years. Moreover, significant changes in nutritional habits have been observed among Saudi individuals (Aldossary et al., 2008). Unlike previously, the increased availability of food; particularly fast food has contributed to higher rates of obesity among males and females (Madani, Al-Amoudi, and Kumosani, 2000). The consequence is a range of dietary associated health complications (e.g. heart problems, diabetic, hypercholesterolemia, and hypertension) and chronic illnesses that nutritional habits might influence (Shaheen Al Ahwal et al., 2016). The prevalence of these conditions, combined with the restructuring of Saudi society mentioned above, demands new medical, social, psychological, and habituated support to improve individuals' wellbeing within the Saudi community.

In recognition of the above, the Saudi government has stated there is an urgent need to establish and develop parallel programs and services to address the social and health challenges faced by Saudi individuals, to achieve balance within the community (Yalli and Cooper, 2008; Yalli and Al-Brithen, 2011). Social care programmes have been established and supervised by the Ministry of Labour and Social Development (MoLSD) to address emerging negative issues. Moreover, within the health care domain, the Ministry of Health (MoH) has begun to expand capacity by creating social and psychological support programmes to meet the social and emotional demands that might arise as a consequence of the emerging health issues (MoH, 2014). These programmes are based on Islamic teachings and delivered by qualified professionals from both the psychology and social work sectors (AL-Sughair, 2015).

History of social work in SA

Similar to the Western world, where Christianity and Judaism are associated with social work practice, social work in Islam derived its principles and values from religious ethics (Ashencaen Crabtree, 2008). In SA social considerations and duties are clearly linked to religion because there is no separation between religion, culture, and the state. In Islam, the Holy Qur'an and Sunna offer a comprehensive plan for human life to ensure suitable circumstances for survival (Hodge, 2005; Soliman, 2013). For example, Islam widely encourages the wealthy to help those in need and to support poorer families, via a measure called 'Zakat'⁶. Prophet Mohammed (peace upon him) said to Moad'ath Ibn Jabal when he sent him to Yemen: *"Tell them that Allah has made it obligatory for them to pay Zakat⁷ upon their assets and it is to be taken from the wealthy among them and given to the poor among them"* (Sahih Bukhari, Volume 4).

It is relevant and important here to emphasise the nature of the social welfare services that have been implemented since the beginning of Islamic era until now, and which are essential within Islamic teaching. The main idea behind obligatory Zakat within the five pillars of Islam is to provide economic harmony within society (Barise, 2005; Soliman, 2013). Therefore, Zakat as a charitable action might include providing money, or material goods in the form of donations to the poor and needy. There is clear guidance in the Qur'an and Sunnah regarding the legitimacy of Zakat, and the House of Money 'Biet Al-maal' was placed to in charge of supervising the Zakat distribution process (Soliman, 2013). The Biet Al-maal was used to store money and material goods paid as Zakat, and Muslims brought their Zakat directly to it. The received funds and resources are then organised into categories and delivered to specific groups of people based on instructions stated in the Holy Qur'an regarding Zakat distribution (Soliman, 2013). Consequently, this seems to be equivalent to the roles currently played by social welfare services⁸ organisations; which aim to ensure justice and balance among all community's members (Yalli and Albrithen, 2011; Soliman, 2013).

⁶ Two types of Zakat are requested from a Muslim. The first Zakat called 'Zakat Al-Fater' is the payment of specific amount of money at the end of the fasting month of Ramadan. The second type of Zakat is called 'Zakat Al-Maal', which represents a required percentage payment for every Muslim of his/her annual income, including money and from property (Soliman, 2013, p. 12).

⁷ Payment of Zakat depends on a Muslim's financial abilities, and the needy and poor are exempt from paying Zakat.

⁸ Social welfare service is a charitable act of financial assistance directed to vulnerable groups, such as the poor, the disabled, or the delinquent.

However, despite the association between Islam and social support, the emergence of social work practice as an independent profession in SA is new relative to Western communities (Yalli and Albrithen, 2011). Moreover, although the MoLSD was established in 1960, the development of some forms of social care such as health and social care, family care, and childhood care were not available in rural and some urban communities before 1980 (Yalli and Cooper, 2008). It is also surprising to note that, despite the cultural differences between Western societies and societies in developing countries (e.g. SA), the SA social care programme is based on the American social care system (Al-Saud 1996; Yalli and Cooper, 2008).

The implementation of a Western social care social system in SA, mirrors the adoption of similar systems in other Arab countries (Yalli and Cooper, 2008; Almaizar and Abdelhamed, 2018). Originally social work practice in SA was introduced by two Egyptian⁹ experts in social science, who were employed in educational field in 1955 (Soliman, 2013). It is believed that these individuals successfully performed their tasks, familiarising the public with the importance of social workers' roles particularly among school students (Yalli and Albrithen, 2011; Soliman, 2013; Almaizar and Abdelhamed, 2018).

Social work has gradually been recognised in several domains within Saudi society. However, it first emerged in the education sector in 1973, when King Saud University established the first academic programme teaching social work. Subsequently, the Ministry of Education (MoE) established a number of similar departments in Saudi universities across different regions. However, out of 26 state and 10 private universities, in addition to 42 other specialised colleges, only 8 state universities have departments teaching social work to undergraduates, while just 3 offer postgraduate courses (Soliman, 2013; MoE, 2016). This indicates an urgent need in SA for more qualified social workers able to work across multiple domains, especially in light of the aforementioned extreme social and economic changes that contributed to the increase in several negative phenomena, as explained earlier (Yalli and Albrithen, 2011; Albrithen, 2014).

In other fields of practice, the Minister of the MoJ recently signed an agreement with the MoLSD highlighting the importance of social workers' roles within the Saudi courts. This reflects increased awareness on the part of decision makers and police organisations regarding

⁹ One of these two Egyptian experts was employed at the King Saud scientific City in Jeddah, while the other was hired to supervise social activities in schools located in the Makkah region (Soliman, 2013).

the significant and supportive roles that social workers could play in navigating contemporary challenges, such as divorce. Although this decision was made relatively late in comparison to developed countries, it is believed that it could make a considerable contribution to addressing social problems prior to legal judgments being made (Alaguetsaidih Newspaper, 2011). Nevertheless, it seems to be difficult to grasp evidence that approves the application of the aforementioned agreement, or even the activation of social workers' roles within the Saudi courts at the practical level. A possible explanation for this might be attributed to the late recognition of the importance of social workers' roles in this area, along with the shortage of trained staff occupying this position.

Development of social work practice in health care

Internationally, social work practice in healthcare was typically the domain of religious adherents and charity workers before its emergence as an independent profession (Erickson and Erickson, 1989; Yalli and Cooper, 2008; Yalli and Albrithen, 2011). In Western societies, for example, social support within the hospital setting was provided to needy and disabled patients by charitable and voluntary services until the end of the nineteenth century (Browne, 2001). This reflected the gradual development of understanding of sociology alongside medical knowledge, which contributed to expanding understanding of how social factors might influence clinical symptoms, resulting in the prevalence of certain medical conditions (Erickson and Erickson, 1989).

The first trained health social worker (called an 'almoner' in the British health care system), was appointed in the UK in late 1894 at the Royal Free Hospital in London; this appointment was followed by a similar one in the USA in early 1900. However, no official academic institutions trained almoners to perform HSWs' roles, rather their work rather tended to be charitably motivated (Auslander, 2001). One aspect of their job was to ensure medical care for individuals who were not financially able to pay for their treatment, but they additionally sought to address social complications that might impede patients' medical treatment (Browne, 2001). At this time, almoners were not supervised by independent departments and did not adhere to specific job descriptions. They performed their tasks in outpatient's department, and with individuals registered at the hospital (Auslander, 2001; Browne, 2001). Hence, social

work in the health care domain was not professionalised before the end of the 1800s (Auslander, 2001).

In early 1905, health social work underwent remarkable professional improvements, as the first formal social work department was established by Dr. Richard Cabot (senior physician). He hired Ms. Ida Cannon as the first social worker to officially provide social services at an out-patients clinic in the Massachusetts General Hospital in USA (Auslander, 2001). Although HSWs were expected to perform similar roles to almoners, the beliefs that Dr. Richard held concerning the importance of social workers positively impacted on the effectiveness of social work practice at that time. This was particularly because the appointment increased awareness about the possible social and environmental influences affecting patients' medical conditions and treatment, strengthening the professional relationships between s and social workers. As a result of this effort, the American Association of Hospital Social Workers was founded in the USA, and the Hospital Almoners' Association and Training Institute in the UK in 1918.

In the following decades, social work practice in the medical field flourished within western communities. This was partly a result of the economic crises in the 1935, that required medical social workers to handle medical care issues associated with financial difficulties (Auslander, 2001). Therefore, not only was the number of Social Work Departments (SWDs) within the health care system expanded, but also formal criteria for social work practice were established in the primary care setting; particularly in the USA and the UK; through the American Hospital Association and the newly formed National Health Service (NHS) in Great Britain (Huntington, 1986; Auslander, 2001).

Globally, the sequence of the health social work emergence has been varied, often mirroring social and economic developmental changes within societies (Auslander, 2001; Albrithen and Yalli, 2012). For example, the development of social work practice within the medical field in developed countries (e.g. USA, and the UK) appears to have been influenced by medical and financial necessity; particularly during eras of economic crises. By contrast, within the Saudi community, economic growth, cultural change, and rapid lifestyle transformation influenced the emergence of social work practice across different domains including health care (Yalli and Albrithen, 2012; Soliman, 2013; Albrithen and Briskman, 2014). Nevertheless, it is noteworthy to refer to the relatively late emergence of social work practice in health care systems in SA, which eventually resulted when prioritizing social welfare programmes to resolve issues related to poverty and financial imbalances caused by the dramatic social transformation in SA

(Albtithen and Yalli, 2012; Soliman, 2013). There is however, another possible explanation for the late emergence of health social work practice as mentioned above; i.e. the conservative attitudes of Saudi citizens with regard to health, social and psychological complications (Al-Shahri, 2002; Yalli and Cooper, 2008; Yalli and Albrithen, 2011; Khalifa et al., 2011; Koenig et al., 2014; Shaheen Al Ahwal et al., 2016).

Perspectives on health social work in SA

Before moving forward by discussing the current health social work practice context in SA, it is important to provide some basic information about the health care system in SA. Similar to many other countries, the health care system in SA is divided into public and private sectors (MoH, 2015). The MoH, is the main healthcare provider in SA and oversees both sectors¹⁰. In addition, some other governmental organisations also provide health services; i.e. the Ministry of the National Guard, the Ministry of the Interior, the Ministry of Petroleum and Mineral Resources, and the Ministry of Education. The MoH, however, is committed to delivering free health care services to Saudi citizens and any pilgrims visiting SA for religious purposes (i.e. Hajj and Umrah) (Albejaidi, 2010). In contrast, the other health bodies are financially and administratively independent, and offer their facilities for free only to their employees, students or trainees (Al-Yousuf, Akerele, and Al-Mazrou, 2002).

The MoH was founded in 1951, with a mission to offer,

[P]rovision of healthcare at all levels, promotion of general health and prevention of diseases, in addition to developing the laws and legislation regulating both the governmental and private health sectors. Aside from that, MoH is accountable for performance monitoring in health institutions, along with the research activity and academic training in the field of health investment. (MoH, 2012, para. 1)

Today, the Saudi government annually allocates the MoH a huge budget to ensure the health sector can meet public demand in terms of curative, preventative and rehabilitation services. For example, in 2017-2018 the budget for the MoH was approximately eighty-four billion Saudi Riyal compared to the previous year (2016-2017) when it was sixty-two billion Saudi

¹⁰ At the administrative level, the MoH supervising both public and private sectors with sort of financial intendency in private sector.

Riyal. Despite this remarkable increase, it is believed that the MoH still needs to make improvements to the public care system (Albejaidi, 2010; Yalli and Albrithen, 2011).

The MoH delivers its services via 280 state hospitals located across thirteen provinces in SA, with a capacity of 43,080 beds. Other governmental agencies run 47 hospitals offering 12,279 beds, and there are 158 hospitals in the private sector with 17,622 beds (MoH, 2015). Despite the administrative dependency on the MoH, each province has its own Regional Director of Health who enjoys a considerable level of operational autonomy (Khaliq, 2012). Additionally, the MoH deploys multi-health professional teams at each hospital to ensure the needs of patients and their families can be met effectively (MoH, 2015).

It is also necessary here to introduce the role of the Saudi Commission for Health Specialities (SCfHS), which was established in 1992 as an independent body to supervise and evaluate programmes provided to practitioners in the field of health. Saudi universities and Medicine Colleges play a significant role in academically preparing health professionals at undergraduate level, and the SCfHS takes on after graduation responsibilities, issuing and renewing health related professional licenses and offering theoretical and practical courses for health professionals for upgrade purposes and to enhance professional performance. This involves encouraging practitioners' skills and enriching scientific theory and practice among professionals who have graduated in medicine, dentistry, pharmacology, nursing, social work, sociology, psychology, and other supportive health specialities, including technicians in several specialities (SCfHS, 2016).

Historically, HSWs appear to play important roles in Saudi health care organisations, and recently these roles have been integrated within other medical teams to deliver efficient health care services (Albrithen and Yalli, 2016). The presence of HSWs aims on the one hand to empower patients and their families by improving their social and psychological capacities, while on the other, to improve the quality of Saudi citizens' lives in general (Albrithen and Yalli, 2012). However, it is interesting to note the relatively late formation of Social Work Departments (SWDs) in Saudi state hospitals in 1973, compared to their inception in other Western and Middle East countries (Auslander, 2001; MoH, 2002).

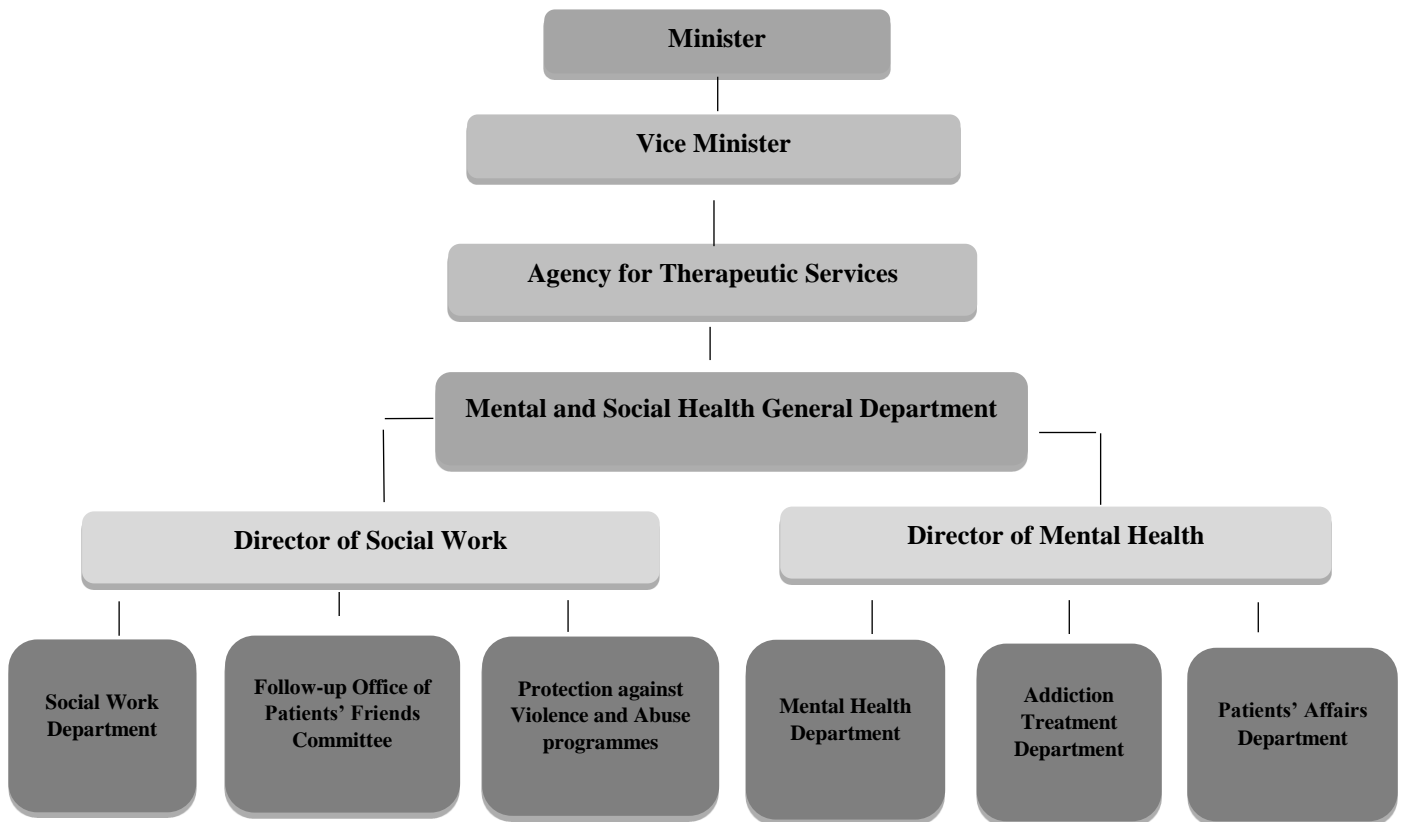
From the outset, in SA, social work practitioners were contracted by the MoH principally from neighbouring Arabic-speaking countries, especially Egypt. This was due to the shortage of trained and qualified HSWs, resulting from the limited number of local social work training institutions in SA (Yalli and Albrithen, 2011; Soliman, 2013). Years later, indigenous

professionals gradually supplanted these pioneering practitioners, and now all state hospitals have SWDs staffed exclusively by Saudi practitioners in either permanent or temporary employment positions (MoH, 2005). According to Albrithen and Yalli (2015), all the participants in their study (n= 215) were Saudi, as all non-Saudi HSWs had been replaced by local graduates from sociology, psychology and social work departments.

In administrative terms, SWDs within the Saudi hospitals are supervised by the Mental and Social Health General Directorate (MSHGD) at ministerial level. The MSHGD was established in 1983 to meet Saudi hospitals' need for more specialised social and psychological support facilities for patients. It is linked to the Assistant Agency for Therapeutic Services, which reports directly to the Vice Minister and the Minister of MoH (see Figure 3). The main purpose of the MSHGD is to maintain the provision of high-quality services to patients who require mental and social treatment in addition to physical therapy (MoH, 2016). Today, the MSHGD offers assistance via the Directorate of Social Work (DSW) and the Directorate of Mental Health (DMH)¹¹.

¹¹ The DMH provides physical and rehabilitation therapy for mental health and addiction patients across 21 mental health institutions, and 92 specialised mental disorder clinics in different regions of SA. In addition, it is responsible for the Al-Amal complex, which is the main provider of services for addiction and mental health patients, working alongside other mental health clinics in SA. It is also among the MHD objectives to set the criteria for psychotherapy practice in SA hospitals and supervises its application and validity in the professional domain. Moreover, it ethically considers patients' rights to ensure the avoidance of any abuse or harm coming to psychiatric patients, in addition to enabling discussion of any difficulties the patients experience during the treatment process, in order to find suitable solutions for them (MoH, 2014).

Figure 3: The organisational structure of the MSHGD within the MoH

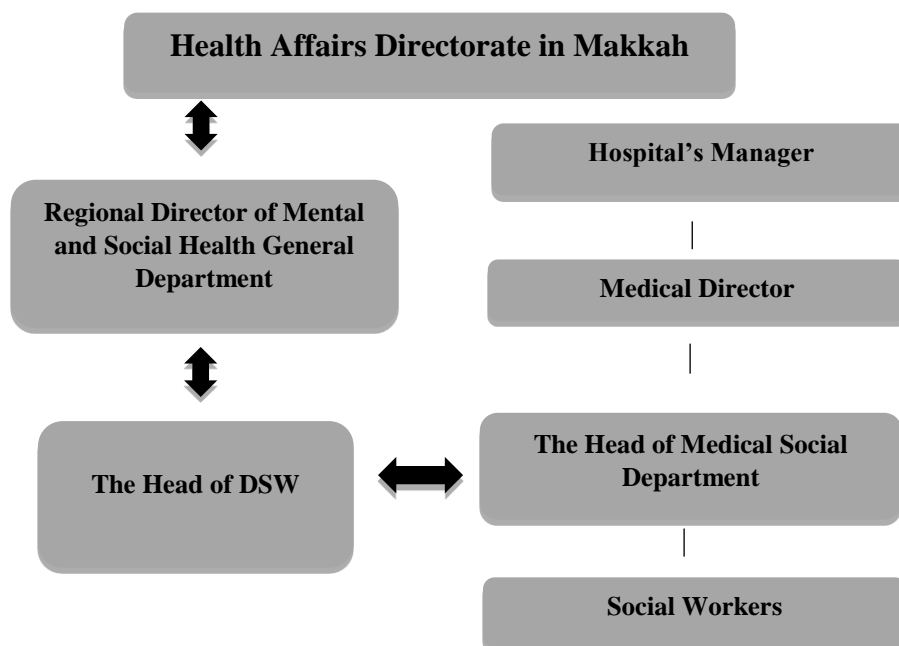


Source: Adapted from the MoH (2014)

Functionally, the MSHGD governs SWDs in state hospitals, under the auspices of the regional directors of Mental and Social Health Departments (MSHDs) within the Health Affairs Directorates (HADs) located in each region of SA. For instance, in Makkah province (where this study took place), the SWDs in public hospitals are linked to the Head of DSW, who reports directly to the Director of Mental and Social Health Department (MSHD) in the Health affairs Directorate (HAD) in the Makkah region (see Figure 4). Hence, the heads of the SWDs in state hospitals play major roles as central channels between the MSHDs and HSWs. The managers of SWDs not only evaluate HSWs functionality, supervise their performance, and engage in planning and preparation for new social programmes to increase social work provision for patients and their families (MSHGD, 2016). In doing so, the heads of SWDs often work in collaboration with a number of community institutions (e.g. National Home Health Care

Foundation¹² (NHHCF), SCfHS and other SA universities), to guarantee efficiency. Furthermore, it seems to be among the objectives of SWDs that they develop HSWs' professional skills by delivering training courses to maximise their practical and theoretical knowledge. Crucially, the managers of SWDs are also accountable for defining their required annual budget and financial needs to MSHDs located within Health Affairs Directorates (HADs) in each province in SA (MSHGD, 2016).

Figure 4: The Administrative Structure of SWDs within State Hospitals in Makkah Province



Source: Adapted from the (MSHGD, 2016)

It is worth noting, however, that despite the continuous efforts of both central and ministerial administrations, hospital-based social workers within the Saudi context frequently request more effective supervision (Yalli and Albrithen, 2011). This is particularly common in terms

¹² the NHHCF was founded in 1997 by Princess Hessah Al-Sha'alan, the wife of King Abdullah bin Abdul-Aziz, in cooperation with SA businesswomen, following the increase in patients requiring long-term physical treatment in public hospitals. The NHHCF provides its services regardless of patients' nationality, sex, age, or religion. A patient is only required to have a referral letter from the hospital at which he/she received medical treatment, as there must be a prior agreement in place between the hospital and the NHHCF in order for the patient to receive support from the home healthcare programme.

of guidance for HSWs on practise related issues and support, especially for newly qualified practitioners (Yalli and Albrithen, 2011). Another concern is that the central administration at some healthcare organisations apply centralised decision-making systems that restrict HSWs freedom to enact their roles or participate fully in budgeting and planning (Albrithen and Yalli, 2015). Finally, it is anticipated that due to the prevalence of bureaucratic systems, which characterize the majority of governmental Saudi workplaces, the effectiveness of the provisions provided by SWDs might need to be improved (Albrithen and Yalli, 2012).

Similar to hospital-based social work practitioners in Western countries, Saudi HSWs have multiple roles and responsibilities (Albrithen and Yalli, 2012; MoH, 2015). These include:

a) daily visits to internal wards and outpatient areas and joining physicians' rounds as needed; b) consultation with other care providers about psychosocial factors and their implications for health; c) budgeting and fundraising activities; d) training in psychosocial aspects of illness and intervention strategies; e) community organizing and capacity building (e.g., organizing support groups, liaising with the community for new social services, etc.); and f) administrative duties (e.g., monitoring and reporting patients' or families' complaints, writing case reports).
(Albrithen and Yalli, 2012, p. 273)

Nevertheless, while the MoH has theoretically approved specific functions to be performed by HSWs, the situation seems to differ in practise. It has been suggested that HSWs encounter challenges associated with the lack of a clear job description, which creates role-ambiguity (Al-Qurni, 2003). They might sometimes find themselves assigned to handle administrative duties that are not related to their job description, which may even relate to other departments within hospital setting (Yalli and Cooper, 2008; Yalli and Albrithen, 2011; Albrithen and Yalli, 2012; 2015).

The medical social work profession tends to assign HSWs to interact frequently with other professional groups inside the workplace context (Albrithen and Yalli, 2016). For instance, since awareness of medical teams and patients' social circumstance is viewed as a key issue for delivering efficient healthcare, inter-professional teamwork between HSWs and physicians are considered an essential element. Moreover, HSWs in many cases might also be required to collaborate internally with other administrative units, such as the Patients' Relations

Directorates (PRDs)¹³. However, the effectiveness of the incorporation of multi-disciplinary professional teams appears to be influenced by factors such as gender segregation requirements (which apply in most Saudi workplaces), and cultural diversity among healthcare professionals (i.e. practitioners other than HSWs) from other Asian or non-Arabic cultures, as both might impact communication efficiency (Al-Aameri, 2003; Albrithen and Yalli, 2013). Moreover, previous research in the Saudi context seems to suggest that HSWs' roles remain misunderstood by their medically oriented colleagues (Yalli and Albrithen, 2012; Albrithen and Yalli, 2013).

Furthermore, interactions among HSWs and physicians in some cases can have positive impact in terms of raising the quality of their performance, potentially also leading to poor relationships and conflict among them (Albrithen and Yalli, 2016; Albrithen and Yalli, 2016). Therefore, while the DSW advocates enhancing the ethos of teamwork among social workers, they also need to pay adequate attention to increasing professional relationships between HSWs and individuals from other medical teams. By doing so the DSW will be able to collaborate and coordinate with other departments at the ministerial and national level, in addition to other medical teams within hospitals, so as to maximise the level of peer-interaction in an attempt to provide comprehensive treatment for patients (MoH, 2014; Albrithen and Yalli, 2016). Nonetheless, while HSWs in Saudi hospitals appear to work as cohesive group, they mostly perceive limitations that might influence their tasks, due to the poor partnership with medical teams within the Saudi hospital context (Yalli and Albrithen, 2011, Albrithen and Yalli, 2012; Albrithen and Yalli, 2013). Not only this, but parallel to other developed countries, (e.g. Australia, America and England) Saudi HSWs identify lack of patient referrals from medical professionals as evidence of how their roles are misunderstood or undervalued by physicians within the hospital context (Albrithen and Yalli, 2015; 2016; Albrithen and Yalli, 2013).

Thus far, it seems evident that the MSHGD has been seeking, at least theoretically, to improve the quality of provision provided by SWDs in Saudi hospitals. For example, it facilitates HSWs by providing physical spaces and equipment to assist the effective delivery of social services (MSHGD, 2016). Offering such resources can significantly increase HSWs' ability to operate

¹³ The PRDs are the main representatives of Patient Affairs within Saudi hospitals, especially as Saudi patients tend to be culturally sensitive considering the conservative and religious society they live within. The PRDs are working as a link between patients and service providers to achieve the highest levels of satisfaction and strive to contain the complaints, observations and suggestions made by patients and their families, and to develop specific mechanisms to search for solutions aimed at and work on their application as well as take advantages of the results for the benefit of patients and their families and departmental staff (MoH, 2015).

different kinds of therapeutic approach¹⁴, in addition to enhancing the role that SWDs play in the treatment process (Albrithen and Yalli, 2012). However, similar to some other sectors managed by the MoH, it is notable that HSWs encounter a number of budgetary limitations including lack of funding, appropriate places and equipment. Moreover, it is valuable to refer to the limited autonomy given to HSWs in certain situations, such as lack of freedom when searching and offering alternative sources of financial support, particularly providing patients with chronic disease the required medical interventions (Albrithen and Yalli, 2012; Albrithen and Yalli, 2015). There is also scope for the involvement of charitable institutions to offer financial support for needy patients requiring medical care upon discharge from hospital. An example of such an organisation is the NHHCF, which reflects the prevalence of voluntary work in the Saudi community. However, it is interesting to note that HSWs generally are not involved in planning and decisions related to funding; either SWDs or patients (Yalli and Albrithen, 2011; Albrithen and Yalli, 2012). Not only that, but Yalli and Cooper (2008) have suggested that *'Participants expressed a need for a realistic bureaucratic system that takes into account the nature of social work and allows a degree of autonomy'* (p. 248).

During the last two decades, awareness about the importance of social work practice in healthcare has grown (Albrithen and Yalli, 2015; MoH, 2014). This can, for example, be seen in view of the increased attention afforded to social work education, with many universities having established courses that specialise in providing training to social workers so that they can qualify to practise in Saudi hospitals (Yalli and Albrithen, 2011; Soliman, 2013; Albrithen and Yalli, 2015; Ibrahim, 2017). However, job knowledge remains an obstacle that prevents HSWs from performing their tasks effectively (Yalli and Albrithen, 2011). For example, courses offered to develop HSWs' skills tend to be relatively inconsistent with fieldwork demands (Yalli and Albrithen, 2011). This is particularly true in relation to therapeutic and communication skills which appear to be necessary to enhance HSWs' productivity and effectiveness. Furthermore, it is interesting to report on the difficulties that HSWs might face in relation to the accessibility of training courses organised by the SCfHS, as a result of inadequate financial support within their workplaces (Yalli and Albrithen, 2011; SCfHS, 2016). Thus, an enormous gap could exist between work requirements and job skills.

¹⁴ For example, self-help groups, group therapy, and individual support, which can effectively assist patients (e.g., those with a life-threatening disease, chronic illness, or addictive disorder) and their caregivers to develop coping skills and improve conditions.

Moreover, another factor that might reflect the expansion of Saudi society's recognition of the significance of HSWs' roles is the establishment of the SA Health Social Work Association (SHSWA) in 2014 following the decision made by the SA Minister of Health (SHSWA, 2015). Similar to the National Association of Social Workers (NASW) founded in the USA in 1955, as well as the British Association of Social Workers (BASW) established in 1970; the SHSWA was founded to realise the same targets as other international social worker associations. However, while the NASW and the BASW appear to play a crucial role in the public domain, especially in terms of reforming social policy and the quality of social services in all sectors (BASW, 2015; NASW, 2015), it is important to clarify that the SHSWA focuses solely on social work practice in the healthcare domain.

The SHSWA intends to develop HSWs' professional capacity by providing unique opportunities to its members, as well as researchers who are interested in health social work, who can register with the SHSWA to share and experiences and professional suggestions that might contribute to the development of social work practice in the health field (SHSWA, 2015). Moreover, the association is also responsible for determining the criteria used to evaluate HSWs' professional skills and to provide frequent training courses to them. Most importantly, it is among the SHSWA's objectives to increase awareness of the role of hospital based social workers within and outside hospitals (SHSWA, 2015). Even though its emergence reflects a remarkable increase in recognition of HSWs by health organisations within Saudi society, and the importance of social support alongside physical treatment, this step has been taken late in comparison to Western culture.

In view of the above, it is useful when discussing the current situation with regard to social work in SA, to report on the lack of Saudi citizen's awareness about the profession of social work (Albrithen and Yalli, 2012). According to Alahidb (2012), who is one of the most important pioneers of social work in SA, the reactionary thinking within Saudi society (including among individuals and organisations) with regard to social work is one of the most negative aspects characterising this community. For instance, some Saudi patients define a social worker as a person who only helps them access financial support (Yalli and Albrithen, 2011). This point of view greatly affects the perceptions of Saudi citizens regarding the importance of social workers' roles, because many feels they cannot offer them anything they need. A further consideration, is that, as in other Middle Eastern communities, the role of the HSW is constrained by the fact that it is not socially acceptable for patients or their families to talk to strangers about their social concerns, problems, or difficulties (Yalli and Albrithen,

2011; Albrithen and Yalli, 2012). Therefore, HSW participation in decision-making with clients is limited, even rare (Yalli and Al-Brithen, 2011; Al-Krenawi and Graham, 2000).

Despite the above, the healthcare domain has become an attractive field of work for graduate social workers (Albrithen, 2014; Albrithen and Yalli, 2015; Albrithen and Yalli, 2013). In addition, the MoH has modified its regulations to meet with the urgent need for the involvement of HSWs in the health sector. Nevertheless, most research conducted involving social work in the health sector has emphasised the significant challenges faced by HSWs in their workplaces (Yalli and Cooper, 2008; Yalli and Albrithen, 2011; Albrithen and Yalli, 2012; Albrithen and Yalli, 2015; Albrithen and Yalli, 2013).

Summary

In summary, this part of the thesis has provided detailed information about many aspects of the Saudi community, including its geographical location, population and cultural and religious position. Moreover, historic developments in SA, together with important cultural features were discussed in this chapter as factors contributing significantly to influencing the lifestyle of Saudi citizens. This chapter also informed the reader about the emergence of social work as a profession in SA and how it aligns with Islamic teaching. In addition, the health care system and social work practice in healthcare were considered in depth, and the various public and private supportive organisations that work to help HSWs were introduced. Finally, perspectives pertaining to the current situation regarding social work practice in the healthcare field in SA were discussed in the context of widespread cultural perspectives. The next chapter will explore how such limitations exist globally among HSWs, and how this could influence their performance and contribute to work-related stress, as well as those approaches taken in different countries to deal with undesirable experiences.

Chapter Three: Literature Review

Overview

The focus of this study is on Health Social Workers' (HSWs) perceptions and experience of work-related stress. This chapter presents concerns raised in previous empirical research investigating this phenomenon amongst HSWs. It provides a brief summary of the strategies employed to search different databases, to identify published studies that examine the issues to be addressed in this research. Secondly, it reports on the development of terminology to define and describe stress in the research context, and critically discusses previous models designed to investigate the occurrence of stress. Thirdly, it addresses the prevalence of stress across occupations and then reviews related literature designed to identify and evaluate data to explain why stress occurs in health care workplaces. Additionally, it critically reviews prior research that examines the experience of work-related stress in the domain of health social work, as well as the techniques HSWs adopt to manage such experiences, along with explicating the role of HSWs' demographic factors in controlling the experience of work-related stress. Finally, factors relating to the purposes of this study will be addressed (i.e. research aim, and research questions).

Literature review strategy

As mentioned in Chapter One, this study is guided by multiple concepts that combine to assist the researcher in exploring issues linked to the experience of work-related stress in health social work. Although investigations have been conducted previously regarding those stressors acting on nurses in Saudi Arabia (Kamal, Al-Dhshan, Abu-Salameh, Abuadas, and Hassan, 2012), a search of the literature revealed a remarkable shortage of research studies undertaken to investigate job related stress in the health social work domain. Moreover, the majority of the literature concerning occupational stress in the context of social work typically focuses on particular contexts of practice 'i.e. social welfare' (Travis, Lizano, and Mor Barak, 2016; Choi, 2017). Therefore, this study was partially reliant on evidence from the international literature undertaken in health care settings, specifically studies in relation to nursing during the last decade (i.e. between 2008 and 2018). This helped to identify the most common factors linked

to occupational stress in health care, to inform the aims of the study. This was judged relevant, since the group targeted in this study shares some aspects of the work environment with other health care professionals, such as nurses (Itzhaky, Gerber, and Dekel, 2004; Damron-Rodriguez, 2008; Chan, Chi, Ching, and Lam, 2010).

To perform the literature search, different databases targeted (e.g. Medline, EBSCO, Scopus, Psyc INFO, Magiran, and SciELO), in addition to University of Hertfordshire library database and the Google Scholar search engine and governmental websites that include statistical reports about issue under examination (i.e. Health, and Safety Executive). The researcher also relied on several electronic publication websites; for example, Sage Publications, which publishes key articles related to social work in several Journals including British Journal of Social work, the Journal of Mental Health, Journal of Clinical Social Work, and Journal of Social Work. This aimed to comprehensively ensure the identification of any gap in research evidence pertaining to the area under exploration. By examining the databases mentioned, the researcher was able to cover a broad range of literature concerning the experience of stress in the health workplace in general and some in the clinical social work domain associated with job stress specifically.

This study aims to include recent international literature, particularly from the twenty-first century conducted in English language, to provide an up-to-date perspective. The researcher excluded studies undertaken to investigate job stress in other social work domains (e.g. social welfare), due to potential differences in terms of the nature of the cases being dealt with (i.e. clients) due to setting, as well as the differences between regulations that might affect social work practice in different workplaces. To achieve this, key terminologies associated with this exploratory study, including stress factors, coping mechanisms, health social workers, and workplaces were entered into the search engines. The preliminary search identified a number of relevant academic sources; however, to achieve the target aims of this study, the researcher narrowed the search by entering key words and synonyms, restricting the search to international studies undertaken within the last two decades (between 2000 and 2021). For example, to identify factors associated with work-related stress among HSWs, key words included ‘work-related stress’, ‘job stress’, ‘occupational stress’, ‘health social worker’, ‘medical social workers’, ‘clinical social workers’, ‘stress factors’, ‘coping with stress’, ‘work-related during COVID-19 in hospitals’, and ‘stress factors COVID-19 in health social workers workplaces’ .

An overall review of the research studies identified revealed an extensive range of literature relating to issues associated with the influential factors linked to job stress, as well as coping strategies in health care and social work field. However, those empirical studies that investigate stress factors and coping strategies in health social work are limited (Lonne, 2003). Moreover, detailed studies that only focus on occupational stress factors and coping strategies in general health care organisations from the perspectives of the HSWs considering their demographic characteristics do not yet exist at either the international or local level (i.e. the Middle East).

The concept of stress and its evolution in research

Before discussing occupational stress, which is the core subject of this study, it is valuable to discuss the concept of stress as a universal phenomenon. It is also important to offer a brief discussion of how the term stress is used in research, highlighting how the components of stress are identified from different perspectives. This will help to clarify how and why stress occurs, and to explain how individuals interact with and cope with it. In this portion of the literature review, the researcher will reference all the models used for evaluating stress by previous researchers. However, only the most widely used and influential models will be discussed and critiqued according to their suitability for investigating organisational stress.

Stress has been defined by many authors in the contexts of different times and situations (Dewe, O'Driscoll, and Cooper, 2012). However, the components of stress can be distinguished such that emergent theories designed to interpret and measure stress can also shape our understanding of stress (Dewe et al., 2012). Research into stress has a lengthy history, and the term stress has been used in research to refer to either a response, a stimulus, the interaction between the two, or continuous adjustment (transaction) (Hardy, Carson, and Thomas, 1998; Dewe et al., 2012; Cooper C. L., Cooper, C. P., Dewe, and O'Driscoll, 2001; Fink, 2017).

Early examples of research into stress took place in the first half of the 20th century. At this time, authors such as Cannon (1932) and Selye (1956) defined the term stress through a purely biological lens, referring to physiological reactions in response to demands, termed 'stressors' (Dewe et al., 2012). Cannon (1932, as cited in Hardy et al., 1998) clarified how stress occurs when the sympathetic nervous system responds to stressors by entering a state of flight or fight, and noted that after the stressors are gone, the body returns to equilibrium (Hardy et al., 1998). Drawing on Cannon's (1932) view, Selye (1936), a Hungarian medical doctor, defined stress

as '*non-specific response of the body to any demand*' (Selye, 1936, as cited in Hardy et al., 1998, p. 5).

In theoretical terms, Selye ignored psychological and cognitive factors to develop the General Adaptation Syndrome model (GAS) to administer a non-specific stress response (Hardy et al., 1998; Fink, 2017). The GAS identified three phases, commencing with the alarm stage, in which the body changes when exposed to demands resulting in a certain level of resistance in preparation for a rapid response. Moving on to the second stage, the response requires long-term adaptation to continue resistance, as the body in this phase is prepared to challenge the force imposed upon a person. Finally, in the last stage of the GAS, the energy of a person continues towards adjustment, and as a result, the individual can become vulnerable or exhausted or even get ill (Hardy et al., 1998; Fink, 2017).

Selye's (1936) conceptualisation of stress processes paved the way for other scholars to take unique approaches to understanding individuals' reactions to stress based on internal systems (e.g. Hardy et al., 1998; Pacak and Palkovits, 2001; Fink, 2017). According to Fink (2017), not all individuals follow the same pattern when responding to demands. Moreover, using the GAS model was not deemed applicable when studying stressors, because it only focuses on physical stressors. Therefore, when studying organisational stress for example, it was argued that although the GAS model could be accurate as a means to clarify an employee's response to material demands (e.g. noise and light), it does not seem to explain how employees react to additional complex sources of stress (e.g. job insecurity and roles uncertainty) (Ross and Altmaier, 1994, cited in Szilas, 2011).

Exploring a different perspective, in the early 1960s, researchers began to give attention to the environment in which individuals were expected to operate (e.g. Holmes and Rahe, 1967; Sarason, Johnson and Siegel, 1978 as cited by Hardy et al., 1998). The term stress began to be used as stimulus focusing on external events, mostly considering events that might harm individuals, and the feeling of tension caused by stress began to be referred to as a strain (Hardy et al., 1998). Generally, stress according to stimulus proponents is defined as '*a force exerted, which in turn results in a demand or load reaction, hence creating distortion*' (Cooper et al., 2001, p. 8). Using this definition, stimulus theory considers four broad categories of incidents that can lead to stress including '*a catastrophic event*', '*a major life event*' '*daily hassles*' and '*chronic circumstances*'. Consequently, this theory suggests individuals who perceive any

such events should apply a level of adjustment to manage the force (stress) imposed on them (Hardy et al., 1998, p. 4).

To understand stress, stimulus theorists constructed and empirically tested a number of scales (e.g. *Social Readjustment Rating by Holmes and Rahe '1967'*, and the *Life Experiences Survey* by Sarason, Johnson and Siegel '1978'). Although these scales contributed to identifying the causes of stress in workplaces to suggest an optimal environment for employees (Cooper et al., 2001), the stimulus model remains limited in terms of generalizability. This is because stimulus theory tends to expect all individuals to respond to an incident similarly (Hardy et al., 1998). However, interestingly, occupational stress research has revealed that when two workers are exposed to the same source of stress in the same workplace under exactly similar conditions, their reactions can differ entirely (Cooper et al., 2001; Szilas, 2011).

As time passed, researchers started to look at stress as a comprehensive process, considering both stressor and strain. Therefore, interactional models of stress started to be used to discover the interactions between stimulus and response (Cooper et al., 2001). Thus, multiple guided models were developed using this approach (e.g. *Person-Environment fit*, *Effort-reward imbalance model*, *Demand-Control model*, and the *General System Model*). However, the majority of the research based on these models failed to examine the job stress process in detail, instead focusing on the relationship between demands as '*cause*' and control as '*effect*', as in the Karasek (1979) model that assumes job strain arises when high job demands are combined with low decision latitude (Cooper et al., 2001; van Vegchel, Jonge, Söderfeldt, Dormann, and Schaufeli, 2004; Szilas, 2011).

The Karasek (1979) model has long inspired researchers in the job stress field (e.g. Juhász, 2002; Salavecz, 2008, cited in Szilas, 2011), as it marked a turning point in stress research by considering coping strategies (social support). It has also been described as quantitative and static (Cooper et al., 2001). This is because it predicts the relationship between the two mentioned variables (job demands and control), if the relationship identified fails to be proven, then no further explanation can be discovered (Hardy et al., 1998; Cooper et al., 2001). Another limitation with this model is that it does not explain the influence of a third variable the '*moderator*', or social support, as mentioned by Johnson and Hall (1988, as cited in Szilas, 2011). Thus, Johnson and Hall (1988) upgraded the model to include social support to describe the stress process comprehensively (Cooper et al., 2001; Szilas, 2011). However, research

employing the upgraded Karasek (1979) model has generally concentrated on social support, ignoring other moderators (Cooper et al., 2001).

Returning to the variable models concerned with stress and coping, another approach model was proposed to investigate stress associated with cognitive appraisal (Hardy et al., 1998; Cooper et al., 2001; Szilas, 2011). This is exemplified in the most frequently used model in research on managing stress, which was developed by Lazarus and Folkman (1984), who believed that stress would occur if a gap existed between individuals' perceived demands (i.e. caused by external and internal environment) and the limited resources available to meet those demands (Hardy et al., 1998; Cooper et al., 2001; Szilas, 2011). Although this approach has left a notable fingerprint enriching the field by combining all the cognitive and behavioural efforts that individuals would make to manage the demands of stressors, it has been also subjected to criticism (Szilas, 2011). In support of this, Szilas (2011) described the transactional model as an individualistic approach that only focuses on person-environment interaction, neglecting the roles of other social and contextual factors that might contribute to the stress process.

In relation to the above, it is vital to mention the contribution of Palmer et al.'s (2004) model of stress, as this has frequently been applied in organisational stress research over the last two decades (Szilas, 2011). It has been suggested that Palmer et al.'s (2004) model would be appropriate to use to investigate work-related stress in multiple fields, especially that involving human resources, health, safety and welfare professionals. Based on the Management Standards approach established in (2001) by the Health and Safety Executive (HSE), Palmer et al. (2004) considered six main hazards when assessing the causes of stress in workplaces. Although Palmer et al.'s (2004) model of work-related stress provides a valuable contribution, having been carefully constructed and updated over time under the supervision of the HSE to ensure comprehensiveness and applicability, the key problem with his model is that social studies scholars might prefer to avoid using it. This is because the majority of social research seeks to examine the impact of work-related stress on human emotions, detailing its emotional effects, and exploring cognitive responses designed to overcome undesirable experiences; whereas Palmer's model is valuable for studies that aim to examine the financial ramifications of work-related stress.

Taking the above argument a stage further, it has been suggested that despite the growing emphasis on more holistic approaches to studying organisational stress (Palmer et al., 2004;

Mazzola, Schonfeld, and Spector, 2011; Szilas, 2011), the majority of existing models tend to focus on using a quantitative approach rather than a qualitative one (Mazzola et al., 2011). This in turn contributes to limiting how far the experience of job stress can be taken, due to the ignorance of substantial elements that can only be captured with a qualitative approach designed to interpret the organisational stress experience within its '*political, social, cultural and economic context*' (Szilas, 2011, p. 53). Therefore, more studies are required to develop a more flexible approach that includes both descriptive and explanatory methods as a way to gain an in depth understanding of issues that have previously been overlooked when considering the phenomenon of job stress (Mazzola et al., 2011; Szilas, 2011). This would be deemed a reasonable approach to tackle all the influential factors associated with occupational stress, as a way to offer sufficient understanding regarding the relationship between staff members and the organisational environment, as well as the outcomes of this relationship (Cooper et al., 2001). In the section that follows, the prevalence of occupational stress in the context of different occupations will be presented.

Work-related stress across occupations

Earlier research studies have highlighted the critical role of stress as a factor contributing to organisational inefficiency, high staff turnover, absenteeism due to illness, poor quality employee performance, and reduced job satisfaction (Sullivan and Bhagat, 1992;; Palmer et al., 2004; and Avey, Luthans, and Jensen, 2009; Wang and Siu, 2015). For example, in a recent report by the UK's Health and Safety Executive (HSE, 2017), job stress is perceived as representing a genuine threat to countries' economy. The HSE (2017) estimates the financial losses for organisations in both the public and private sectors as a result of this phenomena, range annually from £5 billion in the UK economy to \$300 billion the in American economy (HSE, 2017; Fink, 2017). Given these estimations, job stress has prompted researchers from different specialties to investigate its mechanisms and how it represents a threat to communities, organisations, and employee's worldwide (Carson and Kuiper, 1998; Palmer et al., 2004; Coffey et al., 2009; Mazzola et al., 2011; Fink, 2017).

A review of previous research studies has shown that a wide range of literature compares the experience of organisational stress among different professionals, as observed by a number of scholars, including Johnson, Cooper, Cartwright, Donald, Taylor, and Millet (2005), Jones,

Wells, Gao, Cassidy, and Davie (2013), Lavi, Nuttman-Shwartz, and Dekel (2015), and O'Kelly (2016). Perhaps the main weakness affecting these studies is the failure to identify the relevant stressors affecting different occupations; it was however possible to rank the most stressful occupations. The literature concerning job stress emphasised the existence of occupational stress among professionals responsible for interacting with clients. For example, Johnson et al. (2005) conducted a large-scale study, which was a key study in the field, comparing the experience of work-related stress among individuals in different occupations. Their study examined six groups of professionals, and found that those who work in social services and ambulance workers were more stressed than others, scoring worse on average for each factor examined (i.e. psychological well-being, physical health and job satisfaction).

Internationally, a number of empirical studies have emphasised the existence of job stress among employees in different fields, such as police officers, teachers, correctional officers, universities staff, bank employees and IT professionals (Schaufeli and Peeters, 2000, Johnson et al., 2005; Ahsan, Abdullah, Fie and Alam, 2009; Calisir, Gumussoy, and Iskin, 2011; Li, Kan, Liu, Shi, Wang, Yang, and Wu, 2015). Importantly for this research, previous studies covering a variety of countries have noted a significantly higher probability of job stress occurring among health care professionals than in other domains (Lloyd, King, and Chenoweth 2002; Al-Aameri, 2003; Boran, Shawaheen, Khader, Amarin, and Hill Rice, 2012; Lavi, Nuttman-Shwartz, and Dekel, 2015). Lu and Imilia (2011) for instance, not only claimed that *'healthcare workers have long been known to be a highly stressful group and were worryingly associated with higher rates of psychological distress than many other workers of different sectors'* (p. 3), but also referred to increased concern arising among scholars investigating job stress among health workers including nurses, doctors, radiologists, psychologists, psychiatrists and social workers during the last two decades. Along similar lines, Ruotsalainen, Verbeek, Mariné, and Serra (2016) confirmed PL Lu and Imilia's (2011) views predicting the outcomes of job stress among employees in health care settings: *'Healthcare workers can suffer from occupational stress which may lead to serious mental and physical health problems'* (p. 92).

Exploring this group, Woodhead, Northrop, and Edelstein (2016) argued that nurses engaged in long term care might face several challenges potentially causing occupational stress, which could then result in different types of job stress outcomes (e.g. emotional exhaustion, depersonalization, and less personal accomplishment). Lo, Chien, Hwang, Huang, and Chiou (2018) drew similar conclusions when examining hospital nurses and investigating the

relationship between job stress and intention to leave job. In their study, they observed that job stress would directly affect job satisfaction and trigger a depressed mood, which in turn could contribute to increasing the intention among nurses to leave either their workplaces or the profession. This view accords with an earlier research study, undertaken by Khamisa, Oldenburg, Peltzer and Ilic (2015) to detect the link between work related stress, burnout, job satisfaction and the general health of nurses, which concluded that occupational stress is not only associated with all dimensions of burnout including emotional exhaustion, depersonalization and personal accomplishment, but also influences nurses' health condition, including their psychological wellbeing and somatic health.

The relevant research studies also suggest this might be the case in the context of social services (Coffey et al., 2009; Travis, Lizano, and Mor Barak, 2016). According to Acker and Lawrence (2009), work-related stress is frequently identified in professionals working in care services organisations. Since social work is strongly client-based, with workers engaged in complex social situations, in addition to being on a continuum of transformation with regard to the nature of social work practice as a result of administrative, societal and political changes, it is considered a highly stressful job according to the majority of writers (Collings and Murray, 1996; Lloyd et al., 2002; Coyle, Edwards, Hannigan, Fothergill, and Burnard, 2005; Collins, 2008; Savaya, 2014; Fantus et al., 2017). This was illustrated briefly by Coffey, Dugdill, and Tattersall (2004) who concluded:

[M]ental well-being [amongst social workers] is poorer than previous studies have indicated; job satisfaction is considerably lower . . . [and] organizational constraints . . . are higher . . . suggesting that the situation in social services was worse than previously thought. (p. 744)

This finding was also supported by Blomberg, Kallio, Kroll, and Saarinen (2015), who commented that '*Social workers' attitudes towards clients within the welfare system are to some extent related to their level of job stress*' (p. 2089). Thus, there is considerable evidence suggesting that we should consider social work as a particularly highly stressful occupation relative to others.

In view of the above, it is important to mention relevant research studies that explain the interrelatedness of those who work in health care settings. The interface between nursing and social work characteristics is an excellent example of this association. This is unsurprising given that there is empirical evidence suggesting a link between nurses and the social work

profession (Itzhaky, Gerber, and Dekel, 2004; Damron-Rodriguez, 2008; Chan, Chi, Ching, and Lam, 2010). Although there might be remarkable variance in terms of job description by both groups, the literature suggests a high level of similar challenges among individuals working in the same context (Freidson, and Lorber, 2008). For example, Holliman, Dziegielewski, and Teare (2003) highlighted the similarity between nurses and social workers in terms of the nature of the roles they practice, claiming that *'social workers and nurses view themselves as qualified to perform the tasks of supportive counselling'* (p. 224). This view is supported by Johnson et al. (2005) who commented that *'caregivers (for example, nurses and social workers) are more likely to suffer from emotional exhaustion because they are required to display intense emotions within their jobs'* (p. 180). Likewise, Black (2006) emphasised the overlap between professional groups that are frequently engaged in care planning practice with their patients in a complementary and parallel way. Moreover, it has been recommended that nursing and social work education can be combined to a single degree (Allen, Baker, and Rootes, 2014). Therefore, blurred boundaries might exist among the helping professions within health care organisation.

Collectively, these studies outline the critical role of job stress as a significant issue affecting organisational productivity. The evidence presented in this section not only suggests job stress exists across different disciplines internationally, it also reveals that this problem is particularly high among healthcare workers, due to the nature of care work. Considering this, the literature indicates that social workers might share similarities with nurses, in terms of the factors triggering work-related stress. Although a limited number of studies have been conducted in social work particularly in health sector, considerable research has been carried out to investigate occupational stress from nurses' and midwives' perspectives, and this information may inform the current study. Therefore, this review of the literature would attempt to narrow the gap in the literature in the field of health social work by considering relevant empirical work that examines occupational stress among other professionals in the health care setting (i.e. nurses). This is particularly true according to the fact that, there is not yet a valid standardised tool to be used in research that intend to examine work-related stress factors among health social workers. Bearing this in mind, the next section will shed light on the potential sources of stress as perceived by different health care professionals with specific attention being directed towards the nurses' group.

Work-related stress factors in health care organisations

As previously stated, despite the paucity of research on factors associated with work-related stress among HSWs, a number of studies have been undertaken in similar workplaces that provide useful insights for the current study. When reviewing previous research studies, the importance of exploring and specifying the causes of stress among health care staff was clearly noted as an initial issue that might affect both staff and the efficiency of the service provided to patients. There is also well-established evidence from a variety of studies identifying how factors related to occupational stress in the health care field seem to vary according to several organisational and personal characteristics (Santos, Barros, and Carolino, 2010; Banovcinova and Baskova, 2014; Magnavita, 2014; Conradie, Erwee, Serfontein, Visser, Calitz, and Joubert, 2017).

Workplace Environment

Given that Moustaka and Constantinidis (2010) voiced concerns about the physical work environment (i.e. lighting, low temperature, and poor ventilation) contributing to the likelihood of stress, there might be a greater possibility that they will be able to keep their personal belongings safe to enable them to relax in their break times. Moreover, nurses have additionally expressed that their experiences of adversity each day arise due to a lack of parking spaces for professionals, which makes them stressed before they even arrive at work. Similarly, Etim, Basse, Ndep, Iyam, and Nwikekii (2015) referred to additional concerns caused by physical conditions in health organisations that prevent practitioners from performing their tasks successfully. This creates a shortage of essential resources and equipment that nurses require to enhance the level of service delivery to patients and their families, including medical instruments communication devices and offices. Saha Sinha, and Bhasvar (2011) identified another source of stress as being inadequate staff numbers. In their investigation, Saha et al. (2011) observed that approximately 68% of hospital staff including doctors, nurses, administrators, and supportive staff; have noted that being under-staffed is a significant factor in their stress. The participants appear to be under significant pressure, because they are required to deliver services to too many patients despite their being a low number of practitioners in each specialised group.

Relevant research studies in the domain of occupational stress have suggested that a discouraging work environment heightens the risk of work-related stress in healthcare contexts.

This is particularly true in relation to the lack of reward, benefits, appreciation, career advancement, poor payment, and job security, that not only motivates employees, but also enhances their sense of satisfaction and loyalty to their workplaces (Maustaka and Constantinidis, 2010; Santos et al., 2010; Fiabane, Giorgi, Musian, Sguazzin, and Argentero, 2012, Happell, Dwyer, Reid-Searl, Burke, Caperchione, and Gaskin, 2013; Lu, Ruan, Xing, and Hu, 2015). For instance, Liu et al. (2015) surprisingly demonstrated that the exposure of psychiatrists to a high level of job stress was a result of limited career promotion opportunities, job security, and inadequate payment. Similarly, Happell et al. (2013) and Shih, Hou, Lin, Hsiaol, Sun, Chou, and Yang (2016) supported the previous view by acknowledging the pressure that nurses experience because of limited career progression, and the absence of encouragement and recognition for the acts performed by them. Supporting this argument, Abualrub and Alzaru (2008) approved of the relationship between level of job stress and professional and social recognition of professionals' performance, commenting that 'participants who perceived having more recognition for their competent satisfactory performance or outstanding performance or achievements reported experiencing less job stress' (p. 231). Similarly, Lu et al. (2015) and Adib-Hajbaghery, Khamechian, and Alavi (2012) identified significant levels of stress among nurses attributable to their poor salary and lack of benefits accrued in their workplaces.

Scholarly literature has additionally revealed another aspect of the unpromising work atmosphere which appears to stress professionals in health care settings. This is mainly relevant to the shortage of training opportunities to ensure practitioners remain updated with field work requirements and improve their skills to meet work demands (Santos et al., 2010; Lu et al., 2015; Didehvar, Zareban, Jalili, Bakhshani, Shahrakipoor, and Balouchi, 2015; Eltarhuni, 2016). It can be exemplified in the work undertaken by Sarafis, Rousaki, Tsounis, Malliarou, Lahana, Bamidis, and Papastavrou (2016), who noted a link between job stress and uncertainty concerning treatment (e.g. inadequate training), and professional knowledge and skill among Greek nurses. Concerning this, it might be useful to refer to the study by Lin, Hsu, Huang, Su, Crawford, and Tang (2017), who observed a gap between knowledge and practise in health care organisations arising from insufficient training in communication being offered to nursing students in Oncology departments. This seemed to present an obvious stressor for them, especially when delivering bad news to patients and their families.

In addition to the previous dilemmas connected to the nature of roles that health professionals engage in at work, the literature has also highlighted a potential cause of stress associated with

the severely restricted autonomy, and lack of power afforded to practitioners in health care organisations, including limited involvement in decision making (Siegrist, Shackelton, Link, Marceau, von dem Knesebeck, and McKinlay, 2010; Moustaka and Constantinidis, 2010; Mosadeghrad, 2013; Basu, Yap, and Mason, 2016). While a large body of literature illustrates lack of power as a predictor of stress at the administrative level (i.e. superiors and leaders) (Conradie et al., 2017), it seems to also affect health care professionals practising their roles with patients and their families (e.g. physicians, nurses, technicians, and administrative). For example, Eltarhuni (2016) supported this notion through her study, which revealed that around two thirds of health workers appear to experience occupational stress as a result of the significantly low level of participation in decision making

Leaderships and interprofessional relationships

Further reviews of relevant studies concerning health care setting uncover factors that might have influenced stressful experience among employees; especially the lack of support and conflict between the leaders of health organisations. While a large and growing body of literature has investigated the importance of effective and transformational leadership in health care organisations (Gibb, Cameron, Hamilton, Murphy, Eand Naji, 2010; Salanova, Lorente, Chambel, and Martínez, 2011; Gillet, Fouquereau, Bonnaud-Antignac, Mokoukolo, and Colombat, 2013; Nica, 2015; Manning, 2016). Several researchers have stated that many health practitioners experience stress because of the limited support they may receive from their managers. For example, studies carried out by Santos et al. (2010); Gholamzadeh, Sharif, and Rad (2011); Happell et al. (2015) identified that conflict with supervisors, combined with lack of support from both the general administration and senior managers, mean that the stress nurses experience is exacerbated by their workplaces. This seems to also be the case among another group of practitioners in the health setting; i.e. according to Banovcinova and Baskova's (2014) cross sectional study of 100 midwives in Slovakia, the outcomes revealed that encountering problems with supervisors is one of the key factors contributing to stress from the midwives' perspectives.

In line with this, much of the current literature concerning occupational stress within health organisations has also focused on interpersonal relations, and conflicts among practitioners as additional sources of stress in health care workplaces (Hudek-Knežević, Kalebić Maglica, and Krapić, 2011; Pino and Rossini, 2012; Van Bogaert et al., 2013; Happell et al., 2013; Mohammad Mosadeghrad, 2014; Azma, Hosseini, Safarian, and Abedi, 2015; Chiba,

Yoshioka, Kawanishi, Nakagi, Ito, and Yoshida, 2013). In this regard, it is noteworthy that the literature proposed two levels of social relations in the health care setting, including the relationships between members of the different professions (e.g. nurses with physicians), and the relationships between individuals within one professional group (e.g. nurses with nurses) (Kato, 2014; Sarafis et al., 2016). Data from several studies examining organisational stress (Adib-Hajbaghery, Khamechian, and Alavi, 2012; Mosadeghrad, 2013) have suggested the poor relationships between nurses and other professional groups is a major cause of stress in health care workplaces. Similarly, Mosadeghrad (2013) also acknowledged the conflict between nurses and physicians and disagreements about patients' treatment plans are additional predictors of occupational stress in health care settings.

Moreover, despite understanding of the importance of team work, collaboration and effective communication between health professionals as a component of high quality services, there is well established evidence in the literature of poor interaction among professionals contributing to job stress in the health care workplace (Hudek-Knežević et al., 2011, Zwarenstein, RiceGotlib-Conn, and Kenaszchuk 2013; Mosadeghrad, 2014). In this respect, Zwarenstein et al. (2013) observed that the lack of collaboration between physicians and other professionals within health care settings would potentially result in the dominance of physicians when making decisions regarding patients. This might thereby represent a form of stress, due to the underestimation of the roles of other health practitioners involved in medical teams.

Discrimination

Similarly, earlier research studies highlighted additional undesirable attitudes (e.g. inequality, discrimination, bullying, and harassment) that tended to be prevalent within health care workplaces influencing employees (Ariza-Montes, Muniz, Montero-Simó, and Araque-Padilla, 2013; Spector, Allen, Poelmans, Lapierre, Cooper, Michael, and Brough, 2014; Banovcinova and Baskova, 2014). For instance, Mosadeghrad (2013) attested to the notion that discrimination as well as treating professionals unfairly in health workplaces could result in high levels of occupational stress. A year later, Mosadeghrad (2014) drew our attention to the significant association between work-related stress and bullying behaviours that professionals might perceive from their co-workers and managers in health organisations. Likewise, Spector et al. (2014) provided evidence from their quantitative review underlining the existence of occupational stress among health practitioners, reporting that more than a third of nurses

(37.1%) are exposed to bullying, while (27%) appear to have experienced sexual harassment with health care context.

Patients and Families' Attitudes

On the other hand, in accordance with the large body of literature (e.g. Magnavita and Heponiemi, 2012; Magnavita, 2014; Bernaldo-De-Quirós, Piccini, Gómez, and Cerdeira, 2015; Llor-Esteban, Sánchez-Muñoz, Ruiz-Hernández, and Jiménez-Barbero, 2017), it has been suggested that the prevalence of job stress among health care staff can be attributed to the verbal and physical violence they might experience in their workplace. By way of illustration, Itzhaki et al. (2015) demonstrated the significant association between occupational stress and physical and verbal attacks that nurses might receive from patients and their families in mental health units. Although there is stereotype that health workers who deal with mentally ill patients are more likely to witness workplace violence (Edward, Ousey, Warelow, and Lui, 2014; Stevenson, Jack, O'Mara, and LeGris, 2015), this has been noted in other health sectors. This was also exemplified in Sun et al.'s (2017) large scale study investigating the prevalence of violence among 1899 health practitioners, including doctors, technical, nurses, and administrative staff at northern Chinese general hospitals. The study reported that 83.3% of practitioners were exposed to workplace physical and non-physical violence, which in turn was significantly associated with exposure to stress in the workplace.

Furthermore, data from several sources identified the increased experience of work-related stress, due to the attitudes that professionals might perceive from patients and their relatives (Happell et al., 2013; Lu et al., 2015; Kim and Kim, 2016). A study conducted by Sarafis et al. (2016) used the Expanded Nursing Stress Scale (ENSS), in addition to two other instruments, to examine the link between work-related stress and quality of health and life among 246 Greek nurses. The examination suggested that issues related to patients and their families tend to represent the second most influential factor in high levels of stress among participants. This was exemplified in Lin et al.'s (2017) research, which upheld that lack of collaboration and rejection from patients and their relatives can be significant sources of occupational stress for nursing students working with cancer patients.

From another side, Happell et al. (2013) described the stress that nurses would experience due to the unreasonable demands placed on them by patients' families, for example when seeking permission to be with patients outside of visiting hours. Not only that, but if their desires are

not being met, it is likely that professionals would perceive verbal or physical violence, especially from less educated families (Kamal, Al-Dhshan, Abu-Salameh, Abuadas, and Hassan, 2012; Lu et al., 2015). To finalize this point, it is relevant to the aims of this study to mention that compared to Western societies, patients' families appear to represent the most significant source of stress for professionals in Middle East health care workplaces (Spector et al., 2014). This was clearly noted by Eltarhuni (2016), who cited not only a lack of appreciation, but violence and aggression from patients and their relatives, as a factor contributing to high rates of occupational stress among Libyan health care staff.

On the other hand, it has been proposed that patients and their families' not only affect health professionals' physical safety, but also their emotional wellbeing. This corresponds to a growing body of literature that suggests health care staff are commonly exposed to high levels of emotional distress. such pressures can arise when working in setting that requires regular engagement with patients who are suffering, human emotions and deaths (Kamal et al., 2012; Pezaro, Clyne, Turner, Fulton, and Gerada, 2016; Riley and Weiss, 2016; Finley and Sheppard, 2017). In this regard, Wallbank and Roberson (2013) have examined the experience of subjective stress among UK-based doctors, nurses and midwives working in the maternity and gynaecological setting. Their study reported that 80% of those surveyed suffered from moderate or high levels of emotional stress as a result of witnessing miscarriages and neonatal deaths. Elsewhere, Lin et al. (2017) reported that emotional stress among 76% of Taiwanese nurses is caused by cultural factors associated with the refusal of patients' families to permit interventions in advanced terminal cases; e.g. by giving a strong pain killer that will render the patient mostly unconscious.

Roles and workload

Additional challenges are mentioned in the literature suggesting that health practitioners remain at risk of developing occupational stress as a result of issues associated with the roles they are required to fulfil (this covers job description, roles conflict and role ambiguity). This seems to be true in the case of Kamal et al.'s (2015) investigation conducted with a group of residents in an Egyptian hospital. The study detailed a significant relationship between stress and role ambiguity, role conflict, and the perception of doing a job of no value. It also revealed that practitioners were not sufficiently clear about their responsibilities and were also asked to perform additional non-clinical tasks. This in turn appeared to not only increase the volume of work, but also caused individuals to feel undervalued.

In parallel with the above, data from several sources has identified an increased level of work-related stress among health professionals, because of the volume of work expected of them (Saha et al., 2011; Chiang and Chang, 2012; Happell et al., 2013; Dagget, Molla, and Belachew, 2016). Fiabane et al. (2013), for example, studied the effects of organisational and personal factors on occupational stress among health care workers including nurses, physicians and physiotherapists. The study reported workload to be the most significant predictor of workplace stress among participants. In support of this, Kim and Kim (2016) conducted a study using a phenomenological approach to detect subjective experiences of stress among nurses in Korean long-term care hospitals. A strong theme to emerge in the study suggested that heavy workload and responsibilities are the factors that contributed most to work-related stress among participants. Similarly, Happell et al. (2013) concluded that health practitioners are experiencing stress due to the amount of work allocated to them which sometimes forces them to miss scheduled breaks.

Working Hours

On the other hand, several bodies of evidence suggest that shift work, working overtime, and long working hours appear to contribute to job stress in the health care setting (Ndejjo, Musinguzi, Yu, Buregyeya, Musoke, Wang, and Ssempebwa, 2015; Tajvar, Saraji, Ghanbarnejad, Omidi, Hosseini, and Abadi, 2015; Dagget et al., 2016; Lin, Hsu, Huang, Su, Crawford, and Tang, 2017). For example, Happell et al. (2013) argued that night shift work seems to present a physical stressor for some nurses, as it mostly results in their having inadequate sleep. Similarly, Lamont, Brunero, Perry, Duffield, Sibbritt, Gallagher, and Nicholls (2017) found that 54% of midwives and nurses who work at different times tend to experience emotional difficulties that can thus be attributed to occupational stress. Moreover, the length of time health practitioners spend in their workplaces can also present additional sources of pressure for them. This is apparent from Chou, Li, and Hu (2014) study, which described the health care setting as a stressful working environment involving several challenges associated with working hours. In their study, Chou et al. (2014) observed that both administrative and clinical staff who work overtime, rotating shifts and working longer hours report higher levels of job stress.

From a different perspective, being committed to working hours has been suggested to be a potential cause of pressure for health care practitioners. Thus, it is worth referring to the growing interest in health organisations use of biometric technology (fingerprinting) here to

monitor professionals' attendance. Although this technique is described as practical and friendly, as well as an effective method of increasing the level of staff members' daily presence (Sermeus, 2016), it also imposes serious pressure on practitioners aiming to fulfil the requirements of attendance regulations. This is because biometric technology is a highly accurate method of establishing the time that an employee attended his/her workplace. Therefore, any lateness problems will affect the monthly attendance calculation summary and possibly cause deductions in monthly paid salary, which is therefore a reasonable source of stress among health care professionals (Adewole, Abdulsalam, Babatunde, Shittu, and Oloyede, 2014).

Moral Distress

Other related studies suggest a variety of unique causes of occupational stress among health care professionals associated with moral and conscience stress (Glasberg, Eriksson, and Norberg, 2008; Alkirsat and Alatrash, 2016; Conradie et al., 2017). Regardless of the grounds for moral distress (i.e. being attributed to individual or institutional sources), this kind of stressors indicates ethical situations that practitioners might experience if they fail to fulfil the needs of their patients arising from several limitations (e.g. cultural and organisational restrictions). In support of the previous statement, Pauly, Varcoe, and Storch (2012) emphasised the role of ethical dimensions of practice among health care staff; asserting that these can be a significant stressor for *'nurses, pharmacists, social workers, physicians, and health care managers in a wide range of acute and community health care settings'* (p. 2). Not only that, their concern also stresses the need for action to be taken to improve the agenda on moral stress that guides education, policy, practice and research. This can in turn contribute to advancing understanding of the individual and structural factors that surround the experience of moral stress as a way to reduce the conflict between cultural, institutional and personal boundaries, and effectively strengthen ethical practices in health care settings in the future (Pauly et al., 2012). Another comparative study carried out by Whitehead, Herbertson, Hamric, Epstein, and Fisher (2015) also referred to the influence of moral stress on clinical practitioners.

Factors related to Practitioners' Demographic Characteristics

The academic literature on work-related stress also revealed several aspects that might contribute to the feeling of pressure among health workers, arising from their personal circumstances. Eltarhuni (2016) highlighted the interference of practitioners' home

responsibilities in working hours as a significant factor adding to stress in the health workplace. In support of this Hertzberg, Vaglum, Moum, Røvik, Gude, and Tyssen (2015) described the challenges of the relationship between family life and long working hours, which distinguish the nature of occupations in health care, observing that: *'Balancing tasks at work with obligations outside of work became increasingly difficult'* (p. 140). This is considered to add to work-home interface stress among Norwegian doctors. In a similar case in Iran, Adib-Hajbaghery (2012) indicated that nurses seem to be under chronic strain because of difficulties about whether as an employee they should prioritize family life or working career, such as when a sick child needs special care at a time when they have workplace commitments. Moreover, Adib-Hajbaghery (2012) mentioned that nurses' commitments to their work and family obligations mostly leaves them very limited time to relax or engage with their interests and entertainment.

Considering the evidence presented in the current literature, occupational stress in health care workplaces does not seem to be attributed to organisational factors alone, but also to workers' demographic characteristics, which appear to be an effective cause of pressure among employees (Garrosa, Moreno-Jimenez, Liang, and Gonzalez, 2008; Mosadeghrad, 2013; Jones, Hocine, Salomon, Dab, and Temime, 2015; Moghadam, Moosazadeh, Mohammadyan, Emkani, Khanjani, and Tizabi, 2017). By way of illustration, Hertzberg et al. (2015) explained how gender related factors might influence how professionals perceive the experience of stress at work. In this regard, it is important to note that the majority of the previous empirical work in the health care setting has highlighted a greater prevalence of organisational stress among female workers than males. However, Yada, Abe, Omori, Matsuo, Masaki, Ishida, and Katoh (2014) emphasised that male nurses do also seem to experience a level of occupational stress, females do so at a higher rate than males. Yada et al. (2014) suggested that: *'one reason that female nurses had higher subscale scores for psychiatric nursing ability and anxiety might be that they experienced sexual harassment from patients more often than male nurses in psychiatric departments'* (p. 472). Additionally, a similar distinction was identified in the studies of Pino and Rossini (2012) and Adib-Hajbaghery et al. (2012), who found that female nurses report higher levels of stress than men arising from the home/work interface, career and achievement issues, and relationships with people. Similarly, Kamal et al. (2015) argued that while socio-demographic factors did not suggest any difference in the experience of stress among resident doctors, gender significantly influences sources of pressure, particularly for

women, such that: *'being a female was the most important independent predictors of work-related stress'* (p. 85).

The relevant research studies have likewise acknowledged the influence of practitioners' age and field work experience on moderating the level of work-related stress within health care workplaces (Nabirye, Brown, Pryor, and Maples, 2011; Purcell, Kutash, and Cobb, 2011; Adib-Hajbaghery et al., 2012; Mosadeghrad, 2013; Fiabane et al., 2013; Shih et al., 2016). This was apparent in the case of Wu et al. (2012), who proposed that there is a higher potential for organisational stress among newly graduated nurses than their more experienced colleagues. Another example of how the journey of working life might affect occupational stress is explored by Adib-Hajbaghery et al. (2012) who surprisingly reported pressure amongst both newly qualified (i.e. working for fewer than two years) and more experienced nurses. Nevertheless, there seems to be a disparity in how each group perceives feelings of stress in accordance with experience. This is because those who have recently graduated report stress linked to lack of awareness of how to deal with events, while experienced nurses mention tension arising when sudden changes occur in their workplaces, or if they are working in a new section with different patients and partners. By contrast, Shih et al. (2016) surprisingly noted a greater experience of work-related stress among middle generation nurses (i.e. those who have been in the field for 6-10 years) compared to younger nurses with less than five years in work field.

A review of the literature illustrates that the educational background of health care workers could moderate the job strain experience in health care organisations (Nabirye et al., 2011; Suresh, Matthews, and Coyne, 2013; Galdikienė, Asikainen, Balčiūnas, and Suominen 2014; Dagget et al., 2016). For instance, in Taiwan, Lee, Tsai, Tsai, and Lee (2011) observed an association between organizational stress factors and nurses' demographic data, including their educational qualifications. In their analysis, Lee et al. (2011) reported that there is a significant difference between nurses based on educational background, clarifying that: *'Nurses who had an undergraduate education perceived hassles and stress to be higher than those who attended junior college'* (379). However, Trousselard, Dutheil, Naughton, Cosserant, Amadon, Dualé, and Schoeffler (2016) studied stress among nurses focusing on their qualifications, and surprisingly found the highest rate of occupational stress and the lowest level of control was faced by nurses with the highest qualifications.

In addition to the above, a large number of research studies on occupational stress have considered marital status as a mediating socio demographic factor that might influence practitioners' experiences of work-related stress (Chiang and Chang, 2012; Adib-Hajbaghery et al., 2012; Mosadeghrad, 2013; Bernburg, Vitzthum, Groneberg, and Mache, 2016; Mansour and Tremblay, 2016). In this regard, the debate in the literature concerning the negative impact role of a worker's marital status draws attention to two fundamental points. The first concerns how an employee's family life (i.e. children and other family members' responsibilities) might conflict with work commitments, while the second discusses practitioner's families' perceptions concerning the nature of work in health care setting. While Moghadam et al. (2016) have observed better mental health and lower stress rates among married midwives than their divorced and single colleagues, Adib-Hajbaghery et al. (2012) contradict these findings. In their investigation, Adib-Hajbaghery et al. (2012) noted the negative points of view that some partners of female nurses might have concerning their jobs. They mentioned their husbands frequently express regret about marrying health care workers. Adib-Hajbaghery et al. (2012) highlighted nurses suffering when they return home after a long working day to find themselves needing to fulfil obligations to their husbands and children. Further evidence that supports the previous idea was also presented by Mosadeghrad (2013) who reported a higher level of occupational stress among married workers than single ones. Furthermore, Nabirye et al. (2011) demonstrated the association between the number of children a health care worker has and the rate of occupational stress, observing that: *'nurses with no children had significantly lower occupational stress than those who had 1–2 or 3–4 children'* (p. 764).

As explained earlier in this chapter, health care occupations seem to rank amongst the most challenging jobs exposing practitioners to work-related stress experience. Nevertheless, previous studies in the health care setting have explored the association between work-related stress and area of work (i.e. sections within hospitals) (Nabirye et al., 2011; Mosadeghrad, 2013; Lin et al., 2017) Mosadeghrad (2013) pointed out a significant variation in level of stress among 296 Iranian nurses based on their area of specialty. Whereas nurses who work on psychiatry wards experience the highest rates of occupational stress, those working on coronary care units interestingly present with the lowest rates of stress. Similarly, Bernburg et al. (2016) acknowledged differential impact in stress factors between 435 German hospital doctors working in six medical specialties, including anaesthesiology, neurology, internal medicine, surgery, paediatrics, and gynaecology. Using the German version of the Copenhagen Psychosocial Questionnaire, Bernburg et al. (2016) assessed work-related stress and

psychological factors and found that physicians in surgery departments have the highest level of distress compared to their colleagues in other departments. Meanwhile, doctors occupying positions in anaesthesiology wards seem to experience the lowest level of job stress.

Overall, this section has attempted to provide a summary of the literature relating to several key factors associated with organisational and sociodemographic aspects that seem to moderate the perceived experience of stress in health care settings. It can be argued that much of these factors shared a strong commonality with what most health professionals in different specialties might face in such settings. It was therefore thought that the empirical work mentioned above is vital to inform the current study, as it is concerned with occupational stress factors in clinical social work. In light of this, what follows below is a critical review of the international perceptions of factors that might influence HSWs in their workplaces.

Work-related stress factors among HSWs

In spite of the dearth of in-depth studies covering the stress factors that might influence HSWs in their workplaces, several research publications have been identified that go some way to validating the need for more work to be undertaken in the context of the current study (Gellis, 2000; Coyle et al., 2005; Acker and Lawrence, 2009; Quinn, Ji, and Nackerud, 2019). As stated previously, although the majority of health professionals are likely to be subjected to many challenges that might increase the probability of work-related stress occurring, HSWs might experience higher levels of stress when working closely with those undergoing emotional and social difficulties (Arrington, 2008; Collins, 2008; Coffey et al., 2009; Vyas and Luk, 2011; Hussein, Moriarty, Stevens, Sharpe, and Manthorpe, 2014).

Over the last two decades, several studies have examined sources of occupational stress in the health social work domain. Although the literature in this area has been severely limited, a number of personal and organisational factors have been identified as having a distressing impact on HSWs, namely in mental health contexts. To illustrate this, authors have considered the challenges associated with the roles social workers practise in health care settings that are positively associated with occupational stress. A key example of this is the study by Lloyd et al. (2002), which involved a systematic review identifying a variety of factors triggering stress among mental health social workers. The review clearly postulated that the nature of social

workers' roles means that they consistently interact with vulnerable clients and this maximises feelings of stress, especially in the light of discrepancy between philosophy and job demands. Moreover, Lloyd et al. (2002) observed: '*social workers in mental health reported that they felt frustrated because their role was misunderstood by others*' (p. 257). In contrast, the review interestingly addressed a variety of organisational boundaries (e.g. bureaucratic working environment, lack of funding, shortages in staffing, and lack of professional autonomy), and as the perceived negative attitudes of professionals in other units as stressors.

Two years later, Lloyd et al. (2004) conducted another influential cross-sectional (survey) study in Australian public mental health organisations to examine the stressful effect of inconsistencies between the actual and preferable roles performed by 196 occupational therapists and 108 clinical social workers. In this research they demonstrated that HSWs were significantly stressed as a result of performing roles not associated with socially supportive tasks, as they engaged with responsibilities like '*crisis management and in arranging client finances, accommodation and doctors' appointments*' (p. 355). Moreover, Lloyd et al. (2005) described additional effective sources of stress among the same participants within the work context, including client-related difficulties (as causing an increased risk of physical or emotional disadvantage, because of the experiences of clients in mental health setting), in addition to a lack of resources, relationships and conflicts with other practitioners, and their workload.

A further empirical study within the mental health care setting considered prevalent financial regulations as an additional factor that impacts HSWs' efficiency (Acker and Lawrence, 2009). The study participants were 140 social workers in the USA, and the research aimed to detect the association between HSWs' self-competence and organisational stress within a managed care system that prioritizes the financial interests of health care organisations. Acker and Lawrence (2009) emphasised the importance of an effective practice, citing quality of educational preparation. They noted that participants who feel less confident in their capabilities to work also reported higher level of role stress. Furthermore, it was found that caseload size, and the decision to work with patients with chronic and severe mental illnesses exposes HSWs to significant levels of occupational stress, particularly in light of the financial limitations imposed on them in their workplaces. In support of this, Dane and Chachkes (2001) drew our attention to the role of volume of work, and inadequate academic preparation on maximising occupational stress among HSWs, specifically among new graduates.

A significant proportion of previous research into work-related stress in the domain of clinical social work has considered the effects of Secondary Traumatic Stress (STS) on HSWs (Ting, Jacobson, and Sanders, 2011; Cieslak, Shoji, Douglas, Melville, Luszczynska, and Benight, 2014; and Lee, Gottfried, and Bride, 2018), which can arise when examining clients' traumatic life experiences. Evidence of this was provided by Ting et al.'s (2011) large-scale survey in the USA, which relied on perceived stress scale to explore the impact of working with suicidal clients on 245 social workers' emotional and psychological wellbeing and career, taking into account time since the incidents took place. Their outcomes met the expectations of the research team, as those participants who had recently experienced a suicidal incident reported greater and less controllable STS than their colleagues who had not.

Likewise, in research carried out in Midwestern USA, Badger, Royse, and Craig (2008) explored the predictive role of empathy, emotional separation, occupational stress and social support on STS by looking at 121 HSWs at different trauma centres. The researchers reported higher levels of job stress and low levels of emotional separation, which contributed to a high level of STS among participants. Quinn et al. (2019) also studied the possible personal and occupational factors that might increase the development of STS among clinical social workers. In their powerful study, the investigators considered a number of variables with potential to influence the issue under examination, including dealing with traumatized clients, connections with supervisors, clients' caseload, types of traumatic cases and participants' age, gender and income bracket. Their sampling procedure was extremely accurate, and the researcher were usefully targeting clinical social workers who had obtained their Licensed Master's Social Work (LMSW) within 4 years prior to the study, as this group receives frequent and ongoing supervision. The research went through several stages before the respondents were chosen according to the application of exclusion and inclusion criteria; out of a possible 2383 LMSWs, only 107 were deemed eligible to complete the survey. Quinn et al. (2019) pointed out that whereas the types of client traumas found to be non-significant related to the level of STS; caseload size, personal income and supervisory relation all significantly influence the STS experience. Moreover, gender related factors were found to be statistically significant despite the fact that differences among males and females were hard to interpret because of the dominance of female participants numbers within the selected sample.

In Korea, a detailed investigation was conducted recently by Yi, Kim, M.A., Choi, Kim, S., and O'Connor (2018), to illuminate the issue of compassion fatigue as a STS disorder among HSWs. In the study, Yi et al. (2018) interviewed 12 medical social workers working in

oncology departments to understand how watching cancer patients' suffer impacts HSWs emotionally. The findings of the study raised concerns about regular contact with patients' pain, fear and suffering, especially when encountered with limited capacity to help. To clarify this finding, Yi et al. (2018) not only referred to patient death as a great source of stress, but also emphasised the severe experience of guilt that HSWs might internalise when patients ask for help. This is in cases where inadequate resources are available to facilitate HSWs to care for cancer clients. In this regard, Yi et al. (2018) commented: '*The social workers felt stressed when they had to tell the clients that no resources were available for their needs. Sometimes they were criticized and insulted by the clients for not being more helpful*' (p. 344).

In a similar study to the current research, Ostadhashmami, Arshi, Khalvati, Eghlima, and Reza Khankek (2019) employed the inductive approach to understand the experience of paediatric oncology social workers in Iran. The researchers used purposeful sampling to conduct semi-structured interviews with nineteen social workers between 2015 and 2017, alongside field observation. The study identified a number of concepts in relation to the focus on exhausting and stressful service, including: firstly, the nature of work in oncology departments; secondly, a lack of professional competence; thirdly, limited organisational support; and fourthly emotional and stressful demands. Similarly, Yi, Kim, Akter, Molly, Kim and Frazire (2018) employed the focus group technique to establish the experience of compassion fatigue among twenty-seven oncology paediatric social workers in Montana, finding the most common factors to include: firstly, emotional challenges; secondly, devaluation of the profession; thirdly, a lack of support; and fourthly, excessive workload.

In the UK, one of the most impressive studies regarding occupational stress in health social work was that conducted by Huxley, Evans, Gately, Webber, Mears, Pajak, Kendall, Medina, and Katona (2005). In their comprehensive survey, data was collected from 237 mental health social workers, including free-text responses. While the study identified HSWs' commitment to service users as a factor for retention in this profession, issues such as additional paperwork, and administrative tasks placed additional pressure on participants. Furthermore, shortages in staff were identified as a factor increasing caseloads among HSWs, and there were limited opportunities for personal advancement as a result of being undervalued within the medical team. Similarly, in the same year; Coyle et al. (2005) ran a structured systematic review to reveal the impact of work-related stress on mental health social workers, which included nineteen studies conducted in the USA, UK, and the rest of Europe. Their examination revealed that stressors such as, being female, roles ambiguity, role conflict, workload, lack of promotion

chance, feeling undervalued and performing additional legislative tasks contributed to job stress among HSWs in the mental health context.

In the same area, Willems (2014) focused on exploring the development of occupational stress among mental health professionals, hypothesising that: *'mental health care social workers experience higher levels of stress in comparison to other mental health care professionals'* (p. 19). Although the findings of this cross-sectional study rejected this assumption, it clearly emphasised the exposure of health social workers to high levels of organisational stress in the mental health setting. Not only that, it grasped a number of sources contributing to stress and including role ambiguity, inter-professional conflict, lack of appreciation, feelings of being undervalued, workload, and limited social support.

Exploring a different area of interest, Gellis (2001) compared perceptions of occupational stress among 187 HSWs working in two different health authorities, with academic health centres and general community hospitals, using a job stress survey. Although the study reported a significantly higher score for work-related stress at academic health centres than at community hospitals, both groups of HSWs were classified as having a relatively moderate level of stress. However, the HSWs in both of the settings reported factors related to the lack of organisational support as the greatest stressors, they seem to perceiving the experience of occupational stress from different perspectives. For example, HSWs at academic health centres first rated *"lack of participation in policy-making decisions," "conflicts with other departments," "difficulty in getting along with supervisor," "critical on the spot decisions", "conflict with other departments,"* and *"excessive paperwork"* as frequent stressors in their workplaces. In contrast, social workers at community hospitals' considered *"lack of opportunity for advancement," "inadequate salary," "meeting deadlines," "poor or inadequate supervision,"* and *"insufficient personnel to handle assignments"* as the most common examples of factors causing job stress (Gellis, 2001, p. 26). In addition, Gellis (2001) referred to an expected correlation between HSWs' age and lack of support as provoking anxiety, because younger HSWs tend to experience more stress than their older colleagues.

Other studies have explored the relationships between anxiety in the workplace and the increasing reliance on Information Technology programs to meet patients' needs. For example, Barcy (2006) conducted a self-reported survey method to explore the association between computer self-efficiency and computer anxiety among 45 HSWs and nurses. The study indicated a significant relatedness between both variables, as lower task proficiency was

associated with a higher level of computer anxiety and vice versa. Likewise, recent cases reported by Beer (2016) tend to also confirm the poor IT system to be an influential element in maximising the experience of occupational stress in mental health social work sector.

On the other hand, as described in the previous section, health care providers who are in direct contact with the patients are more likely to encounter the moral conflicts that would emerge from ethical dilemmas and discrepancies in values amongst medical teams or professionals and patients and their families (Pauly et al., 2012). A recent review by Fantus et al. (2017) drew our attention to moral distress affecting clinical social workers, which seems to be attributable to a combination of stressors as mentioned previously. Although the study relied purely on library-based data and did not involve any fieldwork, it was possible to critically investigate those sources that might contribute to conscience pressure among the mentioned group. The research adapted conceptualisation of moral distress from the nursing field across '*(i) clinical situations; (ii) working conditions and limited resources; (iii) structural conditions; and (iv) moral sources*' (p. 2279). It was observed that moral distress among HSWs arose from being the main advocator for patients' rights, which means navigating complex cultural and organisational values, limited resources, and severely limited authority. Thus, Fantus et al. (2017) briefly identified the possible influential elements adding to this stress, arguing that: '*moral sources, results from an inability to fulfil professional responsibilities and conflictual experiences with one's personal values, beliefs and worldviews*' (p. 2282). In addition, Dane and Chachkes (2001) similarly emphasised a sense of anxiety among HSWs arising from the neglect by physicians of emotional needs when planning for patients' discharge process, which in turn not only increases the feeling of guilt among HSWs, but also develops the sense of being undervalued and lacking recognition.

It is notable that, despite social work having played a crucial medical role during the COVID-19 pandemic (in particular by providing psychological intervention for patients), this pandemic has placed considerable pressure on HSWs (Raftery, Lewis, and Cardona, 2020; Rana, Mukhtar, and Mukhtar, 2020; Hen and Zuang, 2021; Prasad, McLoughlin, Stillman, Poplau, Goelz, Taylor, Nankivil, Brown, Linzer, Cappelucci, and Barbouche, 2021). However, it is essential to state that understanding of the impact of the pandemic on Health Social Workers (HSWs) has been largely based on the quantitative approach. One example concerns the study carried out in Romania by Dima, Meseşan Schmitz and Şimon (2021) to discover the changes to job stress and burnout caused by the COVID-19 pandemic among social workers, including those employed in the health domain. The study reported high level of workplace stress among

social workers generated by organisational factors (e.g. workload; inconsistencies; instability; ambiguity of managerial decisions; and a lack of clarity relating to working procedures), with less stress identified as arising from client-related stressors (e.g. lack of direct contact with clients; fear of contamination; managing clients' concerns; and issues related to technology).

Furthermore, Seng, Subramaniam, Chung, Syed Ahmad, and Chong (2021) examined the level of psychological distress experienced in Singapore during the current COVID-19 pandemic, well as the role of resilience and organisational support in mitigating distress among frontline social workers in hospitals, family services centre, and social agencies. The study highlighted a high level of psychological distress among the participants who, although resilient, experienced stress, depression, and anxiety. In addition, social workers based in family services centres reported higher levels of psychological distress than those working in the health sector. On the other hand, Ashcroft, Sur, Greenblatt and Donahue (2021) conducted exploratory research to understand the experience of social workers in a number of domains in Ontario (including in relation to mental health), during the COVID-19 pandemic. They employed an exploratory approach, based on an online survey, to identify challenges associated with social workers' employment status, i.e. increased workload, concern for personal health and safety, and early retirement.

In Saudi Arabia (SA), Al-Mansour, Alfuzan, Alsarheed, Alenezi, and Abogazalah (2021) conducted a study using a multistage random sampling approach, based on an online questionnaire. The study focused on detecting occupational factors for stress among primary health centre workers during the COVID-19 pandemic, involving physicians, nurses, and other health professionals (e.g. lab specialists, pharmacists, radiologists, social workers and epidemiologists). The researchers relied on a single dependent variable (i.e. perceived stress) alongside number of independent variables (i.e. role conflict and ambiguity, self-esteem and social support), taking into account the participants' demographic background. The study reported higher level of stress and role conflict and ambiguity among practitioners in fever clinics than those working in general primary healthcare centres.

Moreover, Aughterson, McKinlay, Fancourt, and Burton (2021) utilised a qualitative enquiry to determine the psychological well-being of health and social care professionals throughout the COVID-19 pandemic. Using in-depth interviews with twenty-five participants, from range of frontline professions in health and social care in UK, the study identified stressors related to

issues of the public's failure to adhere to social distancing, fear of transmitting the virus to loved ones, increased workload, and taking decisions about unknown health risks.

An overall review of the literature relating to health social work and work related stress factors reveals a significant emphasis on the mental health sectors, despite the variety of challenging issues HSWs tend to encounter within other healthcare settings (e.g. chronic illnesses). Furthermore, the majority of published studies tend to concentrate on organisational dilemmas, while failing to explore the influence of HSWs' personal aspects on occupational stress (i.e. demographic data). Another significant limitation is that many of the existing studies of clinical social work have only examined stressors such as exposure to STS after being involved traumatic events related to clients. In addition, most studies published during the COVID-19 pandemic have examined stressors linked to role conflict and ambiguity, overlooking factors such as client-related issues. Furthermore, most of the literature concerning the impact of the pandemic has included a wide range of professionals in a single study, thus potentially limiting the specificity of findings.

Methodologically speaking, the most important criticism regarding the employed approach is that, to date, the majority of researchers have tended to rely exclusively on quantitative data, raising the issue of whether they have adequately addressed the phenomenon of occupational stress (see Appendix 1). Therefore, the current study aims to fill in this existing gap in the clinical social work domain through a comprehensive approach capable of empowering the researcher to understand many of the issues related to occupational stress. The following section examines relevant studies concerning coping strategies in HSWs' workplaces.

Coping with work-related stress in health social work

As mentioned at the beginning of this chapter, the transactional model of stress (developed by Lazarus and Folkman (1984) provides a detailed framework with which to better understand the procedures individuals employ to confront stressors, divided into two main phases, referred to as primary and secondary appraisal. While a person at the primary appraisal level evaluates events in terms of representing harm, threat or challenge; in the secondary appraisal stage individuals assess available resources to manage the situation (Gellis, 2002; Glanz and Schwartz, 2008). After this individuals attempt to overcome stress, and this is highly affected by self-efficacy, and focusing on dealing with stressors rather than trying to handle their feelings toward those stressors (Litman, 2006).

On this point, Glanz and Schwartz (2008) added a valuable comment about the influence of the adjustments made in each approach, suggesting that:

The model predicts that problem-focused coping strategies will be most adaptive for stressors that are changeable, whereas emotion-focused strategies are most adaptive when the stressor is unchangeable or when this strategy is used in conjunction with problem-focused coping strategies. (p. 217)

Despite this, criticisms have frequently questioned the capacity of the transactional model of stress to provide a complete picture of the stress management process (Cooper et al., 2001; Goh, Sawang, and Oei, 2010). This might be attributed to its limitations in terms of ability to identify stressors, as well as its focus being on the person-environment side, with relatively less attention being directed towards the role of social contextual elements that could contribute to managing stressful feeling (Szilas, 2011).

Regardless of the limitations, it is interesting to note that a number of scales have been developed to address Lazarus and Folkman's (1984) cognitive approach. Carver, Scheier, and Weintraub (1989) exemplifies a scholar who built upon the cognitive perspective by creating an instrument to assess individuals' coping style. This inventory distinguished between approach coping, which refers to strategies that tend to actively deal with stressors or emotions, and avoidance coping in which individuals generally attempt to avoid stressful situations (Monzani, Steca, Greco, D'Addario, Cappelletti, and Pancani, 2015). In doing so, Carver et al. (1989) combined their coping measurement into fifteen sub scales in which each of them consists of four items that essentially intend to assess both approach and avoidance coping strategies (Carver et al., 1989; Monzani et al., 2015).

Even though Carver et al. (1989) empirically demonstrated the validity and reliability of their measure in several clinical studies (Litman, 2006; Pollard and Kennedy, 2007; Eaton and Bradley, 2008), a major drawback of the Carver et al. (1989) scale seems to be associated with the large number of items (i.e. 60), which might affect its practicality when used within a long research protocol (Monzani et al., 2015). In view of this, Carver (1997) developed what is now the widely used Brief COPE scale to overcome this shortcoming:

[It] measures 14 theoretically identified coping responses: Self-distraction, Active coping, Denial, Substance use, use of emotional support, Use of instrumental

support, Behavioral disengagement, Venting, Positive reframing, Planning, Humor, Acceptance, Religion, and Self-blame. (Monzani et al., 2015, p. 297)

Consistently, Carver (1997) underlined the usefulness of employing the Brief COPE scale when conducting health-related research, and as a result many studies have been conducted to examine occupational stress management in the health field (Bennett, Lowe, Matthews, Dourali, and Tattersall, 2001; Welbourne, Eggerth, Hartley, Andrew, and Sanchez, 2007; Alosaimi, Alghamdi, Aladwani, Kazim, and Almufleh, 2016).

This is particularly relevant with regard to managing occupational stress among health care professionals, many of whom typically rely on a variety of mechanisms that echo those suggested in relation to previously developed theories concerning coping strategies. For example, Gellis (2002) undertook a survey of 155 nurses and 168 clinical social workers to compare three types of coping strategies, involving active problem-solving, problem-reappraisal coping and avoidance coping. The findings indicated that social workers have significantly better success using problem-reappraisal, and active problem-solving methods than nurses, who would prefer to employ avoidance coping techniques. Comparably, Ben-Zur and Michael (2007) conducted a survey using the Hebrew version of the COPE scale by (Carver et al., 1989) to compare coping strategies among female health practitioners in Israel, including nurses, psychologists and social workers. Although this study drew conclusions based exclusively on females' perceptions, it noted no differences among the three groups of participants, and a surprising preference among participants for problem-focused coping over emotion-focused techniques.

Previous research has proposed that religious coping as well as instrumental and emotional support are strategies commonly used by HSWs. In support of this, Dane and Chachkes (2001) studied the effect of working within the health care context on HSWs, using a focus group to investigate how they cope with occupational stress. The study identified spiritual and religious beliefs as some of the most helpful strategies conducted to date to manage emotional reactions. This combines with social and professional support systems surrounding HSWs, which appear to reduce the experience of job stress. However, instrumental support was admittedly more effective than emotional support, since the first one was mostly perceived from individuals who understand the working environment, and could adequately provide appropriate advice in undesirable situations. Not only that, but Dane and Chachkes (2001) additionally listed a number of techniques that contribute to minimising work pressures, including the feeling of

appreciation and gratification perceived by patients and their families, which appear to reflect their satisfaction with HSWs' interventions.

In addition to the above, a significant volume of prior research into managing occupational stress has focused particular attention on managing traumatic stress in HSWs' workplaces, especially among those working in paediatric departments. To illustrate this, Hernandez (2017) recently investigated how HSWs within Paediatric and Neonatal Intensive Care Units in California manage experiences of primary and STS. To better understand the subject under examination, open-ended questions were developed in an electronic survey format and sent to 30 HSWs with a Master's degree or Licensed Clinical Social Workers working in the units mentioned at Inland Empire of Southern California hospitals. To challenge both primary and traumatic stress, Hernandez (2017) reported that relatively similar techniques were used by HSWs, in terms of dependence on spiritual and religious beliefs, familiarising themselves with personal and professional limitations, consulting their supervisors and social work colleagues, and breathing and physical exercises. The only two differences in this regard seem to be that HSWs who have been exposed to STS additionally prefer to avoid being over involved in stressful situations, whereas interactions with family members and friends were identified as a preventive strategy that can be employed to manage primary traumatic stress.

In the same field, it has been suggested that improving HSWs' skills by providing educational and training courses can be an effective method to minimise the experience of work-related stress. In their study, for example, Trowbridge et al. (2017), examined the efficacy of offering Mindfulness Based Stress Reduction courses (MBSRc)¹⁵ to paediatric social workers. This was done with the intention of developing their professional quality of life, and minimising the perceived stress experience among paediatric social workers in Midwest. In total, 21 paediatric social workers were enrolled in the study after an exclusion process designed to fulfil the requirements for participation. The investigators employed a number of measurements, including Mindful Attention and Awareness, Professional Quality of Life, Perceived Stress and Caring Efficacy scales to compare the scores for each element as affected prior to and after the intervention process. Trowbridge et al. (2017) demonstrated the beneficial effect of MBSRc on increasing mindfulness from pre-to post-intervention. Further, the score reported by

¹⁵ The MBSRc was found by Professor Jon Kabat-Zinn in the 1970s, and used a combination of mindfulness meditations to improve quality of life and reduce stress. The program of the MBSRc is an eight week workshop that includes group dialogue, body scan, sitting meditation, walking meditation and mindful movement offered by certified trainers and advocating enhanced self-management and coping skills by integrating mindfulness in daily life.

Professional Quality of Life scale seemed to confirm a reduction in the STS experience among the enrolled participants after completing MBSRc.

The literature referring to managing job stress in the health social work domain has also shed light on the preference for using negative and positive mechanisms to manage occupational stress. This is evident in the case of Ting et al. (2008) who used a self-report questionnaire to investigate the negative and positive coping behaviours of 285 American mental health social workers, particularly those who exposed clients to suicidal incidents. Data obtained from the study surprisingly showed that more than a third of participants apply negative management actions (e.g. smoking, using alcohol, overeating, and isolation), whereas the remainder prefer to act positively towards client's suicidal events and perform physical exercises or use religious practices or meditation. Similarly, Kraemer (2013) confirmed the point made by Ting et al. (2008) emphasising that whereas the study found out that positive coping mechanisms (e.g. prayer and exercise) are effective at managing stress, negative coping (i.e. isolation and using drugs and alcohol) is less common among HSWs.

A considerable number of studies have also been published suggesting the significant role of instrumental support in reducing job stress among HSWs. To illustrate this, Ting et al. (2008) evaluated the differences in the available sources of support HSWs tend to rely on when encountering workplace stress. The study identified supervisors' support as the most used resource, noting that it was preferable over that of peers and colleagues following exposure to clients' suicidal behaviours. This was also the case in Kraemer (2013) which praised the value of supervisors' support and consulting colleagues as the most frequently used strategies after witnessing clients' suicidal behaviour to control pressure in the work setting from perceptions' of HSWs. Gellis (2000) has also confirmed that seeking social support is an effective strategy to buffer work-related stress in HSWs' workplaces.

In a similar vein, Gellis (2000) described the impact of leadership style, particularly transformational and transactional leaderships, on the coping styles of 187 HSWs in Toronto hospitals. The investigation highlighted a significant association between leadership style and coping strategies. For example, Gellis (2000) reported that inspirational motivation, problem-focused techniques seemed to be mostly used by HSWs in workplaces managed by transformational leaders. In addition, seeking social support was positively associated with transformational leaders' behaviour (i.e. individual idealized, individual consideration).

In addition, a small body of empirical work has included the influence of HSWs' demographic factors on moderating the strategies employed to cope with occupational stress. By way of illustration, Ting et al. (2008) reported a significant association between coping behaviours and the gender, age, and education level of HSWs. This is because of the remarkable impact of gender and age in terms of using positive coping as a method to deal with traumatic stress: '*Being older was predictive of the use of more positive coping*' (Ting et al., 2008, p. 215). Furthermore, while the females tend to respond more emotionally to job stress following clients' suicidal incidents, male HSWs actively seek behavioural outlets. Accordingly, Ting et al. (2008) anticipated an increased probability that males will use more negative coping strategies than females, suggesting that:

[W]ith client suicidal behaviors (or other situations beyond their control), problem-focused coping strategies are not always possible, which may result in men resorting to the use of more negative action-oriented behaviors, such as substance use and social isolation. (p. 218)

Likewise, Gellis (2000) also referred to the difference in coping styles among male and female HSWs, as the latter group tend to seek social support more frequently than their male counterparts.

The existing literature related to controlling job stress in the clinical social work domain has recently proposed additional coping mechanisms. For example, Yi et al. (2018) adopted a broader perspective, proposing that HSWs could engage themselves in various activities to cope with workplace stress; e.g. eating tasty food, watching movies, reading books, travelling, meeting friends, drinking coffee or tea, taking break from work or going to the gym. Additionally, Yi et al. (2018) repeated the views of scholars like Ting et al. (2008) and Kraemer (2013) who emphasised the effectiveness of instrumental support provided by supervisors and regular meetings with colleagues to share ideas about work problems. Furthermore, they also suggested that HSWs could minimise the effects of stress by separating their professional and personal lives.

As discussed above, a number of studies have been conducted detailing strategies to cope with occupational stress. However, much research is still needed to comprehensively understand how HSWs navigate work-related stresses (Lloyd et al., 2005; Coyle et al., 2005). Notably, the existing empirical work has largely been undertaken in western contexts, distinguished with unique cultural attitudes and norms that might not represent Arabic societies. Therefore, more

research needs to be conducted in clinical social work in an Arabic context to understand how HSWs experience workplace stress in view of prevailing norms that might choice of coping strategies.

Research Aim and Research Question

The review of the present literature revealed a number of studies that predominantly targeted the experience of occupational stress among health care professionals. Relatively, empirical evidence has clarified that occupational stress in health care organisations seem to increase over time, however, further research investigating the factors associated with occupational stress and coping strategies in HSWs' workplaces are needed. The current review addressed the limited information about the effect of HSWs' personal factors on perceptions of the occupational stress experience. In addition, the subject under investigation was not explored in depth, since the majority of the studies conducted are exclusively quantitative in nature. Consequently, this study aims to explore factors related to workplace stress, in addition to the strategies used to cope with job-related stress, according to the experiences of HSWs in Saudi Arabia (SA), bearing in mind possible association between HSWs' demographic characteristics and other factors associated with workplace stress, and the different coping mechanisms utilised. The research questions developed to fulfil the aim of the current research are as follows:

RQ1. What are the key factors contributing to the occurrence of work-related stress in HSWs workplaces in SA?

The first research question prompted the emergence of the following sub-questions:

- Are there any factors that could expose HSWs to stress in their workplaces in SA?
- Is there any impact from HSWs' demographic characteristics on factors contributing to work-related stress?

RQ2. How do HSWs in SA cope with current experiences of work-related stress?

This led to the following sub-questions:

- Are there any strategies that could enable HSWs to overcome work-related stress in SA?

- Is there any impact from HSWs' demographic characteristics on the coping strategies selected?

By answering these questions, the researcher aims to attain a clear understanding of the key factors that influence Saudi HSWs workplace stress, as well as the mechanisms empowering them to overcome work-related stress, also considering any relationship between HSWs' demographic features and their responses. The information gathered for the present study may serve to develop a body of knowledge in the domain of health social work practice that might enable officials and policy-makers to reconsider existing policies and regulations, in order to effectively improve HSWs' workplace environments so as to reduce the occurrence of job stress.

The next chapter concerns the empirical part of the current study, which offers the reader a detailed description of the chosen research design, and the methods employed to gain data relevant to the topic being studied.

Chapter Four: Research Methodology

Overview

This chapter explains the methodological process used to address the research questions and aims of the study. It begins by discussing the different research designs that are utilised in this field, and then describes and justifies the paradigm selected to guide this study, in addition to the research approach employed. The data collection techniques are also presented, together with detailed information about the sampling strategies employed in both data collection phases, and the strategies applied to analyse the data throughout the research phases. Finally, the quality of the research process is examined, in order to enhance the validity of the research, and to identify the limitations associated with the methodological approach chosen.

As discussed in Chapter One, this study explores the factors related to workplace stress, according to the experiences of Health Social Workers (HSWs), in addition to the strategies they use to cope with job-related stress. It also considers the impact of HSWs' demographic characteristics and other factors related to workplace stress, and the different coping mechanisms chosen by these individuals. In order to achieve these aims, the constructivist grounded theory methodology (CGTM) was selected, to enable the researcher to gain rich, deep, and informative data that would contribute to the formulation of a framework that could guide future studies concerned with the factors relating to stress and coping mechanisms in the field of health and social work in Saudi Arabia (SA), since no previous empirical work has explore this topic. The study pursued the following research questions:

Two principal research questions were generated for this purpose:

RQ1. What are the key factors contributing to the occurrence of work-related stress in HSWs workplaces in SA?

The first research question prompted the emergence of the following sub-questions:

- Are there any factors that could expose HSWs to stress in their workplaces in SA?
- Is there any impact from HSWs' demographic characteristics on factors contributing to work-related stress?

RQ2. How do HSWs in SA cope with current experiences of work-related stress?

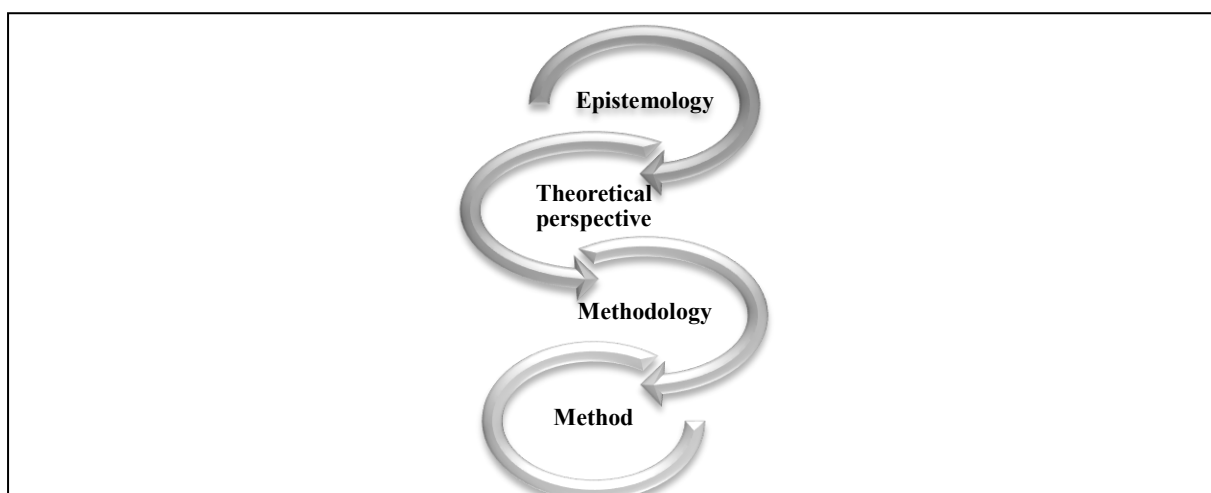
This led to the following sub-questions:

- Are there any strategies that could enable HSWs to overcome work-related stress in SA?
- Is there any impact from HSWs' demographic characteristics on the coping strategies selected?

Research paradigm

In social science research, all studies should be based on a number of essential components that together shape the research design (Denzin and Lincoln, 1994; Crotty, 1998; Saunders, Lewis, and Thornhill, 2009; Gray, 2013). Nevertheless, inconsistency in the use of different research elements and terminology is problematic and can be a source of confusion amongst scholars (Merriam and Tisdell, 2015). For example, Saunders, Lewis and Thornhill (2009, p. 108) proposed a research design that consisted of six fundamental elements, namely, “*philosophies, approaches, strategies, choices, time horizons, techniques and procedure*”. In contrast, Denzin and Lincoln (1994) indicated that there are three main assumptions that shape a research framework, namely ontological, epistemological, and methodological assumptions. However, Crotty (1998) rejected the research elements suggested by Denzin and Lincoln (1994), and instead presented a research design based on four considerations: epistemology, theoretical perspective, methodology, and methods (see Figure 5), defending this framework by arguing that differentiating between ontology and epistemology, and treating the two concepts separately is wrong, as both ontology and epistemology are dependent on each other and work together to address the same dimension, namely a researcher's position.

Figure 5. Crotty's research elements



(Source: Crotty, 1998, p. 8).

The disparity between the arguments proposed by Crotty (1998) and Denzin and Lincoln (1994) have been widely discussed, in terms of the appropriateness of combining or separating ontology and epistemology within a research design (Bryman, 2008; Creswell and Creswell 2017). For instance, Bryman (2008) emphasised the need to incorporate ontology and epistemology within a study framework, maintaining that each element has importance, as the inclusion of ontology in a study framework enables the researcher to examine the nature of reality objectively and subjectively, while the inclusion of the epistemological aspect enables the investigator to examine a given situation empirically.

The variations in the ontological and epistemological views adopted by different researchers causes differences in the philosophical approach to research (Denzin and Lincoln, 2011). For example, while positivist investigators treat their samples objectively, employing quantitative methods that ensure their participants' answers are independent, and not affected by the researcher, post-positivists partially modified the level of researcher objectivity, stressing the impact of the researcher's own knowledge, values, and background in formulating research questions and interpreting findings (Denzin and Lincoln, 2011). Additional approaches, such as critical theory and a feminist approach, were developed and employed to investigate issues that require working towards change and the transformation of existing social structures. Research guided by these two approaches is based on the assumption that reality has been shaped, over time, through a combination of political, social, cultural, ethnic, and gender

factors, and also concerns the study of powerless people (Robson, 2002; Denzin and Lincoln, 2011; Bryman, 2014)

As social science research developed, constructivism was increasingly utilised as a research paradigm to investigate the experiences of human beings, based on the assumption that knowledge is formed by a combination of individual experiences, and the context in which that person lives (Robson, 2002; Charmaz, 2006; Denzin and Lincoln, 2011). The constructivist philosophy rejects the existence of an objective reality, replacing this concept with intersubjective reality, based on the assumption that the mind determines an individual’s reality (Denzin and Lincoln, 1994; Creswell and Creswell 2017). Consequently, human experiences of certain phenomena vary, depending on individual differences, as each person perceives their own reality, according to the social construction of their perception, as well as the culture and context in which they exist; thus, knowledge is produced by social and cultural interactions between humans and their social environment (Denzin and Lincoln, 1994; Creswell and Creswell, 2017) (see Figure 6).

Figure 6: Denzin and Lincoln’s research paradigms

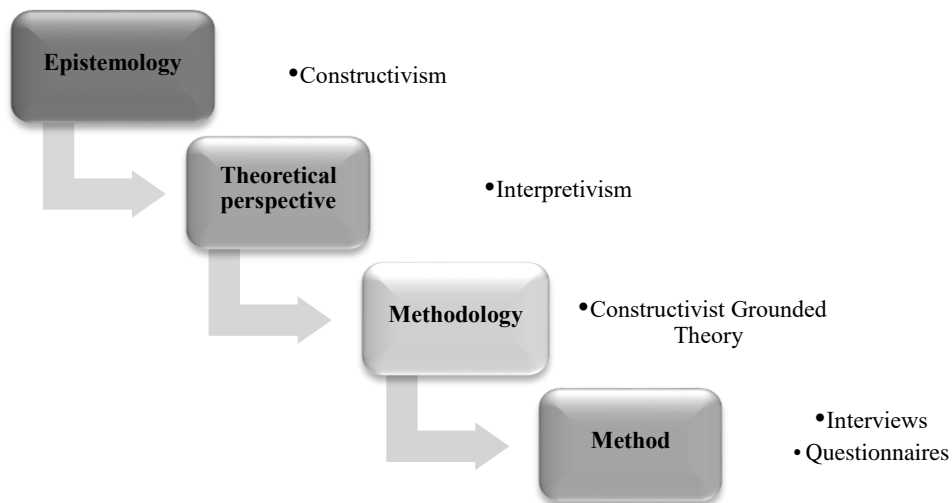
<i>Item</i>	<i>Positivism</i>	<i>Postpositivism</i>	<i>Critical Theory et al.</i>	<i>Constructivism</i>
Ontology	naive realism— “real” reality but apprehendable	critical realism— “real” reality but only imperfectly and probabilistically apprehendable	historical realism— virtual reality shaped by social, political, cultural, economic, ethnic, and gender values; crystallized over time	relativism—local and specific constructed realities
Epistemology	dualist/objectivist; findings true	modified dualist/ objectivist; critical tradition/community; findings probably true	transactional/ subjectivist; value- mediated findings	transactional/ subjectivist; created findings
Methodology	experimental/ manipulative; verification of hypotheses; chiefly quantitative methods	modified experi- mental/manipulative; critical multiplism; falsification of hypotheses; may include qualitative methods	dialogic/dialectical	hermeneutical/dialectical

(Source: Denzin and Lincoln, 1994: 109).

After reviewing the existing disparity in the research world regarding the different components of research, Crotty’s (1998) research paradigm was selected to inform the methodological framework of the present research, due to its clarity and comprehensiveness, as it covers all of

the details that the investigator intended to include within the research elements to achieve the aims of the study. The research design of the present study therefore consisted of four elements: epistemology, theoretical perspective, methodology, and method (see Figure 7).

Figure 7: Research design of the present study



(Source: adapted from Crotty, 1998: 8).

Epistemology (constructivism)

According to Yin (2008, p. 309), epistemology is “*the philosophical underpinnings of researchers’ beliefs regarding the nature of knowledge and how it is derived or created*”. This definition emphasises the importance of the researcher’s epistemological position throughout the research process for determining the type of knowledge that can be obtained, as well as its legitimacy (Maynard, 1994). In this regard, Crotty (1998) outlined three main epistemological stances, namely objectivism, subjectivism, and constructionism. Constructionism adopts the position that meaning is constructed from human experiences, and the approach is therefore perfectly suited to the purposes of most of social research (Crotty, 1998). Moreover, Crotty (1998, p. 58) differentiated between constructionism and constructivism as epistemological positions, suggesting that constructivists focus exclusively on “*the meaning making activity of the individual mind,*” while researchers who adopt constructionism are mainly concerned with “*the collective generation of [and transmission] of meaning*”. In doing so, constructivists emphasise the external validity by assuming that reality is constructed differently by each

individual, as ways of making sense of the world vary from person to person. Meanwhile, social constructionism stresses the impact of society on shaping meaning, and the ways that individuals experience the world (Crotty, 1998).

For the present study, the researcher judged constructivism to be the most appropriate epistemological stance for fulfilling the aim of the study, as well as for addressing the research questions concerned. This was deemed to be the case because the reality that this study sought to explore was dependent on the participants' (HSWs') individual experiences, as each participant had different experiences of work-related stress, and there was also a disparity in their socioeconomic conditions. Thus, a constructivist approach would provide a better understanding of the phenomena under exploration, as argued by Creswell (2013, p. 8)

In this worldview, individuals seek an understanding of the world in which they live and work. They develop subjective meanings of their experiences ... These meanings are varied and multiple, leading the researcher to look for the complexity of views ... Often these subjective meanings are negotiated socially and historically. In other words, they are not simply imprinted on individuals but are formed through interaction with others (hence social constructivism), and through historical and cultural norms that operate in individuals' lives.

Theoretical perspective (interpretivism)

According to Crotty (1998, p. 3), the theoretical perspective can be defined as a “*philosophical stance informing the methodology, and thus providing a context for process and grounding its logic and criteria*”. He identified several theoretical perspectives, including positivism, interpretivism, feminism, and critical inquiry. In the domain of the social sciences, in which researchers seek to understand human interaction with social life, the interpretive perspective is the most widely used theoretical perspective (Robson, 2002; Denzin and Lincoln, 2011; Creswell and Creswell 2017). This is due to the fact that social science research primarily explores how humans understand and respond to certain phenomena, taking into consideration the contribution of the social circumstances surrounding the individuals being investigated (Creswell and Creswell 2017). Moreover, Crotty (1998, p. 67) emphasised the suitability of the interpretivist philosophy for social science research, stating that interpretivists are concerned

with “culturally derived and historically situated interpretations of the social life-world”. Meanwhile, according to Walsham (1993, cited in Guest, Namey, and Mitchell, 2012, p. 5)

Interpretive methods of research start from the position that our knowledge of reality, including the domain of human action, is a social construction by human actors and that this applies equally to researchers. Thus, there is no objective reality which can be discovered by researchers and replicated by others, in contrast to the assumptions of positivist science.

Therefore, interpretivists depend heavily on the constructivist epistemology for understanding reality, assuming it to be socially constructed (Glesne and Peshkin, 2011).

For the current study, the interpretivist perspective was judged to be the most appropriate for addressing the research aims and questions of the main phase of this study, while a quantitative phase was employed to seek the verification of the data obtained from the main study phase (Charmaz, 2006; Birks and Mills, 2015; Charmaz, 2017). Consequently, the study applied a wholly interpretivist perspective to explore the experiences of work-related stress, and how the HSWs described it as a phenomenon embedded within their social world. The interpretive theoretical approach enabled the current study to gain in-depth information about a particular human experience, namely job-related stress, that may interact significantly with number of social and cultural aspects present within the Saudi context (Crotty, 1998).

Methodology (constructivist grounded theory)

According to Crotty (1998, p. 3), methodology is “*the strategy, plan of action, process or design lying behind the choice and use of particular methods and linking the choice and use of methods to the desired outcomes*”. According to this definition, an investigator’s choice of research methodology is influenced by the purpose and aims of a study (Charmaz, 2006). Meanwhile, Crotty (1998) cited various methodological approaches that can be employed when designing a research study, including experimental research, surveys, ethnography, discourse analysis, phenomenological research, action research, feminist standpoint research, and grounded theory.

Several methodologies suggested in the extant literature were suitable for the present study (Crotty, 1998; Morgan, 2007; Gray, 2013; and Creswell and Creswell, 2017). For example,

although it is sometimes best to conduct feminist research in communities in which women's rights are ignored or denied, due to cultural traditions and beliefs, such as in SA, the application of such an approach for the present research would not have helped to fulfil the research aims. This was because the study aim to explore the experience of work-related stress taking into account gender difference in terms of these experiences, regardless of women's position in SA (Robson, 2002). Meanwhile, a case study design is recommended when a researcher seeks to gain in-depth explanations for a certain phenomenon or social behaviour (Robson, 2002; Yin, 2009; Creswell and Creswell 2017). However, there are certain drawbacks associated with the use of case studies in relation to the very limited number of individuals who can be involved as the subject of a study, together with the approach's focus in a certain narrow context. This can affect the process of generalising a study's findings to the wider population (Denzin and Lincoln, 2011; Creswell and Creswell, 2017; Bryman, 2014).

For the purpose of the present study, since no extant research investigated the matter of the experience of work-related stress from the perspective of HSWs in SA, a grounded theory methodology (GTM) was chosen to guide the study. This approach has a number of attractive features that would be beneficial for the purposes of this exploration study, such as its suitability for collecting in-depth and rich data from the HSWs regarding an unexplored area (Crotty, 1998; Charmaz, 2006; Bryant and Charmaz, 2010; Denzin and Lincoln, 2011; Charmaz, 2017). A further beneficial factor of the methodology for the present study was its flexibility, in terms of the integration of several methods that enable the researcher to construct a theory through the application of systematic analysis (Glaser and Strauss, 1967; Charmaz, 2006; Bryant and Charmaz, 2010).

According to Glaser and Strauss (1967, p. 1), a GTM is "*the discovery of theory from data systematically obtained and analysed in social research*". Meanwhile, Bryant and Charmaz (2010, p. 1) added that this process primarily involves a "*systematic, inductive, and comparative approach for conducting an inquiry for the purpose of constructing theory*". The book, '*The Discovery of Grounded Theory*' was published by Glaser and Strauss (1967) as a critique against the approach used by positivists to develop theory, encouraging researchers to actively engage with the field to collect data, in order to generate theory from naturalistic data, instead of "*deducting testable hypotheses from existing theory*" (Charmaz, 2006, p. 4). However, such theories must relate to the context in which they were developed (Charmaz, 2006; Bryant and Charmaz, 2010; Somekh and Lewin, 2011).

Historically, three main versions of grounded theory have dominated the research field, including the 'classical' (Glaserian) version, Strauss and Corbin's (1998) more structured approach, and the constructivist version developed by Charmaz (2006) (Somekh and Lewin, 2011). According to Willig (2013), there are fundamental differences between the various versions of GTM; for example, Glaser and Strauss (1967) asserted that grounded theory research ends with theory building, and therefore that the theory already exists within the data, and there is no need for researcher interaction or interpretation in order to construct a theory. However, other researchers (Corbin and Strauss, 1998; and Charmaz and Belgrave, 2012) criticised the objective epistemological position advocated by Glaserian GTM, instead emphasising the role of induction and construction, versus deduction and discovery, which complements qualitative approaches (Willig, 2013).

Moreover, Charmaz (2002) argued that the Glaserian version of grounded theory does not suit the aims of social sciences research, and is instead more suited to the constructivist paradigm, according to which reality is constructed. She developed the CGTM approach, based on Glaser and Strauss's (1967) version of grounded theory, although she criticised their approach, stating that it calls for the generation of theory from data in a way that is independent of the scientific observer, which implies that reality already exists externally. Instead, Charmaz (2002) emphasised the role of researchers in constructing grounded theory by interacting with participants in the research process. In this approach, the role of participants in constructivist grounded theory research is to impart meaning and provide experiential views, whereas the researcher uses their interpretive skills to build grounded theory from the data obtained. Hence, Charmaz's (2002, p. 510) CGTM stressed the importance of interpretive analysis in knowledge construction, and she stated

I add ... another vision for future qualitative research: constructivist grounded theory. Constructivist grounded theory celebrates firsthand knowledge of empirical worlds, takes a middle ground between postmodernism and positivism, and offers accessible methods for taking qualitative research into the 21st century. Constructivism assumes the relativism of multiple social realities, recognizes the mutual creation of knowledge by the viewer and the viewed, and aims toward interpretive understanding of subjects' meanings.

The main feature that distinguished the CGTM advanced by Charmaz (2002) was the application of a constructivist approach in the treatment of data, and in the production of

analytical outcomes. Researchers following this approach seek meaning in the data collected, considering values, beliefs, and ideologies, since that meaning is obtained via interaction between the researcher and the participant(s) (Charmaz, 2002; 2017a). In this regard, Charmaz (2006) highlighted the importance of individual experiences for constructing meaning, in addition to the researcher's interpretation of the topic under study, and the structural contexts, when using a GTM.

For the purpose of the current study, the researcher chose to follow Charmaz's (2006) CGTM approach, because it was appropriate for a study that sought to explore the lived human experiences of HSWs in a complex and unique context, namely SA. This was because GTMs in general employs an inductive approach for understanding a given phenomenon, and therefore enabled the researcher to understand why these HSWs were exposed to job-related stress in their workplace, and how they dealt with it (Charmaz, 2006; 2017b; Lingard, Albert, and Levinson, 2008; Priya, 2019). Furthermore, the generation of a framework to potentially be applied to a specific social context, especially to explore a topic that has not previously been studied through the lens of grounded theory, requires extensive efforts to ensure that it considers more than one perspective and source, in order to construct the social meaning of the job-related stress factors and coping mechanisms of HSWs in the workplace from different individuals' experiences.

Justification for adopting the quantitative phase

According to May (2011), conducting social science research is a dynamic process, and a research paradigm is not a closed system. This statement enhances the flexibility that researchers have when selecting data collection methods, according to the research problem to be addressed, as indicated by Charmaz (2006). Research methods are defined as "*the techniques or procedures used to gather and analyse data related to some research question or hypothesis*" (Crotty, 1998, p. 3); this implies that a researcher can employ either one method or several to achieve the research goals, and to develop firm and well-researched conclusions about the subject under study (Lincoln and Guba, 2000; Robson, 2002; Creswell and Creswell, 2017).

According to Creswell and Creswell (2017), the shortcomings of quantitative methodologies, such as using questionnaires that are based on closed-ended scales, can be overcome by approaches to research that employ mixed methodologies as part of a qualitative approach,

which enhances the strength of the study, and compensates for the lack of exhaustiveness associated with the quantitative approach as a result of its objectivity. Moreover, Creswell and Creswell (2017) maintained that, while employing a qualitative approach provides an opportunity to explore and understand individuals' interactions with certain phenomenon within a particular social setting, quantitative methodologies offer an opportunity to reduce the phenomenon being evaluated to different, simpler sections that can then be studied more closely.

In contrast, many scholars argued that the application of mixed methods within one study is problematic, due the difference in the ontological and epistemological basis of the approaches used (Hall and Howard, 2008; Flick, 2014; Guetterman, Babchuk, Howell Smith, and Stevens, 2019). However, Johnson and Onwuegbuzie (2004) responded to this argument by stating that there are common features of both qualitative and quantitative methods that can make the use of mixed methodologies less complicated, because both methodologies adopt approaches that engender the segmentation of different aspects of the subject under study. Both methodologies, in their attempts to explain a phenomenon, view the different aspects of that phenomenon as independent. Therefore, the two approaches can be applied together, within a single study, without introducing conflict in terms of the study design, data collection, or management.

In relation to GTMs, although some scholars claimed that the incorporation of qualitative and quantitative methodologies within a single study gives the study distinctive qualities associated with each approach (Strauss and Corbin, 1998), the combination of the two remains a relatively controversial issue (Charmaz, 2017; Biaggin and Wa-Mbaleka, 2018; Guetterman et al., 2019). Moreover, Guetterman et al. (2019) concluded that although mixed methods are widely used in studies guided by a GTM in different areas of research, theoretical development remains absent within such studies. This was supported by Biaggin and Wa-Mbaleka (2018), who claimed that a number of scholars, such as Birks and Mills (2015) and Mills, Bonner and Francis (2006) emphasised the differences in philosophical stance among the three versions of GTM, according to the methods used for data collection. However, Charmaz (2006) considered GTMs to be philosophically neutral, as it is "*a container into which any content can be poured... rather than seeking an inherent philosophical bias that may or may not be present in the method*" (P. 9). In this regard, Birks and Mills (2015) added a valuable point concerning the reliance of all versions of GTM on common elements, such as constant comparison, theoretical sampling, memo writing, theoretical saturation, and coding, throughout the investigation process.

Consequently, and since it is possible to employ quantitative methods alongside qualitative techniques in research guided by a GTM (Charmaz, 2002), both qualitative and quantitative approaches were employed in the present study. This was in order to accurately address the research questions and aims, concerning the stress factors and coping mechanisms in HSWs' workplaces. According to Denzin and Lincoln (1994), the use of both approaches is strongly recommended to enable the researcher to generate and verify a theory at the end of a study. This suggestion was supported by Creswell (2006), who stressed that constructivist researchers should not depend solely on qualitative data collection and analysis, as quantitative data, such as demographic data, enables the researcher to verify issues related to the participants' conditions.

The research process employed for the present study commenced with a qualitative approach for the main phase, namely semi-structured interviews, followed by the quantitative second phase, namely the survey. Designing the data collection process to follow this order enabled the researcher to firstly gain informative and rich data about the HSWs' experience of job-related stress in their workplaces during the first phase of data collection (Onwuegbuzie and Teddlie, 2003). This was not only helpful for allowing the researcher to choose an appropriate standardised tool [i.e. the Expanded Nursing Stress Scale (ENSS)] to measure work-related stress in the second survey phase (quantitative), but also played crucial role in verifying the outcomes of the qualitative aspect (Creswell, 2017).

The main study phase (semi-structured interviews)

Many scholars recommend the use of interviews for data collection in qualitative research, as this enables the researcher to obtain greater insight regarding the respondents' experiences, emotions, and backgrounds (Mack, Woodsong, McQueen, Guest et al., 2005; Charmaz, 2006; Schultze and Avital, 2011; Seidman, 2013). According to Kavle (1996, p. 14), an interview can be defined as *"a construction site for knowledge. An interview is literally an inter-view, an inter-change of views between two persons conversing about a theme of mutual interest"*. Meanwhile, Ritchie and Lewis (2003) claimed that interviews, as data collection instruments, help researchers to access participants' social world and experiences, which can prove highly effective for the data analysis phase, as the researcher can interoperate the findings, according to these social considerations. In terms of CGTM, Charmaz (2006) argued that theory cannot

be discovered in an objective way; rather, it is constructed in an interpretive way, according to the interviewees' experiences and the researcher's own interpretation. Therefore, interviews are important for determining respondents' backgrounds and feelings, since they help to place the respondents' responses and behaviours into context (Charmaz, 2006).

According to Saunders et al. (2009), there are three forms of interview: unstructured, semi-structured, and structured. Semi-structured interviews are the most widely used format in qualitative research, due to their flexibility in terms of question formulation, which can be designed in the form of an interview schedule, as well as while conducting the interview (Robson, 2002). In addition, semi-structured interviews increase the interviewer's ability to control the interview, by asking questions in an order that suits the participant. Furthermore, it permits the researcher to be responsive to any relevant issues raised during an interview, which helps to facilitate a deeper understanding of the topic being investigated, and thus the construction of the social meaning of the reality, which is required in studies guided by the GTM to build a theory based on individuals' experiences (Ritchie and Lewis, 2003; Charmaz, 2006; Creswell, 2011).

In this study, semi-structured interviews were conducted with a total of 18 HSWs (nine males and nine females), who were purposively selected in the main phase of this research (see Figure 8). The researcher selected this type of interview because a constructivist perspective guided the study, and therefore flexibility in the data collection process was required, in order to allow the researcher to ask further questions, or to modify the interview schedule according to the interviewees' responses (Bufkin, 2006; Charmaz, 2006; Bryman, 2008). Considering the nature of the Saudi context, the literature review guided the formulation of the questions in the interview schedule, which consisted of two main sections related to the key research questions. The first section gathered information regarding the factors that may contribute to the occurrence of stress in the HSWs' workplaces, whereas the second section addressed the strategies that the participants employed to cope with their work-related stress (see Appendix 2).

Moreover, since the study was guided by the CGTM, the interviews were transcribed and coded immediately after they had occurred, namely after each interview. Hence, the initial findings from the interview coding of the earlier interviews helped to provide additional questions, namely follow up questions, for the subsequent interviews, in attempt to gain further and deeper information regarding the issues raised within the previous interviews. Each interview lasted

between 60 and 90 minutes, and was conducted at the HSWs' workplaces, at a time agreed in advance. The interviews were conducted in Arabic, the native language of the HSWs and the researcher, and were recorded, to ensure data accuracy, as well as help the researcher with the data coding and analysis (Bell, 2010). Finally, the interviews were conducted in a private room at the participants' workplace, in order to insure confidentiality.

The survey phase (questionnaire)

Questionnaires are commonly used in research studies to collect data from a large number of participants in a short timeframe, either in addition to interviews, or as the only data collection method when the use of interviews is not possible (Robson, 2002). A questionnaire consists of a list of questions that seek to understand the participants' views about a certain subject. Two types of questions can be included in questionnaires, according to the aims of the study: open-ended and closed-ended questions (Boynton and Greenhalgh, 2004). Questionnaires employ closed-ended questions that restrict responses to within pre-defined groups. There are various types of closed-ended questions, for example dichotomous questions that provide two mutually exclusive options, such as 'yes' or 'no', and multiple-choice questions that provide a wider range of options, sometimes allowing respondents to choose more than one option. The third type of closed-ended questions is Likert scale questions, in which a numbered point scale is used as a direct measure of attitude, according to respondents' level of agreement or disagreement with a given statement (Cummings, Savitz, and Konrad, Three; Robson, 2002; Boynton and Greenhalgh, 2004).

The use of questionnaires offers many advantages; for example, it enables the researcher to collect data from different locations or individuals concurrently, without the need for physical attendance (Cummings et al., 2001). Moreover, since most research maintains anonymity in the administration and collection of data, sensitive information can be obtained from the participants, as their identities are not disclosed to the researcher. However, the extant literature indicated several limitations associated with the use of questionnaires. For example, questionnaire surveys can fail to capture the actual thoughts of respondents, since predefined categories may not be representative of the respondents' opinions (Cummings et al., 2001; Robson, 2002; Boynton and Greenhalgh, 2004). Moreover, the responses obtained from closed-ended questions cannot be subjected to further exploration, and they therefore fail to

address the various aspects of the subject under study exhaustively. Additionally, the use of self-administered questionnaires prevents the researcher from observing the emotions and behaviour of the respondents, associated with the issue being investigated (Robson, 2002).

In this study, a self-administered questionnaire was used to collect data from HSWs in the survey phase, due to its effectiveness for collecting data from a large number of people in a short period of time. Specifically, approximately 200¹⁶ questionnaires were distributed across the same public hospitals selected within the first phase and supervised by the SA Ministry of Health (MoH) in the cities of Makkah and Jeddah (see Figure 8). The researcher personally provided 10¹⁷ questionnaires to the manager of Social Work Departments (SWDs) at each hospital, and they were responsible for delivering the questionnaire to all HSWs, and for collecting the completed questionnaires from them. The questionnaires were collected in closed envelopes, after completion by the participants, in order to maintain confidentiality, in accordance with research ethics requirements. The selection of this research instrument enabled the researcher to collect the data required within a limited timeframe of one month, which was necessary to fulfil the requirement of the PhD degree's completion in specific period of time.

The questionnaire consisted of three main sections, in addition to the covering letter that explained the aims of the study, as well as providing the name and contact details of the researcher (mobile number, WhatsApp, and email address). The confidentiality of the participants was also stressed in the covering letter, to reassure the potential participants and to encourage them to participate in the study. The first part of the questionnaire was descriptive that included multiple-choice questions related to the HSWs' demographic data, such as gender, age, marital status, academic qualifications, specialisation, job type, and number of years of fieldwork experience. This is because one of the study's aims was to explore the association between the HSWs' experiences of work-related stress and the coping strategies they employed, and their demographic information.

The second section of the questionnaire was concerned with identifying the specific job-related stress factors in the HSWs' responses. The ENSS was used to identify the HSWs' responses, which rates the stressful situation that nurses can experience in their workplaces, as the HSWs in the present study may have been exposed to similar stressors reported by others in the

¹⁶ Since the total number of Saudi HSWs in public hospitals that are supervised by the MoH is nearly 200.

¹⁷ At each public hospital, there are approximately eight to 10 permanent HSWs, along with additional temporary positions in social work departments within SA hospitals (MoH, 2017).

profession, as identified in the literature review (Chapter Three). The ENSS consists of nine subscales, including the following: death and dying (seven items), conflict with physicians (four items), inadequate preparation (three items), problems with peers (six items), problems with supervisors (seven items), workload (eight items), uncertainty concerning treatment (nine items), patients and their families (eight items), and discrimination (three items). However, after seeking the permission of the ENSS' primary author (French, Lenton, Walters, and Eyles, 2000), some changes were made to some of these items, in order that they were applicable to the sample under exploration in the present study, namely the HSWs (see Appendix 3). These HSWs were asked to respond to each item, in terms of "How stressful it has been for you?" using a response scale of 0 = does not apply, 1 = never stressful, 2 = occasionally stressful, 3 = frequently stressful, and 4 = extremely stressful. For the purpose of this study, the instrument was translated into the Arabic language, since the target population was Arabic speaking, and was then back translated into English by a certified translation office (see Appendix 4).

The last part of the questionnaire was concerned with determining the strategies the HSWs employed to cope with stress cause by their workplace. In order to achieve this, the Brief Cope Scale (BCS) (Carver, 1997) was used; there was no need to obtain the author's permission to use this scale, as it was largely used in its original form for the purpose of the present study. The BCS consists of 14 subscales that involve variations of problem-focused and emotion-focused strategies, including the following: self-distraction (two items), active coping (two items), denial (two items), substance use (two items), use of emotional support (two items), use of instrumental support (two items), behavioural disengagement (two items), venting (two items), positive reframing (two items), planning (two items), humour (two items), acceptance (two items), religion (two items), and self-blame (two items). The participants were asked to rate their agreement with each item by stating 1 = I haven't been doing this at all, 2 = I've been doing this a little bit, 3 = I've been doing this a medium amount, or 4 = I've been doing this a lot. This instrument was also translated into the Arabic language, then back translated into English by certified translation office, in order to suit the aim of this study (see Appendix 4).

In empirical terms, the scales used were validated survey tools that were employed previously by studies that investigated the experience of workplace stress in healthcare professionals in many parts of the world, including the United States, Canada, Serbia, SA, and Thailand. Both scales were deemed to be appropriate for the purpose of the present study, as it was conducted in SA, a country with a culture that is distinguished by certain power relationships within the family and social relationships in a person's life, namely the attitudes of patients' families, as

well as that of social support, that may influence the ways in which the HSWs involved in the study perceived the experience of workplace stress.

It is important to mention that some modifications were made to the scales used, after gaining authorisation from tool's author, where necessary (see Appendix 6), in order to make the statements that measured the issue under exploration more appropriately for the target group, and for the nature of Saudi culture where this study was undertaken. For example, in the ENSS, the word 'nurses' and 'nursing' was replaced with 'HSWs' and 'health social work', respectively. Moreover, a number of changes were made to the ENSS subscales to suit the nature of the HSWs' work structure, according to the data obtained in the main phase of the study's data collection, namely the semi-structured interviews. This was particularly in relation to the categories of death and dying, workload, and uncertainty concerning treatment as influential factors for job-related stress. For instance, a slight change was made to one of the items under the death and dying subscale, namely 'Performing procedure that patients experience as painful', which was amended to 'Performing procedure that bothers patients'. This was because the original statement referred to procedures that were not strictly associated with HSWs' tasks that might be perceived as painful by patients, such as drawing blood. Furthermore, two of the items that measured workload were modified as follows: 'Unpredictable staffing and scheduling' was replaced with 'Working hours and scheduling (*e.g. night shift*)'; 'Demands of patient classification system'¹⁸ was exchanged for 'Promotion and evaluation system for HSWs' performance', as this reflected issues that were more appropriate to those experienced by nurses, and which accounted for their increased workload. Finally, one item under the uncertainty concerning treatment subscale was amended, namely, 'Uncertainty regarding the operation and functioning of specialized equipment', which was replaced with the 'Lack of resources and equipment that enable HSWs to perform their tasks'.

Similarly, a slight modification was made to the Brief COPE Scale, specifically to the substance use subscale, for which the statement, 'I've been using alcohol or other drugs to make myself feel better' was replaced with 'I've been smoking to make myself feel better'. Additionally, the item, 'I've been using alcohol or other drugs to help me get through it' was changed to, 'I've been using cigarettes or shisha¹⁹ to help me get through it'. The reason for

¹⁸ A patient classification system is a method for grouping patients, according to the amount and complexity of their nursing care requirements; it is used to assist a nurse leader to determine workload requirements and staffing needs.

¹⁹ Shisha is very popular in Egypt and other Arabic-speaking countries; it is a hookah tobacco for smoking in a hookah, especially when mixed with flavourings, such as mint.

these modifications to the substance use subscale is that the religious and legal rules in Saudi society, where this study was undertaken, forbid the consumption of any amount of alcohol or other addictive substances, such as hashish and heroin (Al-Haqwi, 2010). However, according to Mansour (2017), the prevalence of tobacco and shisha smoking is considered to be high in SA, particularly in the western region of the country. Consequently, it can be suggested that smoking among healthcare professionals in the western region of SA, including Makkah and Jeddah cities, where the present study was undertaken, was likely to be widespread (Mansour, 2017).

Piloting the questionnaire

In order to verify that the modifications to the scales did not change the essence of the questionnaire, a pilot study was undertaken with 12 HSWs, who were excluded from both phases of main data collection. Using Statistical Package of the Social Sciences (SPSS) version 23, a Cronbach's coefficient alpha test was run to check the internal consistency of the modified version, along with a split-half coefficient to ensure the item-total correlation (see Appendix 5). A Cronbach coefficient value of at least 0.7 was considered to be satisfactory (Bland and Altman, 1997). Meanwhile, the face validity was also checked by sending the designed questionnaire to three professors who were experts in the Health Social Work field in SA, to ensure the applicability of the scales used for the targeted Saudi HSWs.

Sampling and data saturation

According to Charmaz (2006), theoretical sampling and data saturation are among the most important requirements of CGTM. The use of theoretical sampling in grounded theory helps to refine the emerging categories by assuming a narrow research focus (Charmaz, 2006). Researchers can use theoretical sampling either at the beginning of the research, or at a later stage (Charmaz, 2006). Despite the fact that sampling strategies can be diverse in social research, purposive sampling is possibly the most widely-used form, since it targets a purposefully selected population to provide rich information regarding the issue under investigation (Saini and Shlonsky, 2012). According to Polkinghorne (2005, p. 140), purposive sampling is "*a purposive selection of participants and documents that [can] serve as providers*

of significant accounts of the experience under investigation”. In this way, a researcher can, to some extent, guarantee the flexibility and adjustability of a sample size to meet the aims of a research study (Williamson, 2006).

In the context of the present study, and after obtaining the ethical approval of Hertfordshire University Ethics Committee (HUEC), and the Saudi MoH to conduct the research, a purposive sampling technique was employed to recruitment the participants. The researcher contacted the Directorate of Health Affairs in Makkah province, SA, which provided contact information for the managers of SWDs at each state hospital in Makkah and Jeddah cities, namely their mobile numbers and email addresses. However, only 12 hospitals were ultimately chosen to participate in this study²⁰ (see Table 1). At each hospital selected, the researcher met the manager of the social work department, who provided a list of the names of HSWs at the hospital, in addition to their personal and professional information. This enabled the investigator to initially choose 24 participants²¹, according to their personal and professional criteria, considering the variations in their gender, marital status, educational qualifications, specialisations, job type, years of fieldwork experience²², and their department of work. However, not all of the participants chosen were interviewed, or even contacted, rather a snowball technique was employed to the recruitment of the participants for the study, in order to ensure that the most relevant participants were included²³ (see Figure 8). According to Noy (2008, p. 623), snowballing is “*when the researcher accesses informants through contact information that is provided by other informants*”, therefore the snowball technique was useful for the present study for reaching a wide range of participants, who were not chosen primarily before the beginning of the data collection.

²⁰ There are 20 state hospitals in Makkah and Jeddah cities, but the researcher chose only those located within the cities to participate in the study, as the others were located on the city outskirts and could not be reached easily, due to their geographical location.

²¹ The researcher chose two participants (one male and one female) from each state hospital selected. However, in the case of the Maternity and Children’s Hospitals, no male participants were involved, as only female HSWs work with pregnant woman, according to Saudi tradition.

²² Fieldwork experience was calculated according to the HSWs’ number of years of working, with those who had worked for less than 10 years labelled ‘less experienced’ than those who had worked in the field for 10 years or more.

²³ In terms of variations in their demographic identities.

Table 1: State hospitals selected for this study

City	Hospitals
Makkah	King Faisal Hospital
	King Abdul-Aziz Hospital
	Maternity and Children Hospital
	Al-Noor Hospital
	Hiraa General Hospital
	Agyad Hospital
Jeddah	King Abdul-Aziz Hospital
	King Fahad Hospital
	King Saud Hospital
	Al-Amal Hospital
	Al-Thagr Hospital
	Maternity and Children Hospital

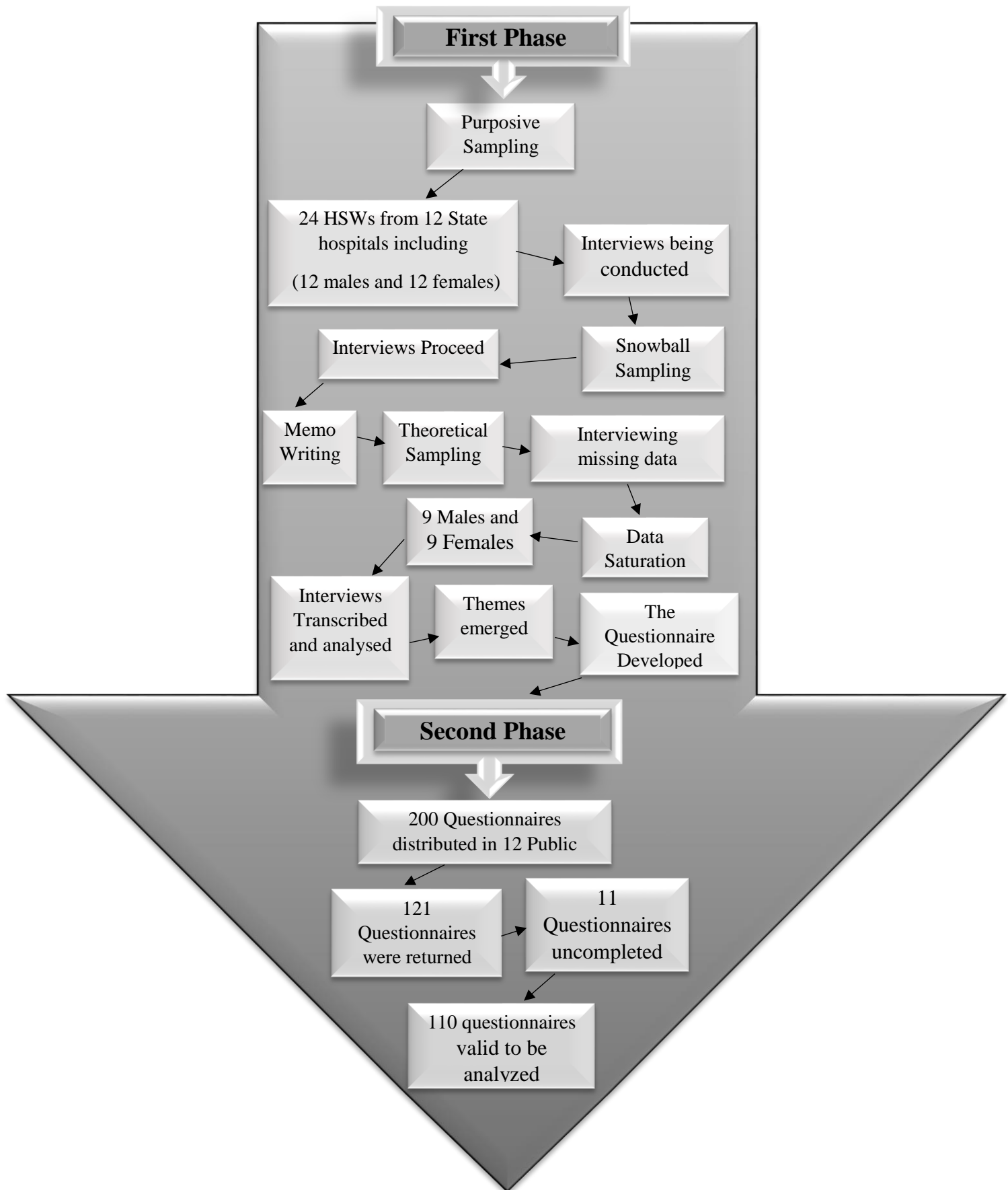
Furthermore, a theoretical sampling approach was crucial to ensure the inclusion of unarticulated voices that could add valuable information to enrich the current study (see Figure 8). As Charmaz (2006, p. 98) noted, theoretical sampling is a means of “*seeking and collecting pertinent data to elaborate and refine categories in your emerging theory*”. Thus, in this study, theoretical sampling was employed, relying on memo writing that helped to direct the investigator towards the missing data source during data collection process. This, in turn, contributed to the exploration of the phenomena of work-related stress more broadly (Charmaz, 2006). Finally, a total of 18 HSWs from different workplaces, and different personal and professional backgrounds, were interviewed in this research study (see Table 2).

Table 2: Interview participants' demographic information

Interview participant (N=18)	Gender	Age	Marital status	Qualification	Specialisation	Years of experience	Job type	Department(s)
1	Female	43	Married	Bachelor	Social work	10 Years	Permanent	Addiction
2	Male	38	Married	Bachelor	Social work	6 Years	Permanent	Internal Medicine
3	Female	37	Single	Master	Social work	3Years	Permanent	Home Health Care
4	Female	37	Married	Bachelor	Social work	11 Years	Temporary	Dialysis
5	Male	42	Married	Bachelor	Sociology	16 Years	Permanent	Cardiology
6	Female	53	Married	Bachelor	Social work	20 Years	Permanent	Mental Health
7	Female	49	Married	Bachelor	Sociology	17 Years	Permanent	Mental Health
8	Male	40	Married	Bachelor	Social work	13 Years	Permanent	General Hospital
9	Male	45	Divorced	Master	Social work	15 Years	Permanent	Addiction
10	Female	39	Single	Bachelor + Diploma	Social work	5 Years	Temporary	Maternity and Children
11	Female	40	Married	Bachelor	Social work	12 Years	Permanent	Maternity and Children
12	Male	25	Single	Bachelor	Social work	9 Months	Temporary	Patient Relations
13	Male	38	Married	Bachelor	Sociology	8 Years	Permanent	Home Health Care
14	Male	36	Married	Master	Social work	10 Years	Temporary	Mental Health
15	Female	30	Single	Bachelor	Nursing + Sociology	1 Year and 9 Months	Temporary	Oncology
16	Female	38	Engaged	Bachelor+ Diploma	Social work	9 years	Temporary	Internal Medicine
17	Male	28	Single	Master	Social work	2 Years	Temporary	Oncology
18	Male	50	Married	Bachelor	Sociology	29 Years	Permanent	Dialysis

The current study employed the concept of data saturation. As Clarke (2005, p. 186) explained, in order to achieve data saturation, research should continue to interview participants “*until nothing analytically useful is being collected*”. Meanwhile, Francis, Johnston, Robertson, Glidewell, Entwistle, Eccles, and Grimshaw, 2010, p. 1230) defined data saturation as “*the point in data collection when no new additional data is found that develop aspects of a conceptual category*”. It can be difficult to determine the exact sample size in such circumstances, since a researcher cannot predict when data saturation will be achieved, as it can be reached at either an early or a relatively late stage of the process (Charmaz, 2006; Bryman, 2014). In this study, although data saturation was reached by the 16th interview, when no additional information was added by the participants that furthered the aim of the study, two more interviews were conducted following saturation (one male and one female) to ensure that the researcher had reached the point at which no additional data was identified, and that including new participants would not contribute further to the objectives of the study.

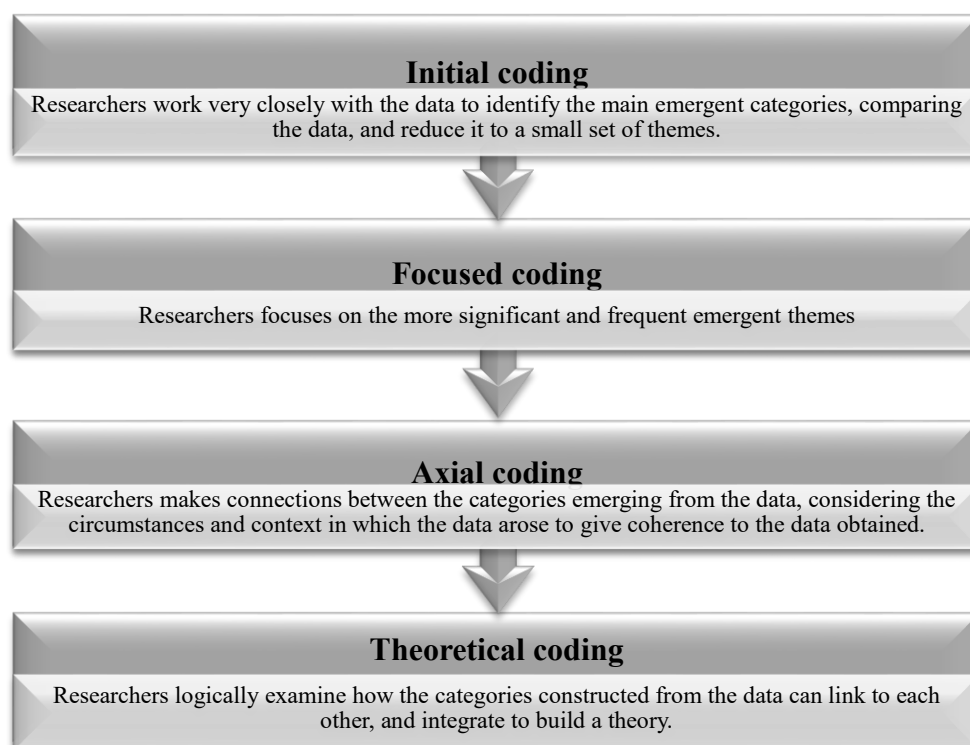
Figure 8: Visual presentation of research sampling and data collection



The main data analysis phase (qualitative)

This study was guided by the constructivist grounded theory (CGT) approach, which explores participants' constructed meanings of reality (Robson, 2002; Charmaz, 2006; Bryman, 2014). The grounded theory coding technique of data analysis identified by Charmaz (2006) was employed. In the early phase of coding, CGT aims to generate the bones of the data analysis, namely the key assumptions, while in later phase, these bones can be theoretically constructed into a working skeleton (Charmaz, 2014). The coding process is described as *“the pivotal link between collecting data and developing an emergent theory to explain this data. Through coding, you define what is happening in the data and begin to grapple with what it means”* (Charmaz, 2006, p. 46). Several phases within the data analysis process are followed by grounded theorists, including initial coding, focused coding, theoretical coding, and axial coding. At each stage, the data is treated differently, proceeding from general to more specific conceptualisations to make sense of the emergent themes, in order to construct the meaning of the phenomenon under study by the end of the coding process (Charmaz, 2006) (see Figure 9).

Figure 9: Grounded theory coding process

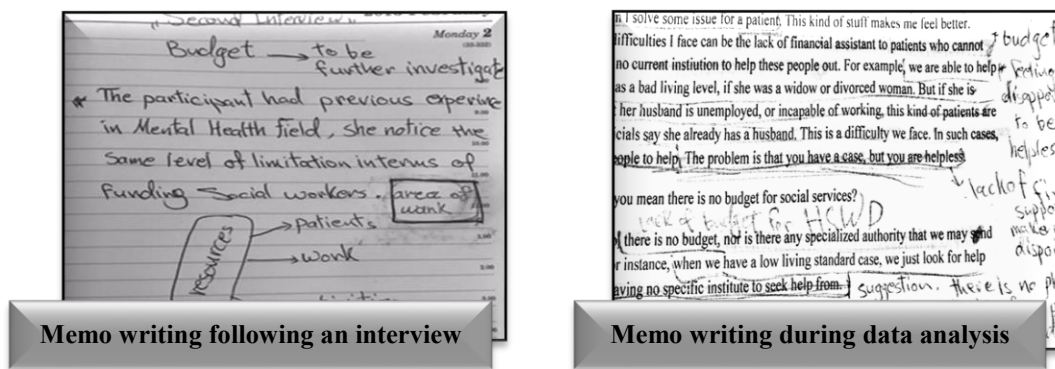


(Source: adapted from Charmaz, 2006: p. 29)

At the outset of data analysis process, the 18 recorded interviews were transcribed into both the Arabic and the English language, and checked multiple times against the recording to ensure accuracy. The transcription was conducted in Arabic, as it was the mother tongue of both the participants and the researcher, one of two possible strategies could be employed before commencing the data analysis. The first was to transcribe and translate the interviews into English, and then begin the data coding process, while the second option was to analyse the data in Arabic, and then translate the results into English (Merriam, 2015). Due to the large volume of data obtained from the interviews, and the fact that translating all of it into English would have been very time consuming, it was decided that the data would be analysed in Arabic, and that the findings would then be translated into English. More importantly, analysing the data in the participants' native language minimises the risk of translation errors, and enables the researcher to focus more on data quality than on the translation process (Merriam, 2015).

Each interview was transcribed immediately after it was conducted, to enable the researcher to identify the initial emergent themes, and to organise them into categories. The NVivo 9 software package was used to organise, classify, and code the data obtained from the interviews. This enabled the researcher to write marginal notes (memo writing) regarding the HSWs' viewpoints in relation to each code generated. Memo writing is *"the pivotal intermediate step between data collection and writing drafts of papers"* (Charmaz, 2006, p. 72), and is therefore an essential part of the process of analysing and theorising the data obtained throughout the coding phases. For instance, in this study, memos allowed the investigator to identify emergent issues linked to the topic under exploration, for further exploration in the subsequent interviews (see Figure 10).

Figure 10: Example of memo writing



As mentioned earlier, Charmaz (2006) referred to initial coding, or open coding, as the preliminary phase of data analysis, in which the researcher must remain open-minded and close to the data collected. As Charmaz (2006, p. 47) explained, “*Initial coding should stick closely to the data. Try to see actions in each segment of data rather than applying pre-existing categories to the data. Attempt to code with words that reflect action*”. A number of methods have proved to be useful during this initial coding to help grounded theorist to discover the world being studied, including word-by-word, line-by-line, and incident-to-incident coding (Charmaz, 2006). As Glaser (1978, cited by Charmaz, 2006, p. 50) explained, line-by-line coding involves “*naming each line of your written data*”; this can work effectively to free researchers from becoming so immersed in respondents’ worldviews that they fail to approach the data critically and analytically (Charmaz, 2014).

In the current study, the researcher obtained the initial ideas about the data collected during the transcription process, since listening to the recorded data enabled the identification of a number of interesting ideas and issues that emerged from the participants’ responses, regarding their experience of work-related stress. This enhanced sensitivity towards issues that might impact the HSWs stressfully in their workplaces, as well as their means of dealing with stress, provided a full picture of the HSWs’ perceptions of their experience of work-related stress. Nevertheless, the line-by-line technique was useful for identifying the potential issues that might constitute themes or sub-themes.

As the initial coding progressed, line-by-line coding, along with memo notes, provided a wide range of topics that enabled the identification of early data patterns that potentially constituted emerging themes that were relevant to the research focus. For example, in response to the first research question, many of the participants were found to refer to matters related to their roles as a possible source of job-related stress in their workplaces, while others identified a lack of financial resources as the most challenging aspect of their workplace. Meanwhile, some of the participants mentioned difficulties regarding their academic preparation and perceived training, whereas others identified leadership as source of pressure in their workplace. Thus, employing the line-by-line technique was useful for determining the narrative characteristics of the interviews, and enabled the identification of deep meaning and detailed explanations concerning a number of points of relevance to the occurrence of stress in the participants’ workplaces (Charmaz, 2006). At the end of the initial coding stage, colour-coding was applied to all the relevant codes to highlight certain features or ideas in the data, prior to the refinement of the coding.

The second main stage of data coding is focused coding, which tends to be more selective, directed, and conceptual than the previous phase (Charmaz, 2014). In focused coding, investigators “[use] the most significant and/or frequent earlier codes to sift through a large amount of data” (Charmaz, 2006, p. 57). Within this phase, the researcher includes the minor conceptual categories from the previous stage (initial coding), in order to sift the previously emerging codes and to determine their usefulness at the analytical level, rather than considering their descriptive account. In doing so, some of implicit statements may become explicit, and the researcher might return to earlier respondents to explore certain points that were overlooked previously (Charmaz, 2006).

In this phase of the present study, the transcripts of all 18 interviews were analysed carefully to compare the participants’ experiences regarding the sources of work-related stress, together with their coping mechanisms (Charmaz, 2006). The comparison of the categories developed previously with the new data engendered the development of multiple headings that provided further issues relevant to the focus of the study. For instance, during the initial coding, several points were made concerning the way in which ‘leadership’ was perceived to contribute to the pressure on HSWs in their workplace. Meanwhile, comparing data to data enabled the definition of the specific aspects of this leadership at different levels, such as ministerial and central, as discussed further in Chapter Six. Furthermore, focused coding was also crucial for identifying the initial relationships between the data patterns (Charmaz, 2006). As the process progressed, the research questions that guided this study were kept in mind to ensure the perceptions of the participants regarding their experience of work-related stress were captured accurately.

In the follow-up phase of data coding, axial coding was employed. At this stage, investigators aim to identify the properties of the categories, and to relate them to subcategories, seeking to give coherence to the emerging analysis, and to assemble all of the fractured data (Charmaz, 2006). Although axial coding has been criticised in terms of the possible restriction that might be caused during the code construction, it extends the power of the emerging ideas effectively (Charmaz, 2006; 2014), because applying this technique can allow researchers to grasp characteristics associated with the occurrence of a phenomena, and provide analytical depth regarding how it operates in meaningful frame (Charmaz, 2014).

As discussed previously, one of this study’s aims was to explore the association between the participants’ demographic characteristics and other factors related to workplace stress, as well

as the different coping mechanisms employed by the HSWs. Therefore, it was important to employ axial coding, in order to address questions such as ‘when’, ‘where’, and ‘who’, as well as to identify the relationships between the categories and subcategories, in order to understand the participants’ experience of work-related stress more fully (Charmaz, 2006). For instance, the application of the axial coding technique identified that only the female participants noted issues related to registering their attendance as a cause of pressure on them in their workplace.

Grounded theorists conduct theoretical coding as it can provide insights into the links between emerging concepts that facilitate the development of combined theories at the end of the analysis. As Charmaz (2006, p. 63) explained, “*Theoretical coding is a sophisticated level of coding that follows the codes you have selected during focused coding*”, and “*theoretical codes specify possible relationships between categories you have developed in your focused coding*”. Thus, the final stage of data analysis requires the refinement and merging of all the emerging concepts into theoretical categories that construct the social meaning of the phenomena under investigation (Charmaz, 2006); this type of coding plays a major role in progressing the analytical story to a more abstract, theoretical level.

At this stage, the researcher treats the categories that emerged in the previous coding phases cautiously, in order to capture the participants’ voices and meanings present in the theoretical conclusion accurately by including raw data in the theoretical memos (Charmaz, 2006). Moreover, since comparison is the main analytical technique used in GTM, the systematic use of comparison maintains a continuous interaction between the researcher and the data that can help to ensure theoretical abstraction at the end of the data analysis process. Importantly, the investigator explicates the central core categories, which in the context of the present study were work-related stress factors and coping strategies, and relates the other substantive codes and sub-categories around them. Furthermore, in this study, the dimensional levels identified by the axial coding also provided detailed information about the general context and conditions surrounding the experience of work-related stress, which contributed to providing a clear explanation of the issue under examination (Charmaz, 2006). Finally, by the end of the theoretical coding phase, a higher level of integration was reached, as all the data that was previously not relevant to any categories was located within the categories developed, which together evolved the study’s ultimate theory (Charmaz, 2006).

Quantitative Data Analysis

A survey-based method was used in the second phase of this study to collect data from the HSWs, and SPSS version 23 was employed to analyse the data obtained. This package was identified as the ideal resource to perform the necessary statistical tests, as it is able to conduct a range of such tests that helped to address the research questions in the second phase of the study (Field, 2009; and Bryman, 2014).

First, the survey data was entered on SPSS, then a number of descriptive statistics, such as frequencies and percentages, were calculated to provide a clear description of the participants involved in the survey phase of the study. It should be noted that 'Does not apply' cases were excluded from the calculations as '0' had no numerical meaning here, and the means were calculated using the reduced denominators, as in Lenton's method (French et al., 2000). In order to describe the level of stress perceived by the HSWs, mean and standard deviation were used for each sub-scale involved in the ENSS, including the nine sub-scales; the same statistical process was applied to the Brief COPE Scale, including the 14 sub-scales, to define the most frequently reported coping strategies used by the participants. The same process was used to describe the influence of each item on work-related stress within each sub-scale.

The impact of the participants' demographic characteristics on work-related stress factors and coping strategies, namely their gender, age, marital status, academic qualifications, specialisation, job type, years of fieldwork experience, and domain of work, was also examined using a number of tests. For instance, a One-way ANOVA test was used to determine the association between stress factors/coping strategies and the demographic variables in the case of one particular predictor, meanwhile, multiple linear regression using the enter method was performed to detect the possible impact of the demographic variables on the work-related stress factors with more than one predictor considering the demographic characteristics that had a p-value of less than 0.1 in the corresponding univariate analysis. Moreover, ordinal logistic regression using the enter method was employed to analyse whether the coping strategies associated with at least two demographic variables.

Before commencing the analyses, the Shapiro-Wilk test (Robson, 2002; Field, 2000) was performed to check the normality of the dependent variables. Therefore, in the case of normally distributed scores, multiple linear regression was chosen. However, for variables where some of the assumptions were violated, a logistic ordinal regression was run. The proportional odds were assessed by a full likelihood ratio test comparing the fitted model to a model with varying location parameters (Field, 2000).

Researcher's position

According to Merriam and Tisdell (2015), a researcher's positionality is an important aspect that must be considered when conducting qualitative research. This is crucial for ensuring the integrity of qualitative research, which tends to rely on a researcher's stance in the interpretation of the findings more than other research inquiries (Alvesson and Sköldbberg, 2017). As Berger (2015, p. 220) explained, the researcher's stance, namely their position, might include "*personal characteristics, such as gender, race, affiliation, age, sexual orientation, immigration status, personal experiences, linguistic tradition, beliefs, biases, preferences, theoretical, political and ideological stances, and emotional responses to participant*". The positionality of research is associated with the concept of reflexivity (Denzin and Lincoln, 2011), and the reflexivity process tends to be "*used in the social sciences to explore and deal with the relationship between the researcher and the object of research*" (Brannick and Coghlan, 2006; 143). Therefore, qualitative investigators must provide information regarding their position concerning key assumptions (Yin, 2015).

It is generally assumed that the position of researchers can influence research in several ways (Berger, 2015). Access to the field of data collection is a good illustration of the possible effect of a researcher's positionality; for instance, a study's participants might feel more willing to share their experiences with investigators who are sympathetic to their circumstances (Drake, 2010). Moreover, this might help to create a relationship between respondents and researchers; for example, while female participants might be hesitant to share certain stories, such as those related to sexual activities, with a male investigator, they may feel more comfortable sharing this information with a female researcher (Kosygina, 2005; Manohar, Liamputtong, Bhole, and Arora, 2017). It has also been suggested that a researcher's insider position, particularly regarding background and worldview, can influence their approach to meaning construction (Kacem and Chaitin, 2006; Berger, 2015). For example, a researcher who has experienced divorce might apply their personal lens when making meaning of, and seeking to understand, divorced individuals' lives (Berger, 2015).

In terms of the research rationale of the present study, it is necessary to familiarise the reader with the investigator's insider position that might influence this research (Creswell, 2011). Prior to attaining her current position as a lecturer in the Department of Social Work at Umm Al-Qura University, SA, the researcher worked at the Medicine College at the same university. In addition, she trained as a social worker in the health domain at undergraduate level.

Therefore, the data collection process, as well as the interpretation of the findings, might be influenced by her personal experiences. As Brannick and Coghlan (2007) argued, being an insider is by far more beneficial than it is disadvantageous. In the context of the present study, the insider position of the researcher was helpful for accessing the participants, due to the researcher's good relationship with certain individuals who might be relevant to the study. It may have been difficult for the HSWs concerned to interact with the investigator confidently and freely, or to disclose their personal experiences, without the presence of a positive relationship or shared understanding of social work. This was particularly important as the study concerned a sensitive topic in the participants' workplaces, and was undertaken in a society that is characterised by a relatively conservative stance concerning issues regarding people's privacy. Therefore, the pre-existing positive social relationships probably enabled the researcher to be welcomed and trusted by the participants.

However, Aléx and Hammarström (2008) highlighted one of the negative impacts of a researcher's insider position, namely the tendency to emphasise a specific aspect of the data that aligns with the interests and beliefs of the investigator, while ignoring the other findings. Therefore, the researcher of the current study was aware at all phases of the data collection, analysis, and interpretation of the need to avoid invalidating the data by bringing her previous experiences to the study. Instead, she was directed by the interests of the participants, and throughout the data gathering phase sought to maintain self-reflexivity (O'Leary, 2010). For example, in order to encourage the participants to elaborate in detail on their own views and perspectives regarding the issue under study, phrases such as "*based on your personal experience*" and "*could you give me more information about that*" were used (Peredaryenko and Krauss, 2013). Moreover, in the data analysis and interpretation stages, the researcher aimed to reveal the reality as expressed by the participants. In doing so, regardless of her personal perspective, she sought to explore the issues related to the aims of the study from the participants' viewpoint.

Most importantly, as a female researcher examining a matter from the perception of both genders, it was challenging to remain unbiased towards the female participants' views (Berger, 2015). Due to an awareness of this possibility, throughout research process the researcher sought to convey an accurate representation of the participants' voices, avoiding any influence that might cause a gender bias. For instance, both the male and female participants were encouraged equally to share their feelings and experiences. In addition, the same research methods were used to gather data from both genders, and the findings and quotations presented

reflected the interests and perceptions of both the male and female respondents. Hence, the insider position in the current study served the aims of the study, and may consequently have produced particularly valid recommendations and implications associated with the issue under investigation (Charmaz, 2006; Denzin and Lincoln, 2011).

The quality of the research outcomes

Since it can be more challenging to test the reliability and validity of qualitative research than quantitative approaches, various methods of quality measures have been suggested for researchers to use to check the quality of their qualitative work (Guba and Lincoln, 1994; Robson, 2002; Roberts, Priest, and Traynor 2006; Flick, 2014; Bryman, 2014). In this study, as both semi-structured interviews and a survey were used as data collection tools, the validity and reliability of each tool was checked separately, employing methodological triangulation between the two phases in attempt to ensure the accuracy of the findings obtained from both phases of the data collection (Creswell and Creswell, 2017; Bryman, 2014).

According to Bryman (2014), the reliability of a qualitative approach to research concerns the extent of data repetition in different circumstances. For example, to avoid researcher bias when interpreting and analysing qualitative data, researchers who use interviews to collect data generally ensure the reliability of the data obtained by sending the interview transcripts to another researcher to ensure that they agree with the findings and interpretation of the principal researcher (Roberts et al., 2006; Bryman, 2014). Meanwhile, validity relates to the quality of the tool selected to investigate phenomena, and how it might be affected by researcher bias (Roberts et al., 2006).

For this study, the researcher employed a trustworthiness procedure to determine the accuracy of the qualitative data that was collected (Charmaz, 2006; Denzin and Lincoln 2011). According to Denzin and Lincoln (2011), trustworthiness can be established via the inspection of four main criteria, namely credibility, transferability, dependability, and confirmability. Credibility is defined as “*activities that increase the probability that credible findings will be produced*” (Lincoln and Guba, 1985, p. 301). Such activities can involve several strategies, such as member checking and an explanation of the researcher’s position (Merriam and Tisdell, 2015). In this study, the credibility of the qualitative data was established using the member checking technique. According to Merriam et al. (2015, p. 246), “*a member check is to take*

your preliminary analysis back to some of the participants and ask whether your interpretation rings true". Consequently, after the interviews were completed, the content of some of the transcribed interviews was sent to a number of the participants, in order to ensure that their content corresponded with the actual meaning the participants intended to express, particularly in the case of those who provided unclear answers, or responses that were open to more than one interpretation. Furthermore, the initial interpretation of some of the data was discussed with the participants to ensure its accuracy.

In terms of transferability, which is "*a process in which the researcher and the readers infer how the findings might relate to other situations*" (Denscombe, 2009, p. 189), although CGTM was employed for the data interpretation stage of this study, which may have been influenced by researcher bias (Roberts et al., 2006; Charmaz, 2006), the generalisations made in the findings remained applicable to other studies conducted in a similar context. The researcher sought to ensure the study's transferability by providing accurate details and descriptions of the context of the study and the data, in order to enable other researchers to judge its transferability to other contexts (Merriam et al., 2015).

Dependability is another criterion that should be tested to ensure trustworthiness in qualitative research. According to Bryman and Bell (2015, p. 403), dependability in the research world requires that "*complete records are kept of all phases of the research process... in an accessible manner*". In this research, all of the interview recordings and transcriptions were retained throughout the data analysis and interpretation phase, so that they could be returned to if necessary.

Finally, the fourth element that must be tested to establish trustworthiness is confirmability. According to Goodnough (2011, p. 147), confirmability can be achieved using a triangulation strategy, and provides "*social researchers with a means of assessing the quality of data by coming at the same thing from a different angle*". In the current study, since two data collection instruments were used, namely semi-structured interviews and a survey, and data saturation was reached, the outcomes of both instruments satisfied the confirmability requirement, and thus increased the trustworthiness of the research. Although slight differences were made to the instruments used to collect the quantitative data concerning the stress factors and coping mechanisms of the participants, since the scales used were modified to suit the target group, a pilot study was undertaken with 12 HSWs who were excluded from the main phase of the quantitative data collection. Using SPSS version 23, the Cronbach's coefficient alpha test was

run to check the internal consistency of the modified version of the scales, along with the split-half coefficient to ensure the item-total correlation (see Appendix 5). Moreover, face validity was also checked by sending the questionnaire designed to three professors who were experts in the health social work field in SA, to ensure the applicability of the scales to the target Saudi HSWs. Finally, to test the reliability of the quantitative phase of the main study, Cronbach's alpha was used for both the ENSS and the Brief COPE scales, as discussed in Chapter Eight (Robson, 2002; Bryman, 2014). While the validity of the translated questionnaire was checked before the process of data collection by back translating from Arabic language to the English to test its accuracy, and to report the validity and reliability to the Arabic version (Bryman, 2014).

Ethical considerations

Ethical considerations are a central element that should be considered throughout the research journey in both qualitative and quantitative research (Robson, 2002; Babbie, 2012; Saunders et al., 2009). Adherence to research ethics enables research to be conducted in an acceptable manner, as well as preventing the researcher from facing any problematic situations during the data collection process; it can also be also important for ensuring the reliability and validity of the research findings (Khanlou and Peter, 2005; Saunders et al., 2009). Ethical considerations require that there is no fabrication in the data collection, analysis, and presentation process. Most importantly, where research involves human participants, the researcher should be mindful that their participants are giving their time voluntarily, and have the right to withdraw their participation and data at any time in a study, especially in research that does not offer any reward or incentive to the participants (Caruth, 2015). It is also necessary to familiarise the potential participants with the objective(s) of the study, the methodology that will be used, the expected outcome(s), and what will be expected of them during the course of the study, as well as the possible risks associated with participating in the study, and the associated benefits (Babbie, 2012).

As qualitative research primarily concerns the investigation of personal experiences within their social context, *“it is important to recognise [from the start] that ethical issues, particularly with reference to protecting subjects, may rule out certain research procedures and/or require certain elements in the research design”* (Babbie, 2012, p. 21). In the field of

social science research, many countries have developed their own ethical principles and regulations for conducting research, such as those of the British Educational Research Association. However, in SA there are currently no agreed ethical guidelines for researchers. Thus, as this research was conducted in pursuit of a PhD from Hertfordshire University, it adhered to the ethical research guidelines developed by Hertfordshire University's Ethics Committee (HUEC). The HUEC guidelines helped the researcher to overcome any ethical challenges. After the project was approved by the HUEC, and before the data collection began, authorised permission was sought to access the sample required from the MoH in SA, which is the primary body supervising HSWs' workplaces through the Health Affairs Directorates (HADs) that are located in each province of SA (Shenton and Hayter, 2004). To this end, a formal letter was sent to the researcher's sponsor, the SA Cultural Bureau London, which is responsible for Saudi students in the UK, who then completed the process of obtaining permission.

Moreover, to ensure that the participants selected understood the study objectives and methodology fully, as suggested by the HUEC regulation, an information sheet was attached to the consent form that was sent to the managers of the SWDs in state hospitals, who were responsible for delivering them to the participants involved in the study. The researcher's business card was also included, which provided full disclosure of her identity and the organisation supervising the project, including a full address and contact information. The participants in both phases of the study were therefore able to contact the researcher if they had any questions regarding the study. Moreover, sufficient time was given to the participants to read the information sheet, in order to ensure their informed consent when they signed the form to indicate their willingness to take part in the research, before the data collection began in both phases (Caruth, 2015).

The confidentiality of the participants' identities and information was also assured throughout all stages of the study. This was particularly due to the fact that this study considered the interaction between the demographic characteristics of the participants and their work-related stress factors and coping strategies. Therefore, a detailed description of the participants' demographic information, together with some of their personal information, was included in both the interviews and the questionnaire responses. All necessary steps were taken to protect the identity of the participants during the data collection stages. For instance, in the main phase of the study, the interview recordings and transcriptions were kept in a personal locker at the researcher's home. Most importantly, due to the sensitivity of the information collected, the

researcher arranged to conduct the interviews in a private room at the participants' workplace. Moreover, in the survey phase, envelopes were attached to each questionnaire, since they were disseminated and collected by persons other than the researcher, namely the SWD managers. The participants were asked to enclose the completed questionnaires in the envelopes using adhesive tape, and to sign over the tape to ensure that the envelope would not be opened by anyone other than the researcher, in order to ensure the participants' confidentiality (Robson, 2002; Khanlou and Peter, 2005).

During the analysis process, the researcher ensured that the identity of the participants was not revealed in either the analysis or the outcomes of the research. Moreover, all of the data collected was held personally by the researcher, as the interview recordings and transcriptions were kept in a personal locker at the researcher's home, along with the entire set of questionnaire hard copies, and the key to the locker was stored in a safe. In terms of the statistical analysis, the SPSS data was stored on the researcher's personal laptop that was password protected, in order to maintain confidentiality (Khanlou and Peter, 2005). Finally, all of the information obtained was used only for the purposes of this study, and was safely destroyed once the PhD was completed.

Since the study explored the social aspects of human interaction with stressful experiences, the researcher was careful to ensure that no harm could be inflicted during any data collection phase (Littlechild, Zavirsek, Rommelspacher, and Staub-Bernaconi, 2011). The participants were informed that they had the right to discontinue with the study at any point, in any phase, if they felt uncomfortable or distressed by either both phases.

Nevertheless, some ethical challenges were encountered when conducting some of the interviews in the first phase. For instance, due to workplace cultural considerations, such as physical gender segregation, that are widespread in the Saudi community, two male HSWs were hesitant to be involved in the study, unless a male member of the researcher's family (Mahram)²⁴ was present during the interview. Their reluctance was due to the fact that any direct physical contact between males and females in SA requires sensitive handling in some workplaces, particularly in the public sector (Yalli and Albrithen, 2011; Hamdan, 2012;

²⁴ A mahram is an unmarried member of kin with whom marriage or sexual intercourse would be considered haram, illegal in Islam, or people from whom purdah is not obligatory, or legal escorts of a woman during a journey longer than a day and night. Examples of such legal escorts are a woman's husband, or an individual she cannot marry as they are blood family. They should also be an adult, for example a husband, father, grandfather and further male ancestors' son, grandson and further male descendants' brother, brother of parents, grandparents and further ancestors' son, grandson and further male descendants of siblings, including milk relatives.

Albrithen and Yalli, 2015; Van Geel, 2016). Thus, as the researcher was married, her husband attended the interviews conducted with these two male participants. It should be noted that in such cases, the presence of the researcher's husband was purely physical, and he did not interfere in the interview, nor was he able to hear the conversation, as the interview was conducted in a large meeting room at the interviewees' workplace. This was in order to not only maintain the confidentiality of the data, but also to encourage the participant to speak freely.

Moreover, although it was clearly stated in the information sheet that all the interviews would be audio recorded, three participants who initially approved their participation in the study were later reluctant to be audio recorded, and appeared to be uncomfortable or distressed about the prospect before the interview commenced, due to the sensitivity of the topic concerned. The investigator assured them that the interviews would be extremely confidential and that the recordings would be stored securely. As a result, two of the participants agreed to participate, but the third refused to be audio recorded for personal reasons (not mentioned), and decided not to participate in the study. The researcher respected her view without questioning her, and withdrew the participant from the study.

Limitations of the research design

Although this research produced interesting findings regarding the experience of work-related stress in HSWs' workplaces in the western province of SA, as is commonplace in research studies, several limitations were identified concerning to the research design. These were as follows:

- The employment of the CGTM in this study is subject to criticism, in terms of the generalisability of the results, since the interpretation of the findings was open to being influenced by the researcher's beliefs and experiences. However, the researcher sought to work closely with the participants after the interviews were transcribed, to ensure that the intended meanings were accurately captured, acknowledging that the research approach used relied on a construction of reality from the participants' viewpoint (Charmaz, 2006). Furthermore, although a sufficient number of participants was recruited to the main phase of this study, including HSWs from different demographic backgrounds, limitations regarding the representativeness of the research participants

may remain, due to the fact that the data collected was probably not representative of all perspectives, such as that of HSWs who work at public hospitals in rural areas. Nonetheless, the participants involved in the current research provided meaningful and rich data that contributed significantly to the understanding of social work in the health field;

- The use of semi-structured interviews was a further potential limitation of this study. Although this style of interview is flexible, and enabled both the researcher and the HSWs to expand the discussion of the issues raised during the interviews, it was also time-consuming to employ (Bryman, 2014), as the average duration of each interview was between an hour and an hour and a half;
- The application of the theoretical sampling technique in the first stage of the study was also a potential limitation, since although its use is a requirement of the CGTM (Charmaz, 2006), the sample size could not be predicted in advance. However, the researcher succeeded in interviewing a sufficient number of HSWs, and achieved data saturation as the responses began to be repeated, and ultimately no new data or categories emerged;
- In terms of the questionnaire phase, there was a limitation associated with the translation issue. The questionnaire was in Arabic, because the participants were Arabic native speakers, but it was challenging to translate the scales used into Arabic correctly, as they were originally developed in the English language. This required a special procedure, and a considerable length of time to ensure the effectiveness of the tool. The researcher worked closely with a certified translation agency that was responsible for the translation of the questionnaire from Arabic to English, and vice versa (see Appendix 3);
- Another challenge the researcher faced in the questionnaire phase concerned the distribution of the questionnaires, as she was required to travel between two cities to drop and collect the completed questionnaire from 12 hospitals across both cities.

Summary

This research employed a constructivist approach, using the CGTM with a mixed methods design applied to two phases, with the aim of investigating work-related stress factors and

coping mechanisms from the perspective of HSWs at 12 state hospitals in the western province of SA. The requirements of the CGTM were followed throughout the study, and the ethical research regulations developed by the HUEC were followed. A total of 18 semi-structured interviews were conducted with both male and female HSWs of various ages, and with varying levels of fieldwork experience, followed by the application of a survey in the second phase of the study. The CGTM strategy developed by Charmaz (2006) was employed to analyse the qualitative data gathered from the semi-structured interviews, while SPSS (version 23) software was used to analyse the statistical data obtained from the questionnaires completed in the second phase. Finally, this chapter discussed the quality and trustworthiness of the data collected in both phases of the study. The next chapter presents the findings of the main phase of the study, namely the analysis of the semi-structured interviews, in order to address the purposes of the study.

Chapter Five: Findings Pertaining Factors Contributing to Work-related Stress

Overview

This study focuses on work-related stress as experienced from Health Social Workers' (HSWs) perspectives. The first set of questions aimed to explore possible influential factors causing stress among the target group. Using NVivo software (version 12) enabled the researcher to explore the generated data thoroughly, during both the initial and final coding processes, in relation to the sources of stress in HSWs' workplaces. Having achieved this, the current researcher recognised a number of factors associated with the occurrence of work-related stress in HSWs' workplaces, most of which were linked to the influence of the dominant culture and issues related to gender. These aspects were then further categorised under several sub-themes emerging in relation to issues potentially impacting on the Saudi community and HSWs' experiences in the workplace. Therefore, in order to ensure the data reporting would be transparent and straightforward to follow, the chief findings of this study regarding work-related stress have been divided into factors linked to both culture and gender.

The researcher's use of Constructivist Grounded Theory Methodology (CGTM) techniques for data collection and analysis generated a considerable dataset. This meant that segmenting the responses, and considering the functions of each coding phase within the main four coding levels in the data analysis process (as identified in the fourth chapter), increased the researcher's capacity to successfully manage the data presentation. Two key themes were identified from the eighteen interviews conducted, relating to sources of stress known to exist within HSWs' workplaces, and involving several sub themes relating to each of the main two concepts (i.e. themes) (see Appendix 8). The researcher reflected upon agreements among HSWs regarding each of the proposed themes, allowing for the variables of gender, age, marital status, qualification, specialisation, job type, level of experience, having additional responsibilities outside workplaces, and the domain to which HSWs are assigned. Although not all the themes were mentioned by all participants, the demographic data could explain the variables associated with each one. Moreover, caution was considered at the interpretative stage when handling rarely mentioned themes. It was also beneficial to refer to evidence collected from others in the Saudi context to improve the reader's comprehension. Finally,

repeat quotations discussing the same ideas were excluded, and the frequency of each point, and associated demographic variables were considered when presenting the data.

Theme 1: Issues related to Culture affecting HSWs in their workplaces

In the context of this theme, the responses of the HSWs were presented alongside details of the Saudi community's culture and traditions, as detailed previously in Chapter (Two). This was due to these exerting a potentially significant impact on workplace stress. The study found that issues emerging frequently from the HSWs' responses tended to be related to the lack of social recognition of the value of social work within the Saudi community, along with the consequent impact on the position of the profession and HSWs' roles. In addition, further factors included: (1) the workplace environment; (2) working policies and regulations; (3) work and personal life imbalance (4) leadership; (5) other professionals' perceptions of the role of HSWs; (6) issues related to patients and their families; (7) issues concerning limited resources; and (8) inadequate academic preparation

Working in a mixed gender workplace

It is interesting to note that for both genders and all age groups, with differing levels of experience, working in a gender mixed environment is considered a potential source of stress. Approximately, nine of the HSWs who took part in this phase of the study stated that being in a mixed setting can affect both attitudes towards them and their behaviour at work. The female participants observed that some Saudi males believe a woman who works in a place that includes members of both genders to be potentially impolite or disrespectful of Saudi norms, as was also indicated in studies by Al-Shahri (2002) Hamdan (2012), RajKhan, Albrithen and Yalli (2012, 2014), Alharbi (2015), Alhareth et al. (2015) and Van Geel (2016). This view seems to affect women negatively, causing many to think very carefully before choosing to work in a hospital setting, as one participant said:

Some Saudi men think that if you work in a mixed environment, this means that you are an impolite person and you can be a bad woman. But, if no women worked in hospitals who would take care of your daughters and wives?!!! This kind of thinking made me very hesitant about deciding to work here.

(Female, Internal Medicine, 9 years' experience)

Another female participant also described the stress she experiences every time she deals with patient escorts of both genders. She unexpectedly identified that not only do Saudi men have negative opinions about girls who work in the health sector, but some women also share their views. This places additional pressure on her, causing her to act very cautiously when dealing with patients' families, to avoid any misunderstanding. She explained:

The patients' escorts some time get a negative feeling toward us being working in mixed place!!! By the way, not only men, but also their wives!!! That makes me feel I need to treat them very carefully, which is an inconvenience for me.

(Female, Home Health Care, 3 years' experience)

The most surprising aspect of the data regarding the influence of working in a mixed gender context is that male HSWs also report being adversely affected by working in such a setting. The male participants stated that working with females exposes them to personal conflicts. For example, one stated that he had a serious problem with his wife, who found it difficult to accept that her husband might meet females in the hospital. This put him under extreme pressure, especially when he first started working there. He explained that:

At first because it is a new thing, a new experience for everyone, and since I am married, and I have to work with girls sometimes... my wife was very nervous about it. I was under serious pressure as our job and environment is like this, so it was like hell on earth.

(Male, Internal Medicine, 6 years' experience)

Similarly, a single male commented that working with women might make it difficult for him to find a girl to marry him in the future. This might reflect the conservative perspectives that still distinguish some of Saudi citizens' thinking, as highlighted previously by several authors (Hamdan, 2012; Al-Sharif, 2012; Van Geel, 2016), he explained:

Being in mixed place... it is not only inconvenient for women, it is so for both men and women. I remember my mom once told me, if you decide to work in a hospital, no girls will agree to marry you.

(Male, Patient Relations, 9 months' experience)

Working in a mixed setting also raises another problem; as stated by one female who had experienced sexual harassment. She shared her experience of subjection to sexual harassment; describing how males (both patients and staff) think that women who agree to work with males are easy going and like to talk to men in a familiar way. This supports out evidence in prior research (RajKhan, 2014; Alharbi, 2015) that refer to the increased probability of women being exposed to sexual harassment when present in the same place as males. The participant also described a situation she experienced when she needed official papers from human resources, and a staff member verbally harassed her. However, the case of this participant appears to be an exception in the data for this study, since of the nine female HSWs interviewed no one else raised a similar difficulty. Thus, this case should be interpreted with caution; as a female in a similar context the author believe the case represents behaviour in the more conservative geographical regions of SA, where women usually avoid any contact with males:

I am subject to harassment frequently males believe that as we go to work in a mixed place, it means that we can easily talk to any man even if we do not have any work with him... even when we have paperwork to complete at employees' affairs, they tell me that they are doing me a favour because they like me, and things like that... and if I see that person the following day, then he keeps asking about the paper he did for me... but of course, he is not asking about the paper, he is trying to get onto other topics... These are obvious things, so that's why I stay in my office and never leave it. I used to witness more things like that when I was nurse. It is the most annoying thing I witness in my workplace.

(Female, Dialysis, 11 years' experience)

Responsibilities outside workplaces

Although women seem to play a major role in holding domestic responsibilities in Saudi culture (Hamdan, 2012; Van Geel, 2016), responses identifying additional personal responsibilities as a stressor were obtained from ten of the participants, including both male and female HSWs, and mainly those who are married. Some experiences were shared by the participants, including those from all age groups, especially married HSWs. For example, one male participant explained how his job takes him away from his family (wife and children), and sometimes exposes him to stress that creates a conflict with his personal life, inhibiting his ability to take

responsibility for his family and children, especially in terms of taking his children to and from school every day. He explained:

Yes, as the head of a social work department I need to be here at work, at every meeting... at the same time, I have personal arrangements with my family. I have kids at home that I have to pick up from school... so yes sometimes I feel this kind of pressure...

(Male, General Hospital, 13 years' experience)

The previous point was also emphasised by another participant who stated that he comes under pressure daily for similar reasons. He maintained that it takes him a long time to give his children a lift home and return to the workplace. The participant said:

I have additional circumstances that definitely affect me, as when I need to get my daughter from school; it takes so much time sometimes because of the traffic. I need to go and come back in a short time, the time I have is not enough, so when I come back the boss says something like 'you were late' ... he does not understand how hard it was to go and do all that then come back again to work.

(Male, Home Health Care, 8 years' experience)

These findings relate to the fact that in SA's conservative culture, women were not permitted to drive until very recently, and therefore, males were wholly responsible for transporting their children and their wives (RajKhan, 2014; Alfasi, 2018). In addition, some Saudi families choose not to have personal drivers for conservative reasons, as this would be allowing women to travel with a stranger without 'Mahram' (Hamdan, 2012; Van Geel, 2016).

In another case, a female interviewee described her daily routine in the workplace as subject to pressures arising from balancing work requirements with her duty to her children. She believes that affects her health trying to keep all the people around her happy and satisfied. Thus, the previous statement explains why single HSWs typically report having greater freedom than those who are married.

When you have some hard work, you do not have time to rest, you must breathe deeply to be able to continue. During a break, my kids call me from home asking about something they need or that I need to get on my way home. I feel everything is upside down, I try to satisfy all aspects of my responsibilities; it is at the expense

of my health and I am more stressed out, I have only Friday off. Even my relatives and neighbours get upset because I don't visit them. But I have no time for that. I only find some time to go out with the kids on a Thursday. I also take them out on Fridays and Saturdays when we finish our daily program. This starts again on a Saturday and ends on a Thursday. This is all additional pressure on me.

(Female, Maternity and Children Hospital, 12 years' experience)

Social recognition in the Saudi social community

A variety of perspectives were expressed concerning the lack of recognition among Saudi citizens regarding the significance of HSWs roles. Six interviewees observed this, including both male and female HSWs with various qualifications, fieldwork experience, and age. This was surprising as a number of organisations, such as the Saudi Health Social Work Association (SHSWA), aims to familiarise the public with the support that HSWs can provide to patients and their families within Saudi hospitals (Yalli and Albrithen, 2011; Soliman, 2013; Albrithen, 2014; SHSWA, 2015; Almaizar and Abdelhamed, 2018). One male participant, for example, claimed that this issue only causes stress for newly qualified HSWs' stating that:

The lack of social recognition by other people can affect some newly hired social workers; there are times when one might wonder why he chose this job. Some say that they have made a mistake because they chose to enter social work at school, we hear things like that... and unfortunately these ideas exist and create a feeling of disappointment for social workers.

(Male, Mental Health Hospital, 10 years' experience)

However, even experienced HSWs seem to feel stressed by how the Saudi public assess the value of HSWs. The participants emphasised this, reporting disappointment and frustration arising because Saudi citizens mostly link the HSWs' role to providing financial support only. This finding is consistent with evidence presented by Yalli and Albrithen (2011). One experienced female participant stated:

I have been working for more than 10 years. I observe how the majority of community think that the role of the social workers is to provide money, there is a

lack of understanding within the community of our roles. In fact, it is very frustrating.

(Female, Addiction, 10 years' experience)

Another lesser concern was raised by the less experienced interviewees regarding the lack of recognition towards social workers' roles within Saudi society. The HSWs noticed that most Saudi clients seem to be confused about the distinction between social workers and psychiatrists and psychologists. Thus, some patients do not seek out help from HSWs, because they feel that to do so would mean they would be subject to the stigma associated with visiting a psychiatrist. One participant mentioned:

Most people give me a very depressed feeling... people in our community do not even know what we do, they always see us as psychiatrists, which makes them feel reluctant to speak with us, as others will think that they are mentally ill.

(Male, Oncology, 2 years' experience)

Supporting this, another interviewee pointed out:

In general life, I believe that one in 10 people know what social work is. Some people think that a social worker is a psychiatrist; they expect me to listen to them while they lie on a comfortable sofa. With all due respect to psychiatrist and specialists in other domains, the social worker's responsibility is broadening, but nobody has recognised that.

(Female, Maternity and Children Hospital, 12 years' experience)

It is interesting to note that this finding seems to accord with the earlier observations suggesting the considerable lack of acknowledgement in Saudi society for members of the social work profession is a key limitation encountered by social workers, particularly in health care domain (Yalli and Albrithen, 2011; Attum et al., 2019). Additionally, there are other studies that have noted the negative attitude that some Saudi individuals have toward mental illnesses (Al-Krenawi and Graham, 2000; Al-Shahri, 2002; Qureshi et al., 2009; Koenig et al., 2014).

Moreover, although the roles of social workers have recently been judged essential within the context of police offices and the Saudi courts, some of these organisations are described as contributory factors with regard to putting HSWs under pressure; as they feel their professional

advice is being neglected. However, this issue was only raised by two out of the eighteen HSWs interviewed. The first participant commented:

Unfortunately, there is a lack of knowledge among some governmental organisations about the importance of the social work specialty and the roles social workers can play with addicted patients.

(Male, Mental Health Hospital, 10 years' experience)

The other participant shared his experience of a patient who had agreed to receive clinical and psychological treatment while being sued by his wife in court for divorce. The court arranged a police officer to take him before the judge while he was in hospital. However, the participant, as a social worker, explained that the patient is at a critical stage of treatment and that attendance at the court (the patient) might make him worse. Unfortunately, the court was not prepared to cooperate, and forced the patient to come to court to divorce his wife in handcuffs. The participant explained:

There was an addicted patient who could not get out of bed, and his wife was asking for a divorce saying that he is causing her trouble... so we told the patient and made him understand what his wife wanted. Later, he was called up to the court, so we wrote a recommendation to the court saying that it could affect and hurt him psychologically and it would be better if the case could be delayed until he had recovered, for now he needs to heal from his withdrawal symptoms, and after getting better psychologically, we will try to resolve the problem between him and his wife. But, they totally ignored our opinion; and so he attended court in handcuffs. This kind of thing causes us frustration... to give our opinion over and over without result.

(Male, Addiction, 15 years' experience)

Although social work practice was established almost five decades ago in SA in several domains (education, social services and justice), the current findings reveal that other official organisations in SA frequently ignore HSWs' professional opinions, as they do not acknowledge the importance of social work as a speciality (Soliman, 2103).

Inadequate academic preparation and training

This part focuses on responses related to matters associated with academic preparation and the ongoing training provided for HSWs within the Saudi community, which seems also to be influenced by the prevalence culture. Issues including the academic curriculum provided to HSWs, as identified by participants, relate to the theoretical preparation and realities of field working in the field. Problems associated with the rules of professional classification obligated by the Saudi Committee for Health Specialities (SCfHS) also emerged in the HSWs answers. These sub themes will be discussed in detail from HSWs' perspectives, highlighting their contribution to stress among HSWs at work.

The quality of the academic programs provided to HSWs, including curricula at the undergraduate level, and training courses following graduation was frequently mentioned by the participants as exacerbating the probability of stress arising in the workplace. Five HSWs with differing levels of experience, including males and females with a variety of academic qualifications clarified points related to the academic curriculum. For example, at Saudi universities, social workers at undergraduate level are not taught to familiarise themselves with certain medical conditions in English. Thus, when they come to work in the field, they find themselves struggling with the language barrier, since health workers prefer to use English, and medical reports are mainly written in English. Moreover, this limitation seems to prevent some HSWs from understanding patients' attitudes; e.g. high blood pressure, and diabetic patients, who can sometimes become aggressive easily. One female participant said:

In universities there is a lack of units teaching social workers terminology in English, like the name of some health conditions like coma. So, it is hard to talk to the doctor about a patient's condition if we do not have this terminology. Then, when I go to a patient who has diabetes, or blood pressure, I need to know how to talk to her not to make her angry.

(Female, Internal Medicine, 9 years' experience)

On the other hand, HSWs also reported their concern when encountering situations where they are exposed to serious health conditions, such as when communicating directly with patients with infectious disease without any kind of protection. This limitation was also attributed to lack of quality in taught courses at universities when familiarising HSWs with different illnesses. Speaking about this issue one interviewee said:

This is a problem with social workers who don't have knowledge of English and especially health conditions. That obstacle could sometimes expose a social worker to dangerous diseases, like if a patient has tuberculosis, a social worker may have no idea about that and enter the room without protection. This is what social work training lacks.

(Male, Dialysis, 29 years' experience)

Another experienced participant commented on the courses provided to graduate social workers seeking advanced qualifications in HSW. He argued that the courses provided by Saudi universities do not match fieldwork requirements, and need to be updated to meet patient's needs. These findings confirm those obtained by (Yalli and Albrithen, 2011; Albrithen and Yalli, 2015), which might be explained by the fact that the social work profession is relatively new, certainly in the medical context, dating to around 1980. A male participant explained:

When we contacted the university about the post graduate diploma especially provided for practising social workers' roles in the medical field, we found it is not enough now to meet the needs we have. I told them that we need something about family treatments, group treatments, very deep things, I want to work on cancer patients, kidney patients, not repetitive things... we want in depth specialist training.

(Male, Mental Health Hospital, 10 years' experience)

From different angle, despite the efforts of the Saudi government to improve social work programmes in educational organisations (Ministry of Education, 2016), six HSWs from both genders, including experienced and less experienced individuals working in different domains agreed there is inconsistency between the theoretical preparation that social work students receive at universities and what they encounter in the workplace (Yalli and Albrithen, 2011). One of the participants, who had almost nine years' experience in fieldwork, reported challenges after graduation, when she was newly hired, as she did not have the fundamental knowledge to practice the social worker role, as social workers are not adequately trained at undergraduate level to work in the medical field. So, when they first begin taking on actual roles, HSWs can find themselves confused and lost, due to the gap they encounter between

theoretical and practical expectations. Not only that, but the participant also noted similar issues affecting undergraduate students who are training as social workers. This appears to demoralise other HSWs within the social work as profession. She said:

I feel that newly hired social workers are a bit lost, they do not know many fundamental things... like me. I used to go to the field of training in the second year of my Bachelor's, but when I started working after graduation in hospital, I was shocked with what I saw in the real life!!! I used to ask about everything as I did not have any background to working on hospital. Now, I can observe the same, the students just came directly to the hospital with no previous experience, which makes them less confident professionally!!! Why? It is really offensive to social work as a profession that students come with a theoretical background that does not match the reality... it is seriously shocking.

(Female, Internal Medicine, 9 years' experience)

Even more experienced HSWs seemed to share similar concerns with newly qualified staff. This was apparent from the response of another participant, who gave a clear example of the gap between theory and practice, sharing his experiences regarding the limited autonomy given to HSWs in their workplaces when handling patients requiring social support, as he found himself with very limited authority to help, leading him to become disillusioned. He stated:

In the process of helping patients, there is no freedom concerning that to help as a social worker using the things we learned and studied... we feel that our background does not match at all with the authority we have at work which makes us disappointed.

(Male, Cardiology, 16 years' experience)

In addition, one of the most experienced male participants despaired over this gap; the reason for his response was not clear, but it may relate to his extensive experience in the field, during which time he has witnessed no improvement, as recommendations are only treated peripherally. It seems possible that these results are due to the application of social care programmes designed in other developed countries (e.g. America, and other Western societies), which tend to have different cultural backgrounds to SA (Al-Saud, 1996; Yalli and Cooper, 2008; Soliman, 2013; Albrithen, 2014; Almaizar and Abdelhamed, 2018). There is, however, another possible explanation linked to the limited authority of HSWs within their workplaces

compared to physicians. This is particularly evident in light of the prevalence of the bureaucratic system that tends to characterize most of governmental Saudi workplaces (Albrithen and Yalli, 2012). He stated that:

Sometimes I start thinking there is no need for social work, if it is like this then our division at the university is not needed, since when we finish studying we come to this... things should be fixed because there is a big gap between the university and reality.

(Male, Dialysis, 29 years' experience)

Finally, despite the role the SCfHS plays in specifying the requirements for health professionals, including social workers (SCfHS, 2016), the employment of HSWs who have graduated in sociology was described as unsuitable by some of the study participants. Strong evidence seems to be emerging within this theme suggesting that stress exists because of a lack of attention being given to specialisms when recruiting newly qualified HSWs. Seven participants of both genders, with different levels of experience who qualified in social work observed that this is a factor that burdens them within their workplaces. One participant stated that recruiting students who had graduated from sociology departments (sociologists) as HSWs might expose others who graduated from social work to embarrassing situations at work. This is because sociologists sometimes give an inaccurate impression of the HSWs' role. He stated:

About specialties; you know that sociology is not the same as social work, and that it may be one of the reasons that sometimes social workers are put in an embarrassing situation, because maybe [those trained as] sociologists are not doing their job correctly and are making a bad impression on the role of social workers. Some of them do not even know what a social worker is, or who social workers are... so they are two different things.

(Male, Mental Health Hospital, 10 years' experience)

In referencing the above concern, another participant emphasised the importance of degree speciality when differentiating between those practitioners who graduated from a social work department and others who studied sociology. She stressed that in her experience, the HSWs

who studied social work are practical and understand social work as a profession much better than those who graduated from sociology departments. She pointed out:

I always notice that social workers who studied in the social work department are very different from sociologists. I feel that they understand; when I first came here, there were three in the social work department who had graduated from the school of social work, the others were not so bad, they did well too, but to be honest not like us.

(Female, Internal Medicine, 9 years' experience)

Another issue was raised in association with the interviewees' experiences regarding speciality, particularly in terms of the existence of unauthorised consultation offices run by non-specialised persons claiming to be social workers. The participants believed that such actions devalue the social worker's role, as well as causing Saudi family members to question their privacy. One female interviewee mentioned:

Recently, I noticed that anybody with a diploma can go and open a consultancy office... it is a serious issue, as the Saudi family has its own confidentiality and problems. I understand that there are rules and principles when practising the role of a social worker, but those who do sessions in consultants' offices should be considered as working for a social association, and each one in a consultancy office should be well supervised, carefully, because the subject can be very dangerous and there is nobody... there is no supervision.

(Male, Patients Relation, 9 months' experience)

Although the reason for this finding is obscure, it may relate to the late emergence of the social work profession; particularly in the health care domain (Yalli and Cooper, 2008). Another possible explanation for this is that the limited number of Social Work Schools within Saudi universities increases the probability of hiring a sociologist to practise HSWs' roles, despite sociology graduates being ill-prepared for the role (Albrithen and Yalli, 2012; Soliman, 2013; Albrithen, 2014).

Other professionals in HSWs' workplaces

Many of the participants identified the opinions of the other professional groups working with them in their workplaces as possible sources of work-related stress. Issues raised related to other employees' perceptions of the responsibilities of HSWs, and how this affects the level of cooperation and support offered to them by other professional groups. HSWs' responses are presented according to two areas regarding the mentioned issue, including underestimation by professional groups and lack of collaboration from other professional groups.

A high proportion of participants from both genders, and different demographic backgrounds referred to the attitudes of other professionals' surrounding them at work as creating additional pressure. One respondent in particular commented that professionals from other specialities frequently underestimate HSWs' role and believe their tasks are very easy and could be readily performed by others without training. Therefore, they question why there are SWDs in hospitals. She said:

I am talking about other employees, the staff, they say that they can do what we do, they think that dealing with the patients' social problems and solving problems are simple things, anyone can do it! It is not necessary to have social workers to do it.

(Female, Internal Medicine, 9 years' experience)

Another interviewee stated that other professionals unfavourably compare HSWs with members of the medical team, whose tasks are readily apparent to others. On the other hand, they underestimate HSWs' roles, implying that HSWs have no apparent job specifications. He stated:

They compare us and say that doctors' roles are very clear, the equipment they need is clear and we all know what they do with patients, but what do social workers do? It definitely affects me to see that my role is not appreciated and is treated as secondary.

(Male, Internal Medicine, 6 years' experience)

Moreover, another participant alleged that within his workplace, there is only one doctor who expresses an interest in and respect for HSWs' opinions. He believes that this may be because

the doctor in question has lived in a Western culture, where HSWs' are accorded importance by doctors and nurses. He said:

There is only one doctor who understands our roles and does care about our interventions and reads our comments on the patient's report. I think because he studied abroad.

(Male, Oncology, 2 years' experience)

Another interviewee alluded to feelings of regret when referring to other professionals' views about the importance of HSWs' roles. She had formerly worked as a nurse before being hired as social worker. However, she indicated that her colleagues' (nurses) were very shocked when she decided to study sociology and work as a social worker in a hospital. They believed that she had demoted herself deliberately. She reported:

I used to work as a nurse, when I started working as a social worker my nursing colleagues said to me that what I was doing was wrong, and I was in a higher position before, and now I am in a less important position. This made me think many times: why did I choose to do this - am I right or wrong!?!

(Female, Dialysis, 11 years' experience)

Significantly, one very experienced participant working in the addiction field shared a story reflecting the negative perceptions of some doctors toward HSWs' role in creating a treatment plan. He stated that doctors prefer to ignore the interventions proposed by HSWs, as the latter might hold different opinions about the treatment of their patients. Thus, in most cases, doctors prefer to decide independently whether the patients are ready to leave or not, regardless of the HSWs' assessment. This result appears to correspond to the findings of a recent study conducted by Albrithen and Yalli (2015), which characterises the relationship between HSWs and medical teams as competitive rather than complementary:

Doctors try to exclude social workers from the medical team. In any case, patients cannot leave unless the decision is made by the whole team, not the doctor only. If the social worker says no, it means that the case puts pressure on the doctor, the case is still under his supervision, and he wants to get rid of cases. One day, the doctor made a decision on his own and the patient was out. When the patient got to the clinic for follow up, we found that the case was still considered too dangerous

to continue without observation, as he had started threatening to kill his mother. We went back to the doctor to tell him about the situation; the doctor was very angry and said: "Why would social workers try to be part of this process?"

(Male, Mental Health Hospital, 10 years' experience)

On the other hand, although inter-professional teamwork between HSWs and physicians is viewed as an essential component of effective practice in health care organisations, the participants in this study identified several frustrating stories in this regard. Ten participants of both genders, working in different fields with diverse experiences, shared numerous stories revealing a lack of support and cooperation from other professionals in HSWs' workplaces. For example, one of the participants working in the maternity and childcare field referred to a lack of collaboration from doctors in the department. She stated that HSWs are always called upon by paediatricians to respond to issues relating to children, however, doctors working with pregnant women rarely collaborate with HSWs. As a consequence, patients frequently fail to access appropriate support from HSWs; for example, mothers who have new babies and might be suffering from postnatal depression. More importantly, this can place more pressure on HSWs as they need to compensate for this on their daily rounds by catching up in person with what is happening for patients:

If any children have a problem, they call us first, but only 30% of obstetricians work with us, 70% do not. They keep saying that they are busy and do not have time to talk to a social worker. However, why do they deprive the patient of their rights? What if a patient needs a social worker and doctors never offer them the chance to meet with a social worker? That is why HSWs try to do their best through daily meetings with doctors every morning.

(Female, Maternity and Children Hospital, 12 years' experience)

Another participant with a role in the internal medicine department shared his experiences when seeking to manage the frequent problem of providing medical devices to needy patients before leaving hospital. He maintained that due to a lack of collaboration with doctors who supervise such cases, patients can take up to a month to leave, because they have not received the necessary devices on time. This wait seems to be caused by the medical team choosing to work independently from HSWs, and as a result patients' needs are scarcely met. This creates

a feeling of isolation and disappointment for HSWs, since they need to work within the medical team on the one hand and satisfy patients' needs on the other. He explained:

We are encountering some serious difficulties, the patients taking so long to leave. This is because some patients are unable to buy medical devices and need some machines for use back at home. However, they cannot get machines out before 2 weeks have passed after filling out forms. I told the doctors that patients need a plan as soon as they are admitted. So, when a patient needs a machine, we can prepare it for him before he gets out. However, they are uncooperative I feel that we are working alone... what can we do? We are always under pressure in these cases.

(Male, Internal Medicine, 6 years' experience)

Overall, strong evidence of limitations on peer interaction arose from the interview data, maximising the pressure at HSWs' workplaces. Although these results might contradict the vision of DSW, which advocates enhancing the ethos of teamwork; it seems consistent with the aforementioned research conducted by Albrithen and Yalli (2015) and Albrithen and Yalli (2016). This particularly relates to the referral of patients by physicians to HSWs to handle the social aspects of their complications. The probable cause of poor inter-professional teamwork in Saudi hospitals probably relates to the negative opinions of some physicians regarding HSWs' roles (i.e. they are either undervalued or they misunderstand HSWs' tasks). There is, however, another possible explanation that relates to the diversity of the cultural background of physicians, as some are from other Asian or non-Arabic countries. This can influence the effectiveness of their teamwork and communication with HSWs, who are generally Saudis, as they may speak other languages (Al-Aameri, 2003; Albrithen and Yalli, 2016).

Patients and their families

This sub theme concerns the participants' experiences of stress that are linked to issues associated with patients and their families. Problems with this central relationship were identified as one of the key contributors to stress, causing pressure for HSWs. HSWs' responses have shed light on issues related to uncooperative families, patients and families' attitude, and patients' expectations.

For example, the lack of cooperation from patients' families was frequently mentioned by the participants to explain why they sometimes felt stressed at work. Six HSWs, particularly those working with cases in the mental health and addiction domain and those involved with chronic illnesses, reported stressful experiences involving dealing with patients' families. One of the HSWs reported her experience of dealing with patients' families in the addiction field, stating that most families do not assist with the treatment process. Many families simply place responsibility on HSWs to help the addicted member of their family to heal, and even when HSWs require additional information about a case, families do not respond when contacted. She said:

The problem facing us is that families are not very understanding of how addiction is, there are certain behaviours that come to an addict's mind that are out of his control, they do not realise that, they bring the patient and say: "You have the patient now, he is your responsibility". Sometimes they do not even answer when we want to get in touch with the family to get some information about the patient. As obviously, we are not going to ask the patient since he is not in his right mind.

(Female, Addiction, 10 years' experience)

Another participant gave the example of a problem encountered with a new mother who had postnatal depression. Although the patient's mental situation was critical, her family refused intervention from HSWs and psychiatrists, preferring to take her to visit a religious man (*Sheikh*²⁵) to heal. In this regard, it is relevant to note that despite the fact that the Holy Quran represents an important religious aspect in all Muslim teachings, including dealing with illnesses, this is not advised at the exclusion of other medical therapeutic interventions, even in cases where there are mental complications. This result, however, is unsurprising, as some Saudi citizens continue to attribute psychological or mental complications to Evil eyes and Jinni, which can only be treated by religious men (Al-Krenawi and Graham, 2000; Al-Shahri, 2002; Khalifa et al., 2011; Albrithen and Yalli., 2012; Koenig et al., 2014; Shaheen Al Ahwal et al., 2016). The participant explained the situation as follows:

Frequently, we face frustrations because the patient's family does not understand his/her condition. As an example, a case I witnessed involved a woman who had post-natal depression and needed psychological treatment to make sure her

²⁵ A Sheikh from the Muslim perspective is a blessed man or woman who reads some verses from the Holy Quran to a patient to cure illnesses including mental disorders.

situation would not get worse. She was not to able to sleep at all, and after a time, her family took her to another hospital who gave them the same consultation... I stated to them how dangerous the situation is, they decided that they did not want the psychiatrist's treatments, as they would take her to a Sheikh.

(Female, Maternity and Children Hospital, 5 years' experience)

Moreover, another participant considered the lack of patients' families' cooperation as a key factor contributing to her own stress. She reported that the greatest difficulties that HSWs encounter when discharging patients arise because families choose not to cooperate with hospital staff once treatment is complete, especially in the case of elderly patients. In many cases, patients can spend several days on hospital without any need for medical care, simply because their sons/daughters have not responded to HSWs' calls to pick them up. She said:

We have problems when we can't reach the patients' families, so we are obliged to extend the patient's stay for 3 or 4 more days until the family shows up or answers our repeated calls.

(Female, Home Health Care, 3 years' experience)

Sorrowfully, another participant shared her experiences in tears, describing how hard she finds it when she tries to get in touch with elderly patients' families to arrange their discharge. Sometimes sons and daughters refuse to take their parents, claiming that they do not have the time or ability to take care of them. In many of these cases, the patients die in hospital awaiting collection by their families. She stated that:

When old people are here, and they need to leave, there is nobody to take them and take care of them, it is very sad to know that they need to go home but his sons are running away from responsibility. I remember a particular patient where a daughter got upset with me when I try to convince her to come and pick her mum up from the hospital... she later died in the hospital.

(Female, Internal Medicine, 9 years' experience)

This result was unanticipated, as social connections within Saudi families are assumed to be very strong, especially with regard to parents (Al-Shahri, 2002; Salamh, 2018). It is suspected that these findings are likely a consequence of the increasing prevalence of nuclear family forms in Saudi society, which might be weakening family's social ties (Al-Sharfi, 2017; Yalli

and Albrithen, 2011; Gazwani and Al-Musa, 2013). On the other hand, families' unwillingness to cooperate with medical teams, especially HSWs can be attributed to the reactionary characteristic of most citizens within the Saudi community, combined with a lack of understanding of the HSWs' roles, and the support they offer to help patients and their families, as concluded by Yalli and Cooper (2008) and Albrithen and Yalli (2012) and reported earlier in this thesis.

From different perspective, half of the HSWs interviewed, including males and females working in different domains and with different levels of experience shared undesirable experiences in relation to patients and their families' attitudes. One participant, for instance, identified that she comes across inappropriate behaviour among people who act offensively towards her, believing that HSWs, as employees working in the health sector, receive an enormous income and so should be expected to endure any behaviour from patients. She stated:

Some patients and their families are impolite! Yes, very much so! This makes us angry, they claim that we are healthcare workers who have a good job with a high salary, so we should keep cool and adjust to angry patients and their families. It does not matter how we feel about it.

(Female, Internal Medicine, 9 years' experience)

Another female participant who works in a mental health hospital told the story of a patient who threw a bottle of water at her head while she was in the isolation room. Moreover, the same participant stated that when she speaks with patients to gather specific information about their social life, they respond by telling her that she is a very nosey person and should not ask about their private lives, as it is none of her business. She stated that:

I remember a patient in emergency, she hit me on my head, although I had come to tell her that I had brought her shampoo and clothes to wash herself, but a nurse took me out quickly and closed the window. Sometimes they also do not help you at all, though they understand your role. I remember an old woman told me: "why do you ask questions to people, leave them alone!"

(Female, Mental Health Hospital, 17 years' experience)

Not only that, but an interviewee working in the maternity field mentioned violence in the form of verbal abuse against HSWs. She stated that a husband of a pregnant woman, who had been

exposed to physical abuse, shouted at all staff members, especially her, using very offensive language when they were dealing with his wife. She reported:

I can remember a case of a pregnant woman who had been physically abused by her husband and she was very scared and hesitant to give any information about what had happened. Her husband was waiting outside and shouting at us using very rude words.

(Female, Maternity and Children Hospital, 12 years' experience)

A further problem raised appeared to be linked to communication difficulties between HSWs and patients. For example, one participant stated that most patients strongly refuse to speak with HSWs, as they associate social workers' roles with those of psychologists and psychiatrists. He indicated that some patients still confuse and fail to differentiate between the roles of HSWs and psychiatrists. Therefore, they avoid speaking with HSWs or professionals other than doctors and nurses, to avoid being stigmatised or classified as mentally ill. Such attitudes can make HSWs feel frustrated and unwilling to practice. He said:

The most hated thing for me is when I come to a patient and tell him that I am a social worker and he says that I am a psychologist. He keeps saying that I am not crazy, those two are the same for them, I try to distinguish myself from psychiatrists because as soon as the patients hear about them they think you are seeing them as crazy people.

(Male, Internal Medicine, 6 years' experience)

Together the collected results might provide important insights into the nature of some Saudi patients and their families, especially in terms of how far their traditional nature informs their resistance to interventions from professionals other than physicians within the hospital context; especially psychologists and HSWs (Al-Krenawi and Graham, 2000; Al-Shahri, 2002; Yalli and Albrithen, 2011; Khalifa et al., 2011). Moreover, the references to physical and verbal aggression made by the participants might correspond to Saudi patients' attitudes, as identified earlier in the Context Chapter. This can be exemplified in the case of recent physical abuse towards a doctor that caused him to have his life threatened (Moore, 2016). Indeed, professionals in the health field, including HSWs, are known to encounter violent behaviour (Mohamed, 2001). In summary, this result might also reflect the lack of the Saudi community's

awareness of the importance of HSWs' roles, as putting pressure on them in their workplaces (Yalli and Cooper, 2008; Albrithen and Yalli, 2012).

Additionally, patients sometimes arrive at the hospital with demands and expectations about the services that HSWs provide based on misinformation accrued from people outside the social work profession. This can cause HSWs distress, as their actual roles might then be in conflict with patients' expectations. Interestingly, eleven participants from both genders and different domains, with varying levels of experience, stated that contradictions between patients' expectations and the kind of help that HSWs deliver add to the pressure in their workplaces. The participants mentioned that the most stressful situations they encounter are when patients and their families ask for assistance that HSWs cannot offer. The patients sometimes suggest that HSWs do not want to help them when they fail to provide specific types of help, especially if they are seeking financial support. One male participant stated:

I feel pressure when the patient's family needs something, and whatever I say to explain the situation and their options they leave angry. There is a problem, when the patient leaves, and you cannot provide him with a service. Patients think that HSWs do not want to help them. If you do not meet their needs, they think this means you do not want to help.

(Male, Home Health Care, 8 years' experience)

In support of this, another participant explained his upset when involved in a situation that prevents him from satisfying patients and their families' needs. This potentially arises because HSWs tend to devote considerable effort to explaining the situation to patients to justify their inability to provide the requested service. He explained:

Some even think that social workers only provide financial support. This puts us under pressure for being unable to satisfy them and places responsibility on us to clarify our roles clearly.

(Male, Dialysis, 29 years' experience)

More surprisingly, one of the participants regretfully observed that perhaps more than 80% of patients and their families seem not to be aware of HSWs' roles, and how they can help them. Moreover, she commented that when they see the sign for social work department in the

hospital, some patients ask for stationery services, like photocopying and binding services. He reported:

I am saying this so sadly, 80 to 90% do not know who a social worker is, or what he does. Even when they read the sign for the office, the first thing that comes into their minds is that social work department provides photocopying services...

(Female, Internal Medicine, 9 years' experience)

According to this data, we can infer that the different beliefs that patients and their families' hold regarding HSWs reflect a general misunderstanding regarding the services that HSWs can provide. This conclusion is consistent with data obtained from Yalli and Albrithen (2011), who reflected on the lack of recognition of the social work profession's importance, and HSWs' roles within Saudi society; particularly in the health care domain, where some individuals might not expect provisions other than medication from physicians (Albrithen and Yalli, 2012; Alahidb, 2012).

Leadership in HSWs' workplaces

Leadership is an important topic informing the character of HSWs' workplaces. The participants identified issues arising at both the central and ministerial level, beginning with the Mental and Social Health General Department (MSHGD), involving supervisors SWDs in Saudi hospitals via the Directorate of Social Work (DSW), and resulting in complications proceeding from hospital administrators and SWDs' line managers. In association with this sub theme, the researchers has explored how such issues contribute to work-related stress in HSWs' workplaces, in relation to two main levels including leadership at ministerial level, and leadership at the central level.

Regarding leadership at the ministerial level, ten out of eighteen HSWs, particularly those with considerable experience in the field, identified matters related to leadership at the MSHGD, which seems to influence their role in the workplace hugely. Some of the participants believe that the role of the Directorate of Social Work (DSW) at the MoH does not seem to have been clearly established yet. This can be attributed to the fact that the majority of those individuals who supervise the MSHGD at ministerial level, and whom are in charge of directing two units including the DSW as well as the Directorate of Mental Health (DMH), are psychiatrists (MoH,

2014). Therefore, less attention might be given to SWDs in the Saudi hospital setting, compared to that granted to other mental health professionals. This might be exemplified in the arguments of participants who have claimed that HSWs are supervised by psychiatrists who do not have relevant experience in the social work field, and therefore HSWs' suggestions and demands are frequently neglected due to their different interests and concerns. One interviewee said:

I also feel that our administration is weak in the ministry; we are not exercising our rights to the fullest because our director is not specialised; currently the director of the MSHGD is a psychiatrist, so when we are in regular and annual meetings, we feel the director is not on our side, as he is not from the social work domain.

(Male, Cardiology, 16 years' experience)

Another participant stressed how hiring unqualified persons to direct the SWD could adversely affect the position of the SWDs with Saudi hospitals and the HSWs themselves, establishing that this is a serious complication broadly affecting HSWs. This is exacerbated by the fact that HSWs' roles might not be clearly understood or appreciated by others:

Previously, a social worker was responsible for social work issues at the Ministry of Health.... then other specialties took over this responsibility, which made things worse. So, there is a need to get the social worker back in charge of the unit and the administration, it is very important as other specialties cannot manage the SWD.

(Male, Mental Health Hospital, 10 years' experience)

Importantly, one participant offered valuable information about the leadership in social work at the ministerial level and described how might this influence HSWs, whether directly or indirectly. Firstly, she stated that although the MoH merged the profession of social work with psychology under the supervision of the MSHGD, this was fundamentally wrong, as each has its own policy and approaches (MoH, 2014). She pointed out that:

The first thing that should happen to improve social worker's status is the separation of social work from psychological health; there should be an

independent administration, ruled by someone who is professional and believes in what he is doing, which will reflect on everything else.

(Female, Maternity and Children Hospital, 12 years' experience)

From a different angle, another interviewee revealed an additional issue linked to administration at the ministerial level, in terms of selecting a leader for the MSHGD. She believed that the issue of the participation of managers of SWDs at Saudi hospitals should not be neglected when choosing leaders at the MSHGD and even SWDs, as they will be responsible for evaluating the performance of HSWs and the managers of SWDs at ministerial level. This perspective appears to confirm the outcomes reported by Yalli and Albrithen (2011). The participants are advocating not only for more effective supervision from officials at the ministerial level, but also to grant HSWs a sufficient level of autonomy at the local level, which may be dependent on the MSHGD's leaders (Albrithen and Yalli, 2015). One participant suggested:

The MoH does not care about involving the heads of the social work departments when electing the MSHGD director!! Why not, he is the one who we can go back to when we have a problem; someone we can count on. It is not only about him being the boss!!! They evaluate us depending on our patient's opinions; so how do you evaluate the heads and directors if not according to the people who work with them.

(Female, Mental Health Hospital, 17 years' experience)

The most surprising aspect of this finding is that all the responses obtained regarding the inadequacy of the leaderships at the ministerial level appear to have been identified by highly qualified and experienced HSWs. This might reflect their understanding of the contribution of leadership to improving social workers' status within the Saudi community, since radical change needs to be undertaken, starting at the ministerial level, to negotiate the challenges encountered by HSWs in their workplaces. Furthermore, despite the common association between the social and psychological lives of patients, at the practical level, there appear to be fundamental theoretical differences between the demands of social work and mental health. However, lack of awareness about such distinctions, compared with the other clinical specialisms in Saudi society might affect interpretations of negative aspects, as identified by HSWs' responses.

In terms of the leaders of SWDs within HSWs' workplaces (at central level), two participants working in the same workplace identified their line manager (the SWD head) as a potential source of stress. They stated that the head of department chooses to maintain a dictatorial system fulfilling their personal desire to protect the status of their administrative position, while routinely neglecting HSWs' requirements. For example, the male participant indicated that he had spoken to the manager of the social work department repeatedly about issues requiring reconsideration, but he had been ignored, and his concerns were not reported to officials at the ministerial level. He said:

The line manager is a very ineffective person, even when we talk to him about our needs and requirements, he cannot convey our ideas to the hospital's administration.

(Male, Cardiology, 16 years' experience)

Meanwhile, a female participant who works in the same hospital described her line manager as unqualified to hold his position. This is because he does not appear to have the required skills to direct the department, and therefore frequently puts HSWs' in difficult situations with other departments. She claimed:

The head of department is unqualified for this position, which creates many problems. Because he is not able to deal with issues at work, sometimes he even does things incorrectly. So, the consequences are sometimes embarrassing, especially when we have to deal with other departments. Therefore, we can suddenly find ourselves doing work that we are not even supposed to do.

(Female, Home Health Care, 3 years' experience)

When interpreting this finding the researcher assumes that since the two participants are from the same workplace and supervised by the same person it is likely that their views about their manager are accurate. However, due to the shortage of social worker numbers in this workplace, the investigator could not arrange an additional interview to gather more information to confirm or refute this. Nevertheless, prior examples of stressful experiences outlined by both participants should not be neglected in the light of the relatively disappointing status afforded to the social work profession within Saudi society. The status of HSWs could result in their being overseen by officials who are not thoroughly vetted before taking on the

role of head of SWDs in Saudi hospitals, as previously noted by Yalli and Albrithen (2011) and Albrithen and Yalli (2015), when discussing supervision and administrative system.

Regulations and policies in HSWs' workplaces

Despite the fact that the Ministry of Health (MoH) have specified that certain roles be assigned to HSWs (Albraithn and Yalli, 2012), all eighteen interviewees in this phase identified complications associated with their roles as a source of pressure. HSWs indicated how stressful some of the situations in which they find themselves involved are. This stress results from the expectation that HSWs can reasonably be assigned as first responders in matters not related to their job description, even when employees from another speciality are needed to resolve problems. One participant exemplified this, thus:

There are duties given to us that are totally not linked to HSWs' specialty, just because everybody is used to the social worker doing them... We have codes, for example, the worst one is code 12, which is for violence or fighting. They used to call it a case of violence and verbal or physical abuse, so, a social worker should be there to calm things down, but also one of the people who should be there is the medical director, the one in charge of the emergency department, not just the social worker!!! When things like that happen, I could be the only one handling it, which does bother me...they leave the social workers in the firing line, which bothers me a lot, the fact that there is no one helping us.

(Male, Internal Medicine, 6 years' experience)

Discussing the diverse expectations placed upon HSWs, another participant spoke about role ambiguity, referring to his previous experience as being a source of pressure, since he previously worked as head of the Social Work Department. He shared his experiences regarding his role being misunderstood by the hospital's administration, and their expectation that HSWs complete a lot of paperwork. Therefore, whatever HSWs do with patients in terms of social and emotional support, the administration does not recognise this unless it is recorded in writing. Furthermore, additional roles seem to be assigned to HSWs, reflecting a lack of understanding of the actual role they play.

Our role is a practical more than a desk-based role, but the administrative staff are always imposing desk-based tasks. As I told you, our roles are directly linked to the patient more than noting and registering things. Departments are always asking about the role of the social worker. According to the administration, there is nothing clear in reality; there are no documents related to our work.

(Male, Cardiology, 16 years' experience)

In another interview, a female participant indicated that HSWs are sometimes required to perform additional administrative tasks (e.g. preparing discharge report) for patients and the family members who accompany them during their stays in hospital. She also mentioned frustration arising when she was exposed to considerable stress because a child had gone missing from the hospital and the administration had put her in charge of investigating what had happened, which she believes should have been a job for the security department. She stated:

There are things that are not actually linked to our job, like writing reports for the patients and their escorts, but other things can make me crazy, like when a child is missing; it is not our job to go and look for him, it is security's job.

(Female, Maternity and Children Hospital, 12 years' experience)

Additionally, a newly qualified participant observed the ambiguity of HSWs' roles with annoyance, sharing his brief experience of being forced to play additional roles that do not fit the HSWs' job description. Since he is responsible for overseas patients, he has been given responsibility for arranging flights when they want to return to their native countries. He remains strongly convinced that this is not his role and that he should not have been asked to perform it. He mentioned this as below:

There are additional tasks like coordinating flights and travel tickets... that is not what we are supposed to do. Like when we are faced with the case of a person who is not from this country, we have to coordinate with the expatriate management administration, it gets the job done but it is not one of the social worker's duties.

(Male, Home Health Care, 8 years' experience)

Interestingly, the participants clarified that refusing to complete tasks not within the HSW's job description could expose them to criticism from the hospital's administration. Thus, they

are under pressure about whether they refuse to take on tasks outside their remit or complete them. The administration evaluates HSWs' performance at the end of the year, and so any refusal to complete a task could potentially affect the outcome of that assessment. Commenting on this, one of the interviewees stated:

Sometimes the administration gives us other duties that cause pressure, because we have two choices with the administration, you can do it or... I mean a bad impression could be created from the situation, which then creates pressure.

(Male, Patient Relations, 9 months' experience)

From a different angle, an experienced participant revealed how the roles that HSWs play could affect them in their workplaces, referring to both essential and secondary tasks. He explained that he previously worked in the field of addiction, and that he identified that when he was working in addiction hospital, he felt very satisfied and that he belonged. This was because he recognised how important his role was when handling social problems in addition to physical ones. Patients and their families consulted him frequently about many things. However, when he moved to the general hospital, he noticed how minimal his role became, as his co-workers only addressed clinical issues and neglected other areas that HSWs deal with (social life), leading to a dissatisfaction with his responsibilities in his current workplace. The interviewee stated:

In the addiction hospital, I see the role of the social worker as more important there than any other place, because of the nature of the patients, as they have social problems.

(Male, Mental Health Hospital, 10 years' experience)

Moreover, while the MoH has established Patients' Relations Directorates (PRDs) to undertake administrative work associated with patients, such as publishing reports, and arranging patient discharge after completion of the treatment process, confusion about the roles that must be performed by PRDs indirectly exposes HSWs to stressful situations, especially when patient care is involved. One participant exemplified the situation, mentioning that HSWs have to cooperate effectively with patients and their families. However, the reality of fieldwork can complicate this relationship, especially when the administrative roles assigned to them need to be performed by another department (i.e. PRDs). Sometimes families come to visit their hospitalised relatives outside of visiting times and security does not allow them entry, so they

might then transfer them to SWDs. This could negatively affect these family members' relationships with HSWs, as they have the impression that HSWs do not want to help them. He said:

The overlap between the social work department and other departments, I even talked about and wrote reports to the director about the lack of organisation, including the patients' visiting hours. Actually, this is the biggest obstacle facing social workers, because it makes them appear to be against him, which is not the case. This is the most important point, and I've been struggling with this point. That's it; this is my main biggest concern.

(Male, Cardiology, 16 years' experience)

These results are likely to relate to the lack of understanding in Saudi society regarding the roles of HSWs, especially within health care organisations, which tend to be characterized by the prioritisation of physician roles (Al-Qurni, 2003; Yalli and Albrithen, 2011; Alahidb, 2012). Therefore, it seems to be suggested that HSWs might find themselves delegated to handle other responsibilities that feel are the purview of other departments (e.g. PRDs). Thus, since the SWDs and PRDs address aspects aside from medical conditions, other staff are prone to confuse the roles of both departments, despite the different job descriptions and structures (MoH, 2015).

The bureaucratic systems, that characterise the work environment in most Saudi public organisations, also appear to influence HSWs' in their workplaces (Albrithen and Yalli, 2012). Five participants from both genders identified the limitations on their authority and the bureaucratic rules that prevent them from enacting their roles expediently. For example, one stated that HSWs do not have the right to contact a public organisation directly, e.g. National Home Health Care Foundation (NHHCF), to deal with a needy patient seeking financial support, including when needing to access medical devices. Permission from the hospital's administration must be obtained first before contacting the NHHCF, which usually takes a long time. He pointed out:

The bureaucracy and the routine processes adopted here are limited and inhibit the social worker from doing his job perfectly. I cannot do all that I am supposed to do; we know that a social worker is supposed to communicate here and there in order to help their patients, but to do that I need to get permission from the

administration and write official letters for routine things, just to be able to help the patient. For example, a patient needs machines and tools and many things; as a social worker, I cannot get those things on my own, I have to appeal to the administration, which makes the whole thing take longer, when the patient might need oxygen, a device for his heart... it slows things down.

(Male, Home Health Care, 8 years' experience)

Confirming this, another participant provided a realistic example of the problems that arise to demonstrate how applying bureaucratic rules inflexibly might negatively affect both patients and their families, in addition to HSWs. She reported how difficult it is to apply policies strictly in all cases, especially in the case of old people and critical cases. She dealt with someone who needed to be transferred urgently to home medicine; however, the hospital administration and the Mental and Social Health General Directorate (MSHGD) focused on applying routine steps based on administrative structure (see figure 4). She encountered serious stress in this case, as she was expected to follow policy at her workplace, and to address her patient's needs. She explained:

Like, two days ago, there was an elderly patient who needed a transfer for home medical treatment; the hospital administration said that the patient needs to go to the clinic and the doctor needs to see her to transfer her. Her son had already brought her to the emergency room, he had signed her in and we had diagnosed her; we tried to check with the administration, but they declined and asked for the whole process to happen again, the woman was old and could not get out and then come back in. In such a situation, social workers start to feel pressured, as our administrator says that we cannot accept a case, and the patients' family said that we must accept her case....

(Female, Dialysis, 11 years' experience)

Expressing frustration, one more participant shared his story, referring to the conflict that arises between patients' needs and the bureaucratic administrative system. He indicated that if the administration were to delineate precisely, and expand on the HSWs' authority, greater efficiency would result. This is because the existing abusive (as described by him) system does not encourage HSWs to assist patients. This finding might also be explained by the fact that the majority of SA's work environments, especially in the public sector, seem to concentrate

more on bureaucratic requirements than on clients' priorities, which hugely extends the duration of the patient treatment process (Yalli and Cooper, 2008; Albrithen and Yalli, 2012), the participants stated:

I am not only talking about the hospital where I work; I am talking in general; if departments are collaborating with social workers, this makes many things easier. When we require something from the administration for a patient before he leaves the hospital, we have to complete a lengthy process, or written procedures to get it. Therefore, even if we help the patient get his needs met, we will never try again for another patient, because of the length of time taken. For example, the administrative procedures are very difficult, as there is no flexibility.

(Male, Mental Health Hospital, 10 years' experience)

In addition, among the most important factors contributing to employees feeling positive in their work environment is the granting of incentives for good work and access to support. Despite this being widely recognised, ten of the eighteen HSWs involved identified lack of appreciation and low motivation as sources of stress in their workplaces. This finding was obtained from participants with different levels of experience, different qualifications, and of both genders. One of the participants mentioned that the environment in the workplace discourages HSWs from being creative, as their efforts are rarely appreciated by administrators. She stated:

One of the reasons why a social worker would not develop himself is that they know their rights are not well guaranteed and preserved... I swear I do the paperwork for the manager and... that is not how the relationship is supposed to be, not an atmosphere to be creative, normally the leader should be a reference, the one I go to for help, or the one who tells me 'do this differently, add this and take this off'... a guide and a supervisor, someone who helps our growth... those we have do not help, and they also become obstacles or even rob us of creativity, which is a problem.

(Female, Maternity and Children Hospital, 12 years' experience)

Another participant supported the above view, adding that lack of support and appreciation gives the impression that social work, as a job is not perceived of as important. She stated:

Something that might put pressure on us, is that no matter how well we work, it is always the same; there is no support from the administration, no motivation, we feel like they do not see social work as worthy of compensation.

(Female, Internal Medicine, 9 years' experience)

Similarly, another interviewee pointed out:

There is not much appreciation from the officials at my workplace, nothing not even a thank you, or if you do something wrong he makes a fuss about it. There should be appreciation and thanks when good work is done, just as there is punishment for bad practice.

(Male, Patients' Relations, 9 months' experience)

Indeed this opinion was a common one; since HSWs' workplaces apply punitive policies when HSWs do something wrong, the participants felt distinguished HSWs should be rewarded and those in need cared for. The discrepancies in managerial approach certainly appear to be partially responsible for demotivating HSWs in their workplaces. Another participant said:

What puts pressure on me is having so many duties, this problem is common at work, it gives more work to the person who is more dedicated and comes on time and so... this seriously puts pressure on me. However, when I get sick, or whatever, they still ask me to do my duties while I am supposed to be inactive that is one of the things.

(Male, Internal Medicine, 6 years' experience)

A possible explanation for these results is that HSWs' roles remain misunderstood by the majority of Saudi citizens, both among the public, and internally within healthcare organisations (Yalli and Albrithen, 2011; Soliman, 2013). However, the researcher who participated in this study noted an exception in the case of those working within the mental health and addiction field. This might be because HSWs' roles in this domain tend to be judged as equivalent to those of the medical team, since the majority of patients admitted to hospitals have complex social difficulties, which need to be investigated by HSWs to ensure a

comprehensive treatment plan. This also appears to be in line with the previous point of view that described health care organisations as prioritising the roles of physicians over those of other health allied professionals (e.g. HSWs) (Al-Qurni, 2003; Yalli and Albrithen, 2011; Alahidb, 2012).

On the other hand, the majority of the professional groups in hospitals receive a workplace allowance; for example, doctors typically receive an infectious allowance for working with patients with a transferable disease. Therefore, HSWs are currently seeking similar benefits, focusing on this when highlighting the pressure and alienation they experience in their workplaces. Four participants from different demographic backgrounds were concerned about the issue of the benefits they believe HSWs should receive, including housing and health insurance, since they come into direct with patients with potentially infectious disease. For example, one participant who occupies a temporary position claimed that permanent employees are more secure than those hired to fill temporary positions (under contracts) and via private companies. This was justified by explaining that the latter are not eligible to receive any allowances, unlike HSWs working under the MoH's supervision. An HSW on a temporary contract explained:

There are social workers who are working in permanent positions with the ministry and others work on contracts in a temporary role. The latter do not feel secure in their jobs; they feel pressure, feeling that they are not equal to those working for the ministry. For example, allowances, like the infection allowance, the ministry gives to social workers now... if some HSWs do not receive it, they can go to court to get it; however, this is not possible for social workers who are on a contract like myself.

(Male, Patient Relations, 9 months' experience)

However, this issue also seems to be affecting HSWs in permanent positions, as indicated by one of the female participants who has been working in the field for eleven years under the supervision of the MoH (in a permanent position):

We do not receive any benefits, for example, housing... many employees have problems with housing and some of my colleagues are struggling and stressed because they have to pay rent and their landlords can force them to leave if they don't pay. Where would they go? They have families and are responsible for

children. We have some assistance... a benefit for infection, because there are many contagious diseases and all the staff working in the hospital are subject to infection. There are some who get the infection benefit and others who do not. And we work face to face with the patients; we are in direct contact with them, so we could get infected at any time. What do I gain then from the Ministry of Health? They should encourage us by giving us incentives.

(Female, Maternity and Children Hospital, 12 years' experience)

These results are likely to relate to the fact that social work profession is still relatively new compared to other medical domains (e.g. medical, nursing), which might lead to vagueness in terms of HSWs' justification to have similar financial advantages to physicians who normally receive higher financial benefits. Moreover, it could be also attributed to the lack of social recognition regarding the importance of the social work profession, which characterizes the majority of the Saudi community, including officials at both ministerial and central level in the health care domain (Yalli and Albrithen, 2011; Albrithen and Yalli, 2012).

Resources in HSWs' workplaces

Concerns regarding the shortage of resources allocated to support HSWs' roles were observed by all participants (eighteen HSWs) as something that can contribute to stress at work. In regard to this theme, the researcher reported HSWs' comments on matters linked to lack of resources, in terms of budget, equipment and resources, and staffing.

As mentioned earlier in the Context Chapter, a huge budget is allocated annually to meet health public requirements in the health sector in SA, with a portion devoted to social services (Albejaidi, 2010, and MoH, 2015). The MSHGD, which supervises SWDs at ministerial level, is in charge of allocating the annual budget to allow HSWs to perform their tasks effectively (MSHGD, 2016). Nonetheless, it seems apparent from all the HSWs interviewed, that no specific budget is dedicated to SWDs within Saudi hospitals, and this is a key obstacle contributing to pressure in their workplaces. For example, one of the most experienced participants in the study indicated that there has been no clear statement from the MoH allocating specific funding to SWDs to support needy patients. Therefore, HSWs have begun looking for help from public organisations within the Saudi community to meet these demands.

This exposes HSWs to stress, particularly in light of the limited authority given to them under the prevailing bureaucratic system. Moreover, HSWs might also experience disappointment, as some organisations might agree to help, while others might not. He stated:

The Ministry of Health does not make clear statements when specifying a special budget for our department to help us provide financial support for patients and their families as needed. This leads us to communicate with the community, to ask for help, as the patients we have at this hospital have special needs, they require special support from the associations who need to provide these things for them. It put us under pressure and causes embarrassment.

(Male, Dialysis, 29 years' experience)

Moreover, the lack of budget seems to exacerbate the stresses involved when organising activities. One participant indicated that HSWs are required to select entertainment and activities for each patient carefully, because there is no specific budget for SWDs. Moreover, if they want to attend lectures from experts on particular issues, they must pay to do so out of their own money. She elaborated thus:

Another point that frustrates me and my colleagues is that the social work department does not have its own budget here, so if we want to do some activities, bring doctors and well-educated people and so on... there is not a budget for social work.

(Female, Internal Medicine, 9 years' experience)

In another interview, one participant noted how challenging it is when the hospital's administration asks HSWs to arrange activities without providing appropriate financial support. She stated that as there is no budget, HSWs end up spending their own money on such activities. There should be specific budgets allocated to hospital SWDs, as it is not reasonable to receive a salary from work and then spend it on work-related activities. She mentioned:

They keep asking us to arrange activities for patients, but we do not have any financial resources. We do not have a budget and so it does not make sense, that we work hard, get a salary then spend it on our work. It does not make sense!

(Female, Maternity and Children Hospital, 12 years' experience)

The investigator in the current research believes these outcomes are likely to relate to lack of recognition within Saudi society over SWDs roles in hospitals, as well as a lack of appreciation for HSWs' tasks (Yalli and Cooper, 2008; Yalli and Albrithen, 2011; Soliman, 2013; Albrithen and Yalli, 2015). This is because the MoH prioritises budgeting to other divisions within Saudi hospitals, ignoring SWDs' demands, resulting in HSWs using either their own money to meet patients' social needs, or communicating with public organisations when looking for financial support. The HSWs' responses regarding the lack of budget confirm Yalli and Albrithen's (2011) findings, which revealed that the remarkable lack of funds available for SWDs in Saudi hospitals undesirably impacted HSWs' performance of their roles.

Looking at it the other way, as was pointed out in the Context Chapter of this thesis, the MSHGD pays great attention at ministerial level to facilitating SWDs in Saudi hospitals with all the necessary equipment to enable them to deliver social services in an effective manner (MSHGD, 2016). However, this did not seem to be the case in practice according to the evidence collected for this research. The majority of the interviewees from both genders, each from different working domains with different levels of experience, tended to raise concerns regarding resources and equipment. The lack of equipment appears to affect HSWs in terms of the theoretical principles they are expected to apply in their workplaces. For instance, one participant indicated that after being hired recently, he had been shocked to find that everything he had learnt at undergraduate level differed from the reality of practice. He offered an example to clarify this, stating that one of the fundamental ideologies informing social work practice is to apply confidentiality when working with clients; however, he also commented that he has struggled to find suitable places to speak with patients about their problems. He observed:

What we studied in the university differs from what we found here! We were shocked that the theory is so different from the reality, you know for social work you must provide a place, a desk for the social workers to sit at with the client privately and take information, in order to apply confidentiality, you know there are confidences and information that should be kept between us. But we did not find that, it is non-existent... really frustrating and different from what we learnt.

(Male, Patients' Relations, 9 months' experience)

On the other hand, while it was stated that it is one of SWDs' responsibilities to help provide medical tools for needy patients, the participants expressed negativity whenever a patient requested use of clinical machines or tools after discharge, because HSWs cannot do anything

to help due to the limited resources available to them. Therefore, HSWs might need to put a lot of effort into calming patients down, and explaining the situation to them, which frequently puts them under pressure and causes distress, as they cannot readily satisfy their patients' needs. One participant noted:

When patients ask the doctor or any administrative officer about something they need like medical devices and wheelchairs, they tell them 'the social work department will help you get that'. But, the reality is counter to that, we do not have any resources to provide them with what they need. This creates a burden on us, our patients and their families, because they come to the social work department in order to meet their needs; so, whatever we say to clarify the situation we can't convince them, they believe that we do not want to help, which puts us in an embarrassing situation and exaggerates our feelings of disregard.

(Male, Internal Medicine, 6 years' experience)

On this issue, the participants exalted the role of the National Home Health Care Foundation (NHHCF) as a charitable organisation supporting needy patients by providing medical instruments. One participant stated her reliance on the NHHCF and the lack of an alternative option. However, she identified another problem that could arise, even where support is received from this organisation. This relates to the lack of a specific place or stock area in which to keep the received devices and tools adequately, until they can be used by patients. Thus, HSWs seem to be under continuous pressure to assist patients to satisfy them with the provision of good services. She explained:

The most stressful thing we face is when patients need some devices, machines. Princess Adilah's association the NHHCF is very helpful for getting us what we need for them... if it were closed at any time, patients would be seriously at risk. But the problem still exists, because we also need a place where we can put the things provided to us. We have no depot at the hospital; we have people who want to provide certain things. If they give us beds or provide us with specific hardware, we need a specific environment; temperature for certain medical devices such as cylinders. For example, we cannot provide a bed and take it to an open place, no one will benefit from it then.

(Male, General Hospital, 13 years' experience)

Moreover, the lack of desktop equipment (e.g. computer devices, printers and telephones) was repeatedly emphasised by the participants as a potential source of work-related stress. This equipment is essential for conducting official work on behalf of patients, such as writing official letters for the police or other government organisations. Therefore, HSWs started to bring their own laptops to complete important missions. One interviewee said:

There is a lack of computer devices at the hospital; we have to use our own laptops to write reports and send them to the police and other administrators. I save them, and I print them out at home! This makes me feel frustrated, as there is no assistance to help me do my job.

(Female, Mental Health Hospital, 20 years' experience)

Similarly, other participants shared their frustrations about finding themselves forced to use their personal mobiles to conduct important calls with patients' families and other governmental organisations, as part of their patients' treatment plan. This could result in privacy concerns for HSWs, as in some cases patients' families save the number and start calling out of working hours, which can make their job more stressful. One participant said:

We are encountering financial problems and lack communication devices; we do not have anything, no phones, no mobiles. I mean, we call the patients' families from our personal phones; even the doctors call us from the men's section to ask us to call patients' families. I do not understand why! Are we supposed to do that? Even at home, patients call me because they know my personal mobile. That is annoying, as sometimes they call you late at night.

(Male, Mental Health Hospital, 10 years' experience)

Supporting this, another participant working in the field of addiction cited bed capacity as a reason why HSWs might come under pressure at work. This is because addicted patients need time to prepare to leave hospital so that they are physically, psychologically and socially capable of interacting normally within the community. However, bed capacity in some mental health hospitals does not allow HSWs to follow an appropriate treatment plan, and they need to discharge patients as soon as they have finished their clinical therapy, regardless of the importance of their treatment. She described this as follows:

As you know addicted patients should stay for at least 1 month in hospital. In addition, there are others outside the hospital who are waiting to be cured. Unfortunately, in this hospital the female section does not have enough beds for long stay patients, as we only have nine beds.... So, we are always under pressure because we cannot discharge patients before they are cured; at the same time, we need to accept new patients.

(Female, Mental Health Hospital, 17 years' experience)

Overall, the lack of resources to support HSWs' roles within Saudi hospitals can be linked not only to the level of social recognition surrounding the importance of social work within healthcare organisations, but also reflects the exclusion of HSWs from funding decisions about SWDs (Yalli and Albrithen, 2011; Albrithen and Yalli, 2012). Furthermore, another factor seems to relate to the fact that in the case of the mental health domain, psychological illnesses in general are stigmatised by the majority of Saudis (Al-Krenawi and Graham, 2000; Qureshi et al., 2009; Attum et al., 2019). Therefore, many mentally ill patients prefer to treat psychological problems by taking a spiritual rather than a medical approach (Khalifa et al., 2011). Consequently, decision makers at ministerial level can be inclined to ignore the psychological needs of patients, when prioritising clinical requirements.

Theme 2: Issues related to Gender affecting HSWs in their workplaces

The issues presented under this theme are those raised by the participants as sources of work-related stress. One of the key contributors to stress was found to be the issue of gender, in particular the problems experienced by female HSWs. The HSWs' responses focused on a number of aspects, including: (1) professional classification for HSWs; (2) working hours; (3) attendance; (4) evaluation and promotion; (4) staffing; (5); workload and (6) patients' problems.

Gender Inequality

Similar to the topics mentioned in the context chapter (Chapter Two) (AlSaleh, 2012; Hamdan, 2012; Alharbi, 2015; Van Geel, 2016), gender inequality and male dominance were identified as concerns by almost all female HSWs regardless of demographic background. The interviewees mentioned segregation between males and females as an important factor

affecting their work environment, and was identified by both experienced and less experienced female HSWs, working in different departments within Saudi hospitals. One of the female participants pointed out that officials are stricter with females than males, specifically in terms of their expectations pertaining to commitment to working hours. She also commented that this was a consideration because not all females drive in Saudi Arabia (SA), since they have only had a right to do so for a few months (Alfasi, 2018). Consequently, many female HSWs have to wait until the end of the working day for their husbands, drivers to pick them up. She said:

Honestly, because HSWs in the men's section have a good relationship with their manager, they do find ways to leave the workplace earlier, they leave at 11. They keep saying that they need to drive the kids to school, they always find excuses. So, because I am a female social worker, I feel more pressure... I mean than being a male social worker. They leave whenever they want, they have cars, but it's hard for us to do that.

(Female, Mental Health Hospital, 20 years' experience)

On the issue of gender, another participant emphasised differences between male and female HSWs in relation to commitment to their work. She explained the duplicity of some male HSWs in terms of registering their attendance at the beginning of the working day and then staying for 2 or 3 hours, before leaving in their cars and returning at the end of the working day to register as leaving (fingerprints are required to clock in and out). She observed that when HSWs in the female section try to contact their colleagues in the male section, they rarely find them at their desks, whereas in the female section, HSWs are always present until the end of the working day. This creates a feeling of being taken advantage of, and puts female HSWs under greater pressure. The female participant said:

Most of the guys can leave earlier than us, they have their cars. They just do the fingerprint, takes their cars and leave... half an hour before the end of the shift they came back to do the fingerprint. We can't do that... we have transportation arriving at a particular time; the driver comes at a certain hour to pick us up from the hospital. So, women can't really do that. When you call the men here, it is not guaranteed that you will find them... but poor women, they are available at any

time, they do all the work. I think this is unfair; there is no equality between men and women.

(Female, Maternity and children Hospital, 12 years' experience)

From a different perspective, one participant referred to the flexibility in the male HSWs' section, which allows them to divide tasks between them, and to leave their workplaces without applying for authorisation in writing from the administration, since their other colleagues choose to cover them during any absences. Conversely, in the women's department female HSWs are not permitted more than two authorised hours leave per month, which might create a feeling of stress, arising from their being treated differently to male HSWs. This arguably arises because male HSWs have a better relationship with administrators, which is probable because the Social Work Departments (SWDs) in Saudi public hospitals are directed by males. Therefore, HSWs are not physically segregated from them, unlike their female colleagues. One participant stated:

There is a considerable difference between male and female social workers. We as women sit at our desks and cannot go out, no cars, so no way to go somewhere and get back. Men can do whatever they want, like dividing work hours between them as they want. For us, we require official authorization, such as is only available once a month, to even take 2 hours to do something and then come back.

(Female, Oncology, 1 year and 9 months' experience)

In addition to the differences in working hours, and lack of opportunities for female HSWs to take a break during working hours, gender inequality seems to also extend to ways of evaluating HSWs' performance. The female participants described the assessment process as being more rigorously applied to females than males. This might also be attributed to the physical segregation applied in the majority of Saudi workplaces, that do not allow evaluation bodies to interact directly with the HSWs in women's sections (Hamdan, 2012; Van Geel, 2016). A female interviewee mentioned:

Even on job applications... in addition to the long hours without breaks... when it comes to evaluating social workers, it is harder on females than males. They are more judgmental of women than men.

(Female, Maternity and Children, 12 years' experience)

Professional classification for HSWs

Interestingly, the regulations from the Saudi Committee for Health Speciality (SCfHS) for professional classification were observed to result in work for female HSWs only. The majority of the female (seven) participants mentioned that in order to attain accreditation from the SCfHS for promotion purposes, they needed to gain 100 hours training a year. However, the availability of training sessions at their institutions was very limited, with only two or three hourly sessions, which makes it difficult to accrue 100 hours a year. Moreover, HSWs are given only 10 days per annum to attend training sessions, so disappointingly the stated requirements cannot be met. One participant argued:

We are supposed to complete 100 hours of training to obtain a specialty certificate from the SCfHS. So, in the workshops provided at King Fahd Hospital, we can't reach this number of hours, they only offer two or three hours, and we have ten days to attend sessions in the whole year so how can we complete 100 hours of study in only 10 days!? That is impossible.

(Female, Maternity and Children Hospital, 12 years' experience)

Supporting this, another female interviewee also signified the stressful dilemma caused by the requirements for professional classification, stating:

It is definitely stressful! 100 hours of training compared to the shortage of availability of training sessions is disappointing, so we do not have the chance.

(Female, Home Health Care, 6 years' experience)

This finding might be influenced by the conservative nature of the Saudi community, which makes it difficult for female HSWs to travel alone to other cities to access appropriate training to meet the requirements of the SCfHS (Hamdan, 2012; Alharbi, 2015; Van Geel, 2016). In support of this supposition, no male participants mentioned difficulties accruing training hours, which could imply a bias against female HSWs.

Working hours

Frequently, working hours were mentioned as potential factors contributing to stress for HSWs at work. This was particularly evident with females, including experienced and less experienced ones. According to one of the participants, HSWs are required to work daily for a long period of time (approximately 9 hours every day). They start work early in the morning and finish later than other professionals, such as teachers and administrators in other Saudi organisations. This puts them under pressure and also damages their relationships with their children and other family members, adding to their stress. One participant identified that:

The long working hours put us under pressure. We officially work from 7:30 a.m. to 4:30 p. m. Then it takes us one hour to get back home at 5:30. We also have other responsibilities. We have children to take care of and want to help them with their homework. Some of them are in college, others in school. I always need to sit and relax. I don't have time for that. This makes me feel anxious and stressed out. Pressure at work, pressure at home, psychological pressure when you want to go out and relax but you can't. Work is taking up all your time.

(Female, Internal Medicine, 9 years' experience)

In support of this, another participant highlighted similar issue relating to how long working hours can affect females HSWs in particular, as when she returns home, she has young children who need additional care. However, after completing her long working day (9 hours) her energy is low, and she is very exhausted and unable to do things with her family and children (e.g. preparing them for exams, or other responsibilities like house cleaning and cooking). She expressed this concern:

We only have one problem, which is the long work hours, I work either in the morning or the evening from 12:20 to 8:20. So I neglect my children during the week I cannot take care of my kids and my house, I feel exhausted after work, and still have a lot of work to do at home.

(Female, Mental Health Hospital, 20 years' experience)

Another female participant expressed a sense of unfairness, because of the length of time they daily spend in their workplaces, which not only consumes their time, but also affects their ability to perform physical work with their families when they get back home, she said:

Nine and a half hours is too much to work, from 7:30 to 5 pm. It's a pressure on our kids and it affects our homes. We come back home very tired and bored... Honestly, I can't deal with my children's schools, exams, cleaning, cooking... that's too much. As my colleague always says, the biggest challenge for working women is the long hours of work.

(Female, Addiction, 10 years' experience)

According to HSWs' responses, working hours are an evident source of stress, especially for the female interviewees. It seems possible that these results are due to the norms of Saudi culture that expect women to be primarily responsible for their homes and children (Hamdan, 2012; Van Geel, 2016; Al-Sharfi, 2017). Therefore, female HSWs are perhaps more likely to experience pressure caused by their attempts to fulfil both workplace and domestic demands.

Moreover, another striking result emerged from female HSWs' responses with regards to their working schedule including night shift work. It should be noted that marital status did not affect the results, as both married and unmarried, mothers and non-mothers, all cited nightshifts as a source of work-related pressure. Female respondents stated that it is very difficult for women to leave their houses and families late at night, and others believed that it is culturally unacceptable within the Saudi community for females to work in mixed settings until midnight. Despite this, when female HSWs explained their feelings to officials in their workplaces, the administrators sometimes simply responded by asking why they had accepted the position if they are unable to work at night. This was clarified by one female participant:

I don't like the shift system; I prefer that women work in the mornings and men can do night shifts. It is hard for girls to go out at night!!! You know the culture here, but when we tell them that, they keep asking us: Why did you accept the work as you know the conditions of the job.

(Female, Oncology, 1 year and 9 months' experience)

While another participant has expressed her frustration because she needs to come in at midnight sometimes to check on the cases of patients she is supervising. She explained how hard it is leaving home during the night after a long working day to do extra work out of working hours for no financial reward:

Sometimes there are cases where I have to come at night just to check up on them and see what is happening. That is hard, to come at night, I mean usually we work like any employees, from 8 AM to 5 PM, right? And that is additional work when we come at night, we are here as the one supervising the treatment that is all? If the patient asks for us or if the director does, I must come and see what is going on. But the most stressful thing is that we do not get any overtime for this!!

(Female, Internal Medicine, 9 years' experience)

Interestingly, this situation is made worse by the nature of SA's conservative society, in which women are expected to spend the evening at home with their family and not to go out without a 'Mahram', except in an emergency (Yamani, 2000; Hamdan, 2012; Van Geel, 2016). Therefore, the female HSWs involved in this study appear to be under greater pressure than the men in terms of issues related to nightshifts at their workplaces.

Attendance

Notably, four of the female HSWs stated that the daily attendance system that is currently being implemented is a potential source of work-related stress. This is because it can be difficult for them to register their attendance at the time required, as they mostly rely on somebody else to give them a lift to work. However, although their timely attendance is not necessarily within their control, the administration does not accept any excuses, and makes salary deductions if they are late. One participant argued that:

I meant that the administration shows no mercy when we come late and all that, they count the minutes, they cut it off the payment!!! And there is nothing you can do about it.

(Female, Internal Medicine, 9 years' experience)

Similarly, another female participant described the fingerprint system to prove an HSWs attendance as a dictatorial aspect of their workplace, which is especially punitive for those who live far away from their workplaces. This seems to support the supposition that although Saudi women have been recently allowed to drive, the reality at the practical level is that many

(Alfasi, 2018) must still rely on their drivers, husbands, or brothers, to deliver them to their workplace on time (Hamdan, 2012; Van Geel, 2016). She stated:

First, the timing of the fingerprint, we have a lot of traffic in Makkah. I live maybe an hour away from the hospital. My house is in the North of Makkah and the hospital is in the South. So, it takes time to get here. Second, you have to do the fingerprint at 8 a.m. sharp, if you arrive 8:01 a.m., it will be considered a delay. They don't take into consideration the traffic and what can happen on our way to work.

(Female, Maternity and Children Hospital, 12 years' experience)

Evaluation and promotion

The criterion applied by officials to evaluate HSWs' performance in their workplaces was also listed among potential factors contributing to work-related stress, particularly for female HSWs with different levels of experience. One experienced participant, for example, pointed out that different issues linked to the process of promotion, such as employing traditional methods, tend to focus on the amount of work performed rather than the quality of outcomes. She added that when officials come to evaluate HSWs' efforts, they do not distinguish between individuals by judging the level of their work. This is typically because of personal relationships between some inspectors and the family members of the female HSWs (e.g. brothers and husbands), creating bias:

Evaluating social workers involves a very old method with routine inspections taking place from time to time during the year giving us orders, so that is their way of evaluating our performance. There is another thing, which is that the social workers are just evaluated on number of cases. Another annoying thing is that the ones who work and the ones who do not are treated the same... that is a big problem for the social workers. The evaluation also sometimes is dishonest too, as some ask others to erase their mistakes from the evaluations so personal contacts count too? Helping people they know first.

(Female, Maternity and Children Hospital, 12 years' experience)

On the issue of promotion, female HSWs explained the stress they encountered if they do get promoted. One participant pointed out that she had to move to a different city and leave her mother who needs special medical attention. Moreover, she encountered serious difficulties in terms of transport. She observed that the obstacles she encountered were rewarded by only a slight increase in salary, leading her to question the desirability of promotion in the future. She said:

When I got promoted, I had to work in Al-Taif, I was the one who was taking care of my diabetic mum. So, it was very hard to move to Al-Taif and leave my home in Jeddah, and transportation is not available, so it is hard for a woman too... I was obliged to hire a driver. I guess they appoint social workers according to the area s/he lives in, why do they send people who live in Jeddah out of it? That's miserable; they give you an extra 900 SR for tougher conditions. I don't need this promotion. That's not good especially for women.

(Female, Home Health Care, 3 years' experience)

It seems possible that these experiences relate directly to the norms in Saudi society, in which males dominate the public sector, making it likely that promotion opportunities for women are either limited or ill-conceived when offered, leading to greater stress among female HSWs (Albrithen and Yalli, 2012). This is because the administrators responsible for evaluating female's performance are usually physically separated from female workers. Thus, their assessments of them lack accuracy, and a sufficient level of care is taken when establishing the suitability of new roles for individuals. Moreover, as was suggested previously by Alfasi (2018), few Saudi women drive and many are not permitted to travel alone without a 'Mahram', and this can make any changes in role or job location problematic, as mentioned by the last female participant (Hamdan, 2012; AlSaleh, 2012; RajKhan, 2014; Alharbi, 2015).

Staffing

Generally, only three female HSWs from different work settings appeared to experience pressure resulting from the shortage of social workers available to complete the tasks expected of their departments. One participant clarified that the principal difficulty imposing pressure on her, was that in the female section there are only two HSWs. Consequently, if one is unable

to come to work one day, the other would then be expected to cover her colleague's tasks. She emphasised how difficult this can be, because sometimes she has to choose between the needs of her family and demands at work. She reported:

The biggest problem that this hospital has is that there are only two social workers here, so if they are both absent... it is too much pressure, sometimes when she is not around, and I have to go do something, I cannot go. Sometimes I have to come here even if I am sick or if my sons are sick.

(Female, Addiction, 10 years' experience)

Likewise, another participant mentioned a similar situation arising because of the lack of HSWs numbers in the male section, which means more effort was needed from female HSWs to meet patients' needs, placing additional pressures on female HSWs.

There are a lack of social workers' in the men's department also; there are only three in the whole hospital. So, that puts the female section under pressure to work very hard to help them.

(Female, Dialysis, 11 years' experience)

Additionally, the final participant revealed an interesting point with regard to the shortage of HSWs employed at her workplace. She emphasised that it would be better to appoint a sufficient number of HSWs in Saudi hospitals, instead of imposing a heavy workload on only a few HSWs. She maintained that the number of social workers graduating annually from Saudi universities easily exceeds the needs of hospital SWDs. She pointed out:

The administrators at my workplace keep saying that they do not have enough social workers, so, why do not they hire more social workers. Every year, there is a large number of new graduates! The number of graduates is so high. Why don't they hire them?

(Female, Oncology, 1 year and 9 months' experience)

Thus, it might be useful to point out that while the number of Social Work Schools has been recently increased within the Saudi universities; namely in the public sector (Soliman, 2013), a shortage of practitioners employed in SWDs remains a limitation (Yalli and Albrithen, 2011; 2012). However, the most striking result to emerge when discussing this result was that male

HSWs did not find their limited numbers a source of pressure at work; although one female participant identified that there were too few males in the social work department at her workplace. This may reflect the higher level of cooperation and flexibility afforded to male employees as identified previously with respect to the dominance of male power in Saudi workplaces (Yamani 2000; Al-Hamdan, 2012).

Workload

As expected, considering HSWs' responses regarding the additional clerical tasks assigned to them, which are not related to their job description as social workers as well as the shortage of staff in female HSWs section, it is interesting to note that only female participants referred to intensive work as a contributory factor to their stress. HSWs emphasised this, explaining that they perform intensive work daily in their workplaces which can involve them to fulfil additional administrative tasks beside their actual roles. For example, they are responsible for performing tasks as identified by Albrithen and Yalli (2012), such as training university students, and carrying out the roles required of them by the hospital's administration (e.g. tasks do not necessarily relate to their speciality). One participant stated:

We perform several tasks here... train college students, students who have finished college, the ones who want certificates from the Saudi Committee for Health Specialties. We also go around divisions and ask if they need anything, give notes and so on, provide codes, we sometimes get some suicide cases, violence... in addition to the things we do that are out of our specialty of course, that causes me stress.

(Female, Internal Medicine, 9 years' experience)

Another participant also emphasised the stressful impact of the volume of work required daily from her and her colleagues in the social work department. She explained:

We are actually exposed to a heavy workload, as we do field training for students, those who graduated with distinctions and we work in family therapy, instructions...etc. We take care of patients, departments, emergencies, women and

*children, women's health, cases of violence, calls from the nursery, from the ICU...
I think it is too much to deal with...!!!*

(Female, Maternity and Children Hospital, 12 years' experience)

Not only that, but the HSWs have indicated that in their workplaces they are asked to complete work (e.g. communicating with patients to arrange appointments with doctors) belonging to other departments. The HSWs' tasks should only focus on the social side of patient care, as taking responsibility for additional administrative tasks increases the volume of work and distracts HSWs from completing their actual tasks. One female participant stated:

There are additional tasks. I do like escorting patients and arranging patients' appointments for check-ups. It purely does not belong to us, so, it does seriously waste the social worker's time and adds more pressure on him/her, we are frequently exposed to a heavy work because of that!

(Female, Oncology, 1 year and 9 months' experience)

Patients' problems

From different point of views, the nature of patients' problems might also undesirably affect HSWs in their workplaces, particularly female HSWs. The participants identified situations that seemed to expose them to pressure and emotional complications when dealing with patients, whereas none of the male participants mentioned any issues arising in that regard. The female participants working in the field of addiction, as well as at maternity and children's hospitals, were most likely to state that patients' problems could negatively influence their feelings. For example, one participant from the addiction domain stated that addicted patients arrive with depressing and challenging problems. She deals with very complicated cases, which are described as being beyond anyone's understanding, and nobody can believe that such problems exist in Saudi society, especially when they admit patients who have been victims of physical, sexual or financial abuse:

Look, there are things that if others were to hear about, they would get depressed, there are also things happening in our community that make you depressed... you would not even expect... there is so much pressure on us, especially if we get

violence related cases in the hospital... because we hear some unimaginable things...

(Female, Addiction, 10 years' experience)

In addition, another participant working in a maternity hospital clarified that she often undergoes chronic stress handling the social side of patients' lives. This is because she is handling a very sensitive area of the patient's life, asking for information that nobody else might know about. Moreover, she maintains that negative experiences in her workplace can affect her when she returns home, as she keeps thinking about cases that can affect her emotionally, even outside the workplace. She mentioned that:

I always have this image of myself, as a surgeon who goes in for the deepest wounds that nobody else can reach. We reach into the private life of the patient; their thoughts, feelings, secrets that they might not have been shared with even herself. We deal with sensitive places where the least mistake could cause a big problem, which makes our responsibility a heavy one. In addition, when I have a case to deal with I became worried about it for a long time. I keep thinking and worrying about it, even at home and I ask God to protect the situation.

(Female, Maternity and Children Hospital, 5 years' experience)

A possible explanation for the aftermath of interactions between female's participants and patients' experiences is the sensitive nature of women, as in comparison men tend to be more logical and practical. In addition, stress can be heightened when working with children and addicts who are vulnerable and demand more attention and support from HSWs than other patient groups. Thus, the professionals working in these domains might experience higher levels of stress, especially when they are responsible for addressing the social and psychological aspects of patients' experiences (e.g. HSWs).

Summary

In concluding this section, it is vital to underline that the results identified a number of negative impacts related to specific cultural aspects distinguishing most aspects of life in SA. These

included the workplace environment and gender, and tended to exacerbate occupational stressors for the HSWs interviewed for this study.

When it came to cultural issues, the participants identified working in a mixed setting as contributory factor to stress, due to the conservative nature of Saudi culture, which appeared to have a negative impact on HSWs of both genders. Additionally, stress was generated by HSWs' additional responsibilities, particularly for those who were married, due to the difficulties of balancing work and domestic responsibilities (i.e. caring for their children). Furthermore, the majority of participants (including males and females from differing demographic backgrounds) cited the lack of recognition by the Saudi community's of the social work profession and HSWs' roles as also being a source of workplace stress.

Moreover, HSWs raised concerns related to external issues, including the quality of academic preparation and training courses. Thus, HSWs from differing demographic backgrounds identified one cause of stress as being inadequate courses run within Saudi universities, including a lack of attention given to the English language and medical vocabulary at undergraduate level, stating that these could expose HSWs to risk, particularly when dealing with patients suffering from infectious illnesses. A further contributor was found to be the gap between theoretical preparation at undergraduate level and the reality of fieldwork. Furthermore, HSWs graduating from social work training believed that the current lack of attention on the recruitment process can exert a negative impact, due to the Ministry of Health (MoH) employing HSWs with degrees in sociology and social work, despite sociology graduates being inadequately prepared for these roles.

A significant point to emerge from the participants' answers concerned their relationships with other professionals in the workplace, in particular the underestimation of their role by other professionals (e.g. doctors, nurses, and other administrative employees). Moreover, the lack of cooperation from such colleagues placed additional pressures on HSWs. It should be noted that it possible both issues are associated with a general lack of awareness of the roles played by HSWs.

This study has also identified issues related to patients and their families as forming a source of work-related stress at the internal level. In particular, HSWs working in chronic illness departments and mental health identified a lack of cooperation from patients' families as generating pressure when carrying out their responsibilities. This tended to be due to an assumption that HSWs offer psychiatric care, a subject that is generally sensitive within SA.

HSWs stated that they were also placed in difficult situations by the negative attitudes of some patients and their family members toward HSWs, along with expectations from patients, particularly when they requested services the participants were unable provide. Such complexities can be attributed to the status of the social work profession in SA, as well as a lack of awareness among the majority of Saudi patients of the actual role played by HSWs.

In addition, this study recognised that leaders can also exert a considerable impact on the stress in the workplace, as reported by HSWs at all levels, including ministerial and central. This aspect influenced HSWs' experiences regarding leadership at the administrative level, with highly experienced participants from both genders identifying problems related to Mental and Social Health General Directorate (MSHGD) as a source of stress. Additional sources of stress concerned exceptional cases being identified by hospital managers, as well as the managers of Social Work Department (SWDs), due to personal considerations. Nevertheless, HSWs' responses regarding the head of MSHGD could, to some extent, be associated with the lack of awareness among Saudi officials at MoH of the actual needs of SWDs within Saudi hospitals.

Additionally, the most significant finding to emerge from this study is that HSWs' generally encounter a number of difficulties associated with their roles and job description. For instance, the majority of the interviewees stated finding themselves in charge of performing additional tasks outside their job description, and which could increase their volume of work. A number of HSWs also cited the bureaucratic system applied to administrative transactions. Another theme to emerge from the evidence concerns the lack of incentives within workplaces and the limited support on offer, particularly for those working in areas other than mental health. This point was related to the limited recognition by Saudi citizens of the significance of this role. Finally, the lack of any working allowance was identified as a source of pressure for a number of participants, particularly in the light of the fact that other professionals (e.g. physicians) are permitted to receive recompense for working with highly infectious patients.

Moreover, one of the more significant findings to emerge from this study, being raised by the majority of the participants, concerned the availability of resources to enable HSWs to adequately perform their tasks. The lack of an independent budget for SWDs within Saudi hospitals was identified as a core source of stress for all the study participants. Moreover, HSWs also faced complications associated with the accessibility of the required equipment, particularly in the mental health and internal medicine departments, due to a lack of devices required by patients before leaving hospital. These results can be seen to highlight the influence

of Saudi culture, in particular the lack of social recognition for the social work profession. On the other hand, it could also emphasise the limited employment opportunities accorded to Saudi women compared to men.

In addition, the majority of female participants raised the issue of the impact of gender inequality, in particular in relation working hours and the inability of some women to drive. Moreover, the participants stated that gender enhanced the experience of stress in relation to evaluation and promotion, working hours, attendance registration, and shortage of female HSWs. Finally, patients' experiences of suffering appeared to have a negative impact, predominantly on female participants, particularly those working with vulnerable patients (i.e. children and those suffering from addiction).

This study therefore offers an opportunity to explore the issues influencing the participants to improve the quality of HSWs' workplaces. For example, the findings also highlight a need for official bodies within Saudi society (i.e. MoH, universities, SCfHS, and police offices and courts) to recognise the uniqueness of Saudi culture, as well as the quality of the educational and health system, within their policies, practices, and approaches. This would create a healthy workplace environment, capable of ensuring greater proficiency among HSWs, and improving the quality of health services.

This study also identified an urgent need for job descriptions to be revised to conform to the actual roles HSWs are expected to play. In addition, it would be beneficial for MoH to establish an adaptable scheme to manage working hours for HSWs, taking into consideration their domestic responsibilities and the conservative nature of Saudi culture. Furthermore, it is vital to apply fixed regulations to govern the professional development opportunities provided to HSWs, particularly females, to develop their knowledge and skills in an effective manner. Furthermore, it should be a priority to ensure that appropriate incentives and support systems are available in HSWs' workplaces, with the aim of creating a desirable working environment. Moreover, the MoH should reconsider the guidelines concerning benefits and allowances, in order to provide HSWs with equal opportunities to their peers (i.e. doctors and nurses) in healthcare workplaces.

This study also recognised the need for greater efforts to ensure adequate resources are made available to facilitate HSWs in performing their tasks effectively, including specifying annual budgets, office equipment, sufficient staff, and accessible medical equipment required for home care patients. It is also essential to accord sufficient power and authority to managers

responsible for directing SWDs at both ministerial and central level, allowing them to manage HSWs' workplaces more effectively. Moreover, all related organisations need to make continued efforts to increase the awareness of patients and families regarding the roles of HSWs. Finally, it is crucial to establish a productive collaboration between HSWs and the physician team, as a means of both benefiting health service users and ensuring effective inter-professional teamwork.

Chapter Six: Findings Pertaining to Coping Mechanisms

Overview

The current study aims to explore the experience of work-related stress from the perspective of Health Social Workers (HSWs); particularly in relation to stressors and coping strategies. Employing NVivo software to analyse the data concerning coping strategies generated a number of themes, which can be classified as: (1) Personal skills, (2) Emotional and Instrumental Support, (3) Religious Strategies, (4) Leisure Activities, (5) Venting, (6) Managers of Social Work Departments, (7) Patients and their Families, (8) Taking a break from the workplace, and (9) Fieldwork Experience. When strategies were repeatedly mentioned, the researcher considered only their frequencies and did not include all relevant quotations. This informs the organisation of the findings discussion as it relates to those factors that contribute to work-related stress (see Appendix 9).

Theme 1: Personal skills

Notably, the HSWs' degrees of work experience were found to affect their ability to employ personal skills to manage stress at work, regardless of gender, specialisation, and qualifications. Thirteen participants identified a number of personal skills they had applied when overcoming (or avoiding) pressures associated with their roles as HSWs. One participant, for example, revealed that skills that can be gained through training sessions assist him significantly in developing his capacity to handle challenges at work, such as handling patients' anger and understanding their psychological conditions:

Training sessions (like anger management and how to handle difficult situations, and personal illness) require high levels of training. If they take enough specialised training sessions on anger management and communication with patients, HSWs learn how to handle stress better.

(Male, Mental Health Hospital, 10 years' experience)

In addition, the importance of using personal skills was highlighted by the participants in relation to the importance of applying the principles of social work practice. The aim of this, for example, was to maintain a professional approach and when dealing with patients' social problems, as well as to understand the psychological and physical status of patients. Such skills

can assist in maintaining a professional approach and improving HSWs' ability to overcome negative feelings in their workplace as a way to resolve stressful issues. One participant stated:

In all cases, the first characteristics social workers need are to be patient and not nervous. Patients and their families are often anxious because of the patient's disease. Patients can say obscene words, but initially I should be tolerant and understand their situation. One patient encountered many pressures before arriving here, and they noted that if the social worker approaches him/her nervously, then they will never find a point of convergence and arrive at an understanding. We should try to satisfy patients and deal with them, even if they are not as we want them to be.

(Male, Cardiology, 16 years' experience)

Interestingly, the participants' personal skills in terms of dealing with job stress appear to involve an ability to avoid thinking about workplace pressures during their free time (i.e. when they get back home), and vice versa. Thus, this perhaps contributes to the stability of their mood during the day. One interviewee, for instance, mentioned:

It is about control. As soon as I get out of here, I leave my worries behind. It is important not to take them home, and the same thing with any worries I may have at home.

(Female, Internal Medicine, 9 years' experience)

In a similar vein, another participant working in mental health identified another strategy in handling stressful experiences, this is with regard to trying to avoid taking any decision while under pressure. She prefers instead to stay calm until she can take herself from the stressful incident, and then start planning to deal with problems. She explained that:

My way is to stay away from the issue, and to relax in order to think and make up my mind. I never make a decision while I am under stress. I wait until I can get myself out of the stressful situation, and then I think about a solution to the problem. Once I have detached myself from the problem, and I am relaxed, and then I start thinking about a solution.

(Female, Mental Health Hospital, 20 years' experience)

Significantly, the role of gender tends to be identified within this theme in relation to applying self-adjustment techniques, which seem to be employed only by female HSWs as a way to control stressful experiences, in particular those caused by internal factors. It is apparent that the majority of female HSWs adapted to the limitations in the workplace environment; specifically, in terms of issues related to the availability of resources and other policy regulations (e.g. workload). The female interviewees might believe that any challenges they faced in the workplace should not cause problems, as HSW's main function is to provide social and emotional support to patients and their families. Hence, it could be predicted that HSWs would need to have courage to confront any limitations, in order to avoid a negative attitude. One participant clarified this, thus:

When I come to work, I try to adjust myself according to the circumstances in the hospital. In this way I am able to perform my duty. Otherwise, I would not be able to improve on anything, because if I start saying I need this and that, and nobody listens or provides me with anything, I would never be able to finish my job. Therefore, I always try to make something from the things I have. I try to make friendly calls to companies, or call my friends who might be able to assist me. That's how I can achieve my goals. I live in society, and I try to use my relationships with others to achieve my purpose. I need to talk to patients in a way they understand, because they are not educated, and I need to clarify things. This is mainly about adapting in order to make things work.

(Female, Maternity and Children Hospital, 12 years' experience)

A potential explanation for the influence of experience on increasing participants' capacity to expend their personal efforts to manage work-related stress is that they enable them to become familiar with the most appropriate ways of dealing with different problems. The majority seem to have worked in the field for over ten years, and have therefore gained sufficient experience. Conversely, some female HSWs' solutions to the pressure they face are associated with their working environment and their limited access to resources, which appeared to relate to their limited authority in the workplace. As noted previously, it seems to be rare for female employees to hold an administrative position, particularly in the public sector, therefore their participation in decision-making tends to be very limited (Al-Hamdan, 2012; Van Geel, 2016). Therefore, female HSWs most probably try to adapt to existing workplace structures.

Theme 2: Emotional and Instrumental Support

Family support seems to have arisen from the interviewees' responses, as a mechanism that assists them when they experience work-related stress. Six HSWs of both genders, and with a variety of experiences, agreed that sharing their negative experiences with their family members (including parents, husbands and wives, siblings and children), as well as with friends surrounding them can provide comfort and help minimise the effects of any pressure at work. This included taking into account the confidentiality of patients, by ensuring they did not refer to any names or details that might reveal the identity of a case. One participant, for instance, stated that:

The first person I go to is my wife. Although many people prefer not to get their wives involved in work, I feel I should keep my wife in touch with what I do, of course not in detail to maintain patients' confidentiality, but whenever something happens I tell her, sometimes I ask for her opinion. I try to do not get my elders involved (like my parents), so it's mostly my wife.

(Male, Home Health Care, 8 years' experience)

Supporting this finding, another participant confirmed that family support can contribute significantly to reducing the feeling of pressure caused by HSWs' workplaces, even if families do not help with resolving problems. She stated:

At home, my family, my mother, father, husband and kids, try to help me. I feel that spirit of trying, even if they can't solve the problem, and it means a lot to me.

(Female, Maternity and Children Hospital, 12 years' experience)

Similarly, the participants also suggested that discussing problems with their friends outside of work (including those who might work as social workers), is a useful technique for reducing feelings of work-related stress. For instance, one of the interviewees argued that he tends to share the challenges he experiences with close friends, or friends in other similar workplaces who have had comparable experiences to work through job stress. He stated:

I talk to my close friends outside the workplace about work pressures, I consult them, and listen to their advice. I also have some friends who are social workers at different hospitals and share the same experiences as me in the same field of work.

Sometimes we talk to each other and meet to have tea or coffee together and talk about work problems.

(Male, General Hospital 13 years' experience)

In general, these results might be explained by the fact that the nature of Saudi society, is distinguished by the prevalence of strong social ties between family's members and friends (Sacarellos et al., 2016; Al-Sharfi, 2017). Therefore, HSWs might prefer to express their stress with their families and friends outside the workplace in order to deal with job stress; especially in light of Saudi citizens' limited knowledge of the roles of social workers (Albrithen and Yalli, 2012; Albrithen and Briskman).

From different point of views, the majority of the participants of both genders (particularly those who have worked in the field for over five years) acknowledged that strong relationships with their colleagues in SWDs, as well as professionals in other departments (i.e. psychologists) helps to reduce their tension at work. One participant, for example, observed that the existence of connections with colleagues in SWDs makes it possible to share both negative and positive experiences, and to exchange ideas and advice, since they are working under the same conditions and with specific clients (i.e. patients). He explained:

I go to my colleagues first. Family cannot do anything more than offer psychological support and comfort, and things like that. To make things better and change, I must speak to people in social work departments, and consider how problems can be resolved and matters improved.

(Male, Internal Medicine, 6 years' experience)

In addition, the participants tended to admit to the importance of having good relationships with their colleagues within SWDs. The support of colleagues helps them manage their additional responsibilities outside the workplace (e.g. transport of children to school). Friendly relationships between HSWs makes it possible to divide roles and duties without the need to make an official request from administrators. One participant explained:

The assistance of colleagues is very important. For example, I have kids at school, so I have to go out and get them in the morning and afternoon, which means I have to leave work and get them. Although there is official permission to do so

within two hours, I do not want to make this an official matter, so the help of colleagues is very important, as they cover my job until I get back to work.

(Male, General Hospital, 13 years' experience)

Another participant confirms the impact of good relationships with colleagues at work, saying:

My friends are the thing that eases everything at work. They support me, as we very much understand each other. This support means a lot to me. 'F' has been my friend for twenty years now. We have breakfast together... now we are like sisters; she supports me, and I do the same for her.

(Female, Mental Health Hospital, 20 years' experience)

Moreover, strong relationships among HSWs seem to prove also helpful when managing critical cases (e.g. aggressive patients and those with infectious disease), as HSWs can share information between them in order to avoid problems arising. Therefore, the pressure that HSWs might experience at work can be relieved by the presence of close friends, which also helps to improve the working atmosphere. One participant explained:

When we have a problem with a patient, most of our colleagues at work know what is happening at the hospital, because we do shifts, and we all have to know what is going on. We warn each other about any patient who tries to create problems with specialists, and patients who suffer from serious infectious illnesses.

(Male, Dialysis, 29 years' experience)

The most interesting point raised by the interviewees concerning the effectiveness of strong relationships between HSWs and professionals in other departments to reduce stress at work, was that such ties might help to resolve many of the problems HSWs encounter. For example, a participant working in the field for over nine years clarified this, stating the importance of having a positive relationship with other sectors at work. This is because stressful situations can arise among HSWs as a result of each department's attitude toward HSWs' tasks, e.g. lack of collaboration from physicians. Therefore, it seems probable that many issues can be resolved if HSWs have an effective social network in their workplace. She commented:

It is very important to have strong relationships with other departments within the hospital. It is also a role of social workers to grow relationships with doctors, and

so on. By doing so, we can help patients, and even ourselves. I have friends in all departments! I go to visit them in break time and talk to them. This helps me to cope with difficulties at my work, because I know nice people who ease everything for me.

(Female, Internal Medicine, 9 years' experience)

Considering the effect of strong relationships within workplaces, HSWs responses appear to confirm the encouragement of the Directorate of Social Work (DSW) supervised by Mental and Social Health General Directorate (MSHGD) at ministerial level, who calls for active generation of professional relationships between HSWs and practitioners from other departments (Albrithen and Yalli, 2015; MSHGD, 2016). This not only provides more comprehensive provision for patients and their families, but also is a possible element supporting HSWs to navigate the pressures in their workplaces. However, it is possible that only the most experienced HSWs within this study selected this strategy to cope with stress and difficulties at work, due to having worked for over ten years in the field, thus enabling them to create more effective social networks at work than those with less experience.

Theme 3: Religious strategies

Interestingly, the most striking theme to emerge from HSWs' responses when discussing their techniques for coping with work-related stress was the influence of prior beliefs on controlling stress. It is interesting to note that all eighteen HSWs (both male and female), working in different departments within Saudi hospitals, and with different lengths of experience of working in the medical field affirmed that their strong spiritual beliefs gave them sufficient support to handle work-related stress. For example, the majority suggested they do not look to patients and their families, or even officials in their workplace for compensation, rather that, as Muslims, they undertake their work for the sake of Allah and for reward from almighty God. This helped them to generate a sense of personal fulfilment, which somewhat protects them from experiencing pressure at work. One interviewee observed:

I believe that God will reward me for everything I do. For example, sometimes I am asked to contact people when this is not my job, but I do it for God's sake. I am not a perfect worker, so when I do those additional things for the sake of God, this can

compensate my slackness in other areas of work. So, if one does it this way, one will be relieved.

(Female, Mental Health Hospital, 20 years' experience)

Similarly, another male participant stated:

I do my job for the sake of God, which is why I am always comfortable. Even when something outside of my role as a social worker is assigned to me, I do it, for God.

(Male, Mental Health Hospital, 10 years' experience)

On the other hand, one surprising issue was raised in some cases revealing a possible influence from religious motivations that might contribute to minimising the pressure caused by additional administrative tasks appointed to HSWs. One participant for example clarified:

I try to accept any roles assigned to me, because I want to be helpful and wait for rewards from almighty God (Allah)!

(Female, Internal Medicine, 9 years' experience)

Supporting this, another participant agreed with this statement, while emphasising the importance of being honest and faithful when practising their role, arguing that:

The most important thing in the work environment is that we should do the work with the patient for God only, not just doing what we are asked to do. No! We need to do it correctly for God, doing it from heart for the God, doing everything to help the patient, and his whole life! So, there is a lot to gain from Allah.

(Male, General Hospital, 13 years' experience)

Moreover, another participant stated that discussing patients' problems and suffering seems to help a lot with increasing her gratitude to God for giving her a comfortable life. Gratitude interestingly appears to be an effective religious technique for minimising any feelings of disappointment and unhappiness. She stated:

The ability to help is a blessing, and so is seeing people's problems and sickness. I mean, when you see patients' problems, you start thanking God for the peace you have.

(Female Maternity and Children Hospital, 12 years' experience)

These findings, however, were predicted, and possibly confirm the contribution of spiritual and religious motivations as ways of managing the stress or pressure caused at HSWs' workplaces. This is an accordance with the fact that participants are belonging to a highly religious society, in which Islamic teachings influence all aspects of life, playing a role in every single situation, including handling work-related difficulties (Al-Shahri, 2002; Al-Hamdan, 2012; Almasabi, 2013; Soliman, 2013; Van Geel, 2016).

Theme 4: Leisure activities

Surprisingly, only the female participants (i.e. six HSWs) from different domains and levels of experience, tend to use entertainment activities to manage feelings of pressure and stress, including experiences of work-related stress. These include: (1) physical exercise, which works positively to minimise negative feeling; (2) art activities (e.g. drawing); and (3) shopping in or walking around malls. For example, one of the interviewees seemed to admit that physical exercise plays a role in managing her experience of stress in the workplace. She mentioned:

I believe that sport is very helpful for reducing the level of stress. There are many things I can do; therefore, I enrolled in a gym for physical exercise five years ago. Even when I could not go, I did exercise at home.

(Female, Dialysis, 11 years' experience)

Another participant found drawing to be the best way to distract her from thinking about her problems during the working day, as well as to dispel negative feelings. She stated:

I do many things at home to forget work's physical and psychological complications. For example, I like drawing. I sometimes draw for a long time, then I just tear it up, and that's it.

(Female, Internal Medicine, 9 years' experience)

Interestingly, some females prefer to spend their time shopping to reduce pressure (as many women find shopping a pleasurable experience). One participant reported:

I just go shopping or walking, that is a solution for me and makes me feel happy.

(Female, Home Health Care, 3 years' experience)

The most surprising aspect of the data to emerge under this theme is that the males did not mention using any leisure activities as helping them to overcome work-related stress. This may be because men are more practical and realistic when dealing with problems. Another possible explanation for this could be that male HSWs might enjoy greater authority to discuss work problems with officials at both administrative levels (i.e. ministerial and central), something that is not available to females, as a result of conservative cultural aspects of Saudi society (Al-Shahri, 2002; Al-Hamdan, 2012; Van Geel, 2016). Thus, while male employees can speak to officials and request changes in their workplace, females are forced to rely on personal coping strategies to minimise their work-related stress.

Theme 5: Venting

Surprisingly, despite the majority of Saudis viewing consulting mental health professionals when facing psychological issues negatively (Al-Krenawi and Graham, 2000; Qureshi et al., 2009; Attum et al., 2019), some of the HSWs expressed a different view. Irrespective of demographic factors (e.g. gender and years of experience), five participants emphasised the role of mental health professionals (i.e. psychiatrists and psychologists) in minimising the experience of stress in HSWs' workplace. For instance, at some hospitals psychologists are able to offer relaxation sessions to assist HSWs to release the harmful effects of pressure:

To manage the pressures on me, I sometimes seek help from psychologists in my workplace... I tell them I am very stressed, and I need to relax. They have a relaxation chair there, and that actually helped a lot.

(Female, Addiction, 10 years' experience)

Supporting this, another participant emphasised the importance of talking with psychologists, who might advise them on the best way to maintain emotional balance within the workplace, e.g. taking a short break when exposed to stress. She said:

At work that is the strategy given by the psychologist, may God help her; it helped me a lot at the personal level. When working with a psychologist, I learned to take small breaks, which are energising and help me to accomplish my duties correctly.

(Female, Home Health Care, 3 years' experience)

Moreover, the participants identified psychiatrists as being, at times, the only solution for expressing emotional and undesirable feelings, which may then reduce the impact of work-related stress, i.e. speaking with professionals can create an environment of comfort for HSWs at their workplaces, in particular those working closely with mental health professionals. One participant suggested:

We face pressures, including administrative pressure, work pressure, and pressures relating to a patient's treatment. Being able to discuss our emotions is a solution and a cure. Thus, I resort to the psychiatrist to express my emotions.

(Male, Mental Health Hospital, 10 years' experience)

Another female working in the mental health department approved the same strategy as the most effective way to manage work-related stress. She pointed out:

I sometimes talk to the psychiatrist in my workplace. Having somebody to talk to is helpful. I like to consult specialists like a psychiatrist and psychologist. I believe in the value of my role and hers, I admit it.

(Female, Mental Health Hospital, 17 years' experience)

The use of this technique by HSWs had not been anticipated by the current researcher, due to the stigma within Saudi society about consulting mental health professionals (Albrithen and Yalli, 2012; Koenig et al., 2014; Attum et al., 2019). However, as professionals and highly educated individuals, HSWs may have different perspectives concerning the importance of maintaining good mental health. This might lead them to believe that consulting mental health professionals can assist them with minimising the impact of stress caused by their workplaces, in particular as all professional groups (i.e. HSWs, psychologists, and psychiatrists) are being supervised by the same administration at the ministerial level (i.e. MSHGD).

Theme 6: Managers of social work departments

As was mentioned in the previous chapter, leadership at central level appears to be a contributory factor to job-related stress within HSWs' workplaces, and is included as stated by a minority of participants (only two HSWs work in the same workplace). However, a further seven participants (of both genders and level of experience and domains) shared their experiences with SWDs' heads, identifying them as the appropriate individual to approach when facing pressure at work. The responses of the HSWs established that the managers who direct SWDs are experienced at being primarily responsible for handling the obstacles experienced by HSWs when carrying out their duties. In addition, one participant interestingly pointed to the flexibility of her line manager in supporting her if she needs to take a break from work, despite the complicated attendance system applied within HSWs workplaces. She stated:

We have a head who eases things up when he feels that there is too much work on our shoulders, and he helps alleviate those pressures. The head is my main supporter, he is a very understanding person, and knows exactly how hard the work is, so he does what he can to ease things for us. Even if I ask him for a day off because of something I need to do, he does not say no.

(Female, Addiction, 10 years' experience)

Similarly, a male interviewee said:

Well, sometimes, I go to the head of social work department, he is very experienced; I go to him for counselling, depending on the case.

(Male, Cardiology, 16 years' experience)

Certainly, the above participants seemed to value the role that their line manager (i.e. SWDs' managers) can play in supporting them when practising their roles, especially when managing problems with patients and their families. One interviewee said:

My line manager is good towards me, and (despite occasional trouble from patients and employees) he always supports me. I rely on him for many things.

(Female, Oncology, 1 years and 9 months' experience)

These participants have benefitted from the assistance of heads of SWDs as a mechanism for combatting work-related stress, and so may feel safe and secure in approaching authorised

individuals in the workplace. Not only that, but SWDs' managers are also considered the main mediator between HSWs and the MSHGD being, at times, primarily responsible for SWDs within Saudi hospitals. In addition, the fact that HSWs' line managers had graduated from Schools of Social Work means they possess the necessary skills and abilities to emotionally support the employees they supervise.

Theme 7: Patients and their families' attitudes

Surprisingly, the attitudes of patients and their families were found to be factors that might potentially alleviate work-related stress among HSWs. Ten participants of both genders, with different levels of experience and qualifications viewed the appreciation of patients as resulting in a feeling of self-fulfilment that helped to reduce their experience of work-related stress. One participant explained:

When I see the patient is satisfied, this in itself makes me relax and increases my sense of self-fulfilment. When I do something good for a patient, or a patient's family, this in itself gives me the motivation to do more and better things. Even if we have problem with the administration, I think that if I can help the patient, I will not care about anything from the administration. The most important thing for me is giving a service to patients and to their families.

(Male, Internal Medicine, 6 years' experience)

Moreover, the participants seem to share a common viewpoint regarding over when their patients pray for them while providing support; they experienced pleasure, which enabled them to forget the pressures of work. One female said:

When a patient prays for me, that is all I need; hearing their prayers helps me for sure, and makes me feel that, even if I get stressed, it will be appreciated by my patients!

(Female, Internal Medicine, 9 years' experience)

Supporting this, another participant highlighted that:

I feel happy when I help someone, and s/he prays to God for me. Sometimes, with these prayers, I feel relieved after being so stressed out... and when I remember that

one of the patients has prayed for me... there is nothing better than a sick person's prayers... it opens all doors and relieves all discomfort. I really like their prayers; they appreciate it when you do something for them, they will always remember.

(Female, Maternity and Children Hospital, 5 years' experience)

From a different perspective, the participants also stated that HSWs appeared to enjoy the activities they organised for their patients as a part of their treatment plan. Thus, spending time with patients, watching them playing and having fun, can have a positive influence on HSWs, as this removes them from the atmosphere of routine work, while at the same time creating feelings of satisfaction that enable them to implement enjoyable experiences for patients. One interviewee stated:

When we organise activities, or entertainment programmes, for long-stay patients, we enjoy them. It is fun for us, as we meet the hospital staff and have food together sometimes. It is really fun for us too.

(Female, Mental Health Hospital, 17 years' experience)

Overall, these results also seem to reflect the religious nature of the Saudi community, as HSWs linked their happiness and job satisfaction to patients' pleasure and prayers (Al-Shahri, 2002; Al-Hamdan, 2012; Albrithen and Yalli, 2012; Almasabi, 2013). In addition, this may also demonstrate the humanitarian nature of the social work profession, as HSWs might consider their patients' satisfaction as a vital reason for forgetting the pressure of work (Yalli and Cooper, 2008; Soliman, 2013).

Theme 8: Taking a break from the workplace

Remarkably, a lesser used mechanism by HSWs to minimise work-related stress was to stay away from the working environment. Of the eighteen HSWs interviewed, only two participants (one newly qualified and one highly experienced) stated that they had taken a holiday when experiencing stress at work. They identified this as the most effective method for reducing negative emotions. A newly employed participant, for example, mentioned:

I take a vacation directly; I do not want work problems affecting me in my personal life. If I notice that I am suffering from pressure I take a vacation. I have sixty days

a year, so I can take five days, which is a week, and a week would make me feel better.

(Male, Patient Relations, 9 months' experience)

A more experienced participant also makes an interesting point in relation to HSWs needing to periodically take a break from work. They suggested that they should not work in a specific domain for six years, as work-related stress can increase with intensive, and continued, experience of the same issues. He stated:

There are times when one must take a vacation, so that is one of the things that decreases pressure. It can also be reduced by changing your field of work, and not staying more than 6 years in the psychological or addiction fields, but moving on to some other specialty, or working in a public hospital, or on cancer or kidney wards, or at primary care centres.

(Male, Addiction, 15 years' experience)

Although his recommendation is beneficial for those working in the fields of addiction and mental health (in which he himself worked for over fifteen years), it cannot be generalised to other cases within this study. None of the other participants (who had worked in this field over a longer period of time) viewed this as a technique to reduce stress, rather perceiving it as an act of desperation. Moreover, the newly qualified participants did not appear to have become engaged with his workplace, as his answer reflected the absence of a sense of belonging to a working community. Therefore, a note of caution is due here, since the other HSWs within this study did not report the use of this technique, it is reasonable to conclude that this result might not represent all HSWs within Saudi hospitals.

Theme 9: Fieldwork Experience

It is noteworthy that, alongside the techniques used by HSWs to deal with work-related stress, length of experience appeared to have a considerable impact on stress levels. This was due to the level of empowerment experienced by HSWs, as many had spent a considerable amount of time undertaking fieldwork when encountering stress in their workplace. Seven participants of both genders, who had worked as HSWs for over ten years, believed that their ability to deal

with tension at work had probably improved over time, since first starting out in their post. One participant clarified that:

My experience helps me a lot. Because there are things that need to be solved through my personal experience, I used to get frustrated very easily from not knowing what must be done. As well as not knowing about the environment in which I was working, my education was limited, but with experience... from interacting with others, and with the help of sessions and lectures, I developed better tools to handle situations.

(Male, Dialysis, 29 years' experience)

Another participant seems to confirm this finding, stating that:

Experience helps me learn more. At the beginning, I was less confident. When I gained enough experience dealing with people, I understood certain things. My reaction to solving problems got better and faster. It was different many years ago. My experience has taught me the best way to deal with stress at work.

(Female, Maternity and Children Hospital, 12 years' experience)

In general the participants acknowledged the importance of years of fieldwork experience as valuable; particularly in terms of learning about how to control work-related stress caused by issues related to the roles assigned to HSWs. One interviewee shared his experience arguing:

When work was not part of the role assigned to me, I used to just accept it. I got used to it. Years of experience made that easier.

(Female, Mental Health Hospital, 17 years' experience)

In contrast to the above, a further participant, who was highly qualified and had twenty years of fieldwork experience, did not agree that length of experience can lessen work-related stress. He maintained that experience would not be beneficial if factors contributing to work-related stress remained within the workplace. However, his perspective might not represent the views of other HSWs, but rather reflect a personal lack of optimism:

As long as other factors remain, length of experience is unable to help me. My lack of satisfaction is still there.

(Male, Mental Health Hospital, 10 years' experience)

Summary

To conclude, the participants in this study identified a number of techniques that they have employed to overcome their experiences of work-related stress. Coping strategies were comprised nine core themes including: (1) Personal skills, (2) Emotional and Instrumental Support, (3) Religious Strategies, (4) Leisure Activities, (5) Venting, (6) Managers of Social Work Departments, (7) Patients and their Families, (8) Taking a break from the workplace, and (9) Fieldwork Experience. This was besides considering the impact of HSWs' demographic background, as acknowledged to influence the selected coping strategies (e.g. gender and fieldwork experience).

In relation to personal skills, the result provide important insights into the role of years of fieldwork experience in enabling HSWs to use their personal skills, to deal with work-related stress effectively (e.g. joining training sessions, controlling anger, not thinking while experiencing stress). Turning to emotional and instrumental support, the results indicate the importance of strong relationships between the HSWs themselves and with other professionals within health workplaces, as it was proven as an effective method to deal with job stress. This is in addition to the importance of sharing their undesirable feelings with loved ones, including family members, and friends, as a means to minimise stress for HSWs.

Most importantly, the religious nature of Saudi society has been reflected in the results of this study, in terms of strong spiritual beliefs that enhance the HSWs ability to cope with the pressure caused by their jobs. On the other hand, gender plays a role in applying daily leisure activities to limit the impact of work-related stress, as only female HSWs practise entertainment techniques (e.g. drawing, shopping, and physical exercises) as a way to manage the experience of stress.

Regarding findings linked to venting strategies, seeking assistance from mental health professionals was also acknowledged by the participants as another technique that can be employed when experiencing stress at workplaces. Moreover, SWDs' managers are playing

crucial role in supporting the HSWs when they face any obstacles that might expose them to pressure at their workplaces. The study also suggests that the feeling of self-fulfilment that HSWs gain from helping patients and their families, as well as patients' satisfaction a vital reason that can minimise the pressure of work. Taking rest from workplace environment (i.e. applying for holiday), was mentioned by the minority of the participants as an effective technique to deal with work-related stress, while the other HSWs do not mention this point. Finally, the study demonstrates the considerable impact of the length of fieldwork experience on stress levels, as HSWs who have been working in the field for more than ten years show greater ability in managing work-related stress experience.

In general, these findings can be used to establish an effective support system for HSWs to deal with issues linked to work-related stress when it exists. For example, great attention should be given to offer training sessions for HSWs to develop their abilities to face workplace challenges. It is also important to raise HSWs' awareness and encourage them to share their challenges with individuals, who are close to them (e.g. family's member, and friends), in order to minimise the negative experience caused by their job. Moreover, spiritual considerations should not be neglected when discussing coping with work-related stress in Saudi workplaces, as it can play a crucial role in increasing positive energy that enable the HSWs to cope with workplace complications. It would be helpful to the MoH and the Saudi Health Social Work Association to consider providing entertainment activities for HSWs (e.g. art, gym, and social clubs), to serve as another mechanism to release negative energy caused by work pressure.

On the other hand, regular meetings involving HSWs from different domains are recommended to increase opportunities to exchange ideas and experiences associated with work difficulties, as well as the strategies to overcome them. Such meetings would also be useful if they occurred between HSWs and other health care professionals, not only to share challenges and successes, but also to enhance interprofessional relationships. Ensuring supportive central leaderships (i.e. SWDs' managers) should be a priority in a healthy workplace environment, as it can effectively increase feelings of loyalty from HSWs to their workplaces. It might also be important to include mental health professionals within HSWs' support systems, to encourage them to consult mental health teams, including psychiatrists and psychologists, if needed. Moreover, there must be fixable regulations within the MoH agenda to enable HSWs to take a break from the workplace if required or to change their domain of work to ensure HSWs' wellbeing. Finally, offering regular workshops for HSWs from different workplaces organised by more experienced HSWs, can help by providing opportunities to share a wide range of experiences.

This concludes the findings for the qualitative part of this study. However, as mentioned previously, in order to accurately answer the research questions quantitative methods were also employed. The following chapter presents the statistical data that might verify the findings obtained from the qualitative data by employing further measures.

Chapter Seven: Quantitative Results

Overview

As stated previously, the present study was designed to explore the experience of work-related stress from the perspective of HSWs in SA, by identifying factors potentially contributing to stress in the workplace. The study also explores possible strategies to enable HSWs to mitigate stressful experiences within the Saudi context, in consideration of the association between stress factors and the HSWs' demographic characteristics. In order to achieve the goal of this study, the research employed two main data collection instruments in two separate phases, i.e. semi-structured interviews in the main phase, followed by a questionnaire in the second phase. This enabled the researcher to gain informative and rich data concerning the HSWs' experience of job-related stress in their workplaces during the first phase of data collection (Onwuegbuzie and Teddlie, 2003, while the second phase played crucial role in verifying the outcomes of the qualitative aspect (Creswell, 2017).

The qualitative findings revealed HSWs' workplace stress arose from firstly, issues related to the Saudi community's culture and traditions, and secondly, gender. Moreover, the main phase identified several strategies applied by HSWs to cope with job stress, including; (1) personal skills; (2) emotional and instrumental support; (3) religious strategies; (4) leisure activities; (6) venting; (7) managers of social work departments; (8) building good relationships with patients and their families; (9) taking a break from the workplace; and (10) fieldwork experience. The findings also indicted a notable difference based on gender and length of fieldwork experience in relation to both work-related stress factors and coping strategies. Thus, this chapter deals with the quantitative aspects of the study findings, comparing the statistical results with those from the qualitative phase, in order to ensure qualitative data verification.

Of the two hundred questionnaires distributed, a hundred and twenty-one were returned to SWDs' managers at public hospitals. Of these, eleven questionnaires provided incomplete information. Since more than 90% (110/ 121) of the questionnaires returned had complete information, in line with the recommendation by Woodward (2014) univariate analyses were performed on a "complete case" basis. That is, analyses were conducted on all one hundred-ten questionnaires, and missing information from the other eleven questionnaires was not estimated (see Figure 8).

The participants first completed 9 questions relating to their demographic data. The second section sought to verify relevant work-related stress factors that influence Health Social Workers (HSWs) in their workplaces, using a four-point Likert scale to capture their levels of agreement or disagreement with the proposed factors. The third section concerned the HSWs' use of strategies to manage workplace stress; as determined using a four-point Likert scale, to establish the extent of how frequently HSWs use the coping items listed. The analysis of responses was followed by addressing considerations pertaining to the reliability of the two main scales adopted in this phase. After this, the results detailing the impact of HSWs' demographic data on work-related stress associated experiences, as well as the chosen coping mechanisms were presented, using SPSS version 23 for statistical analysis.

Sample Description

This section will provide descriptive statistical information about the participants based on information gathered in the first phase, including demographic data pertaining to the 110 HSWs (e.g. gender, age, marital status, academic qualification, specialisation, job type, and years of experience in their field of work, responsibilities outside workplaces, and departments). The data will be presented in tabular form, including frequencies and percentages.

Table 3: Description of respondents' gender

Gender	N	%
Male	44	40
Female	66	60
Total	110	100

From the previous table, it is evident that 40% (n= 44) of the respondents were males, while females represented 60% (n= 66) of the sample in this phase (see Table 3).

Table 4: Respondents' demographic data

	Total	%
Age		
Less than 30	19	17.3
31-35	29	26.4
36-40	41	37.3
41-45	13	11.8
More than 45	8	7.2
Marital Status		
Single	22	20.0
Engaged	4	3.6
Married	77	70.0
Divorced	6	5.5
Other	1	0.9
Qualification		
Bachelor	70	63.6
Bachelor with Medical Diploma	13	11.8
Master	23	20.9
PhD	4	3.6
Other	0	0
Specialisation		
Social Work	72	65.5
Sociology	33	30.0
Psychology	5	4.5
Other	0	0
Job Type		
Permanent	81	73.6
Temporary	27	24.5
Other	2	1.8
Work Experience		
Less than 5 years	26	23.6
5-10	45	40.9
11-15	25	22.7
16-20	10	9.1
More than 20	4	3.6
Responsibilities Outside Workplace		
Yes	62	56.4
No	48	43.6
Department		
Surgery	5	4.5
Oncology	4	3.6
Cardiology	5	4.5
Emergency	5	4.5
Mental Health	14	12.7
Home Health Care	3	2.7
Maternity and Children	12	10.9
Dialysis	7	6.4
Neurology	2	1.8
General	28	25.5
Medicine	19	17.3
Patient Relation	6	5.5

The previous table (4) shows that the largest group of respondents (n=41, 37.3%) comprised those aged between 36 and 40 years, with only a small minority (n= 8 ,7.2%) being over 40

years old. Although n= 77 (70%) were married, and only n=1 (0.9%) selected ‘other’ for marital status. Furthermore, while most of the respondents (n=70, 63.6%) were qualified up to Bachelor’s level, several respondents (n=4, 3.6%) had gained a PhD degree. Moreover, it can be observed that approximately two thirds of the respondents (n= 72, 65.5%) held social work qualifications, whereas only n=5 (4.5%) had graduated from psychology schools. In total roughly three quarters of those surveyed (n= 81, 73.6%) had a permanent job, whereas n= 27 (24.5%) worked by contractual arrangement, and only 1.8% other type of jobs. The table also indicates that many of respondents (n= 45, 40.9%) had 5 to 10 years of fieldwork experience, while n= 4 (3.6%) had experience in excess of 20 years. The previous table also shows that n= 62 (56.4%) of respondents hold responsibilities outside work, compared to n= 48 (43.6%) who have not held any additional responsibilities outside their workplace. Finally, n=28 (25.5%) respondents were practising their tasks at general hospitals, and a small minority (n=3, 2.7%) were working on home health care sections.

Work-related stress factors

As mentioned in the Methodology Chapter, the Expanded Nursing Stress Scale (ENSS) has been used to examine the most influential factors affecting work-related stress among HSWs. This section sheds light on stress factors based on the nine elements identified by the ENSS.

Table 5: The most stressful and least stressful subscales perceived by HSWs

Stress Factors	<u>M</u>	<u>Std</u>
Patients and their Families	2.42	1.08
Uncertainty Concerning Treatment	2.38	0.98
Workload	2.35	1.05
Death and Dying	2.35	1.09
Problems Relating to Supervisors	2.00	1.12
Discrimination	1.96	1.02
Conflict with Physicians	1.84	0.97
Problems relating to Peers	1.71	0.94
Inadequate Emotional Preparation	1.61	0.86

Note: (For individual scale items 1= ‘never stressful’; 2= ‘occasionally stressful’; 3= ‘frequently stressful’; 4= ‘extremely stressful’). (M= Subscale Mean, Std= Standard Deviation for Subscale).

The previous Table (5) identifies the most stressful subscales, as perceived by the participants in the survey phase. The most stressful factors overall were Patients and their Families and Uncertainty Concerning Treatment. Whereas, the least stressful were Problems Relating to Peers and Inadequate Emotional Preparation.

Factor 1: Death and dying

Table 6: Stress factors related to death and dying

Stress Factors	1	%	2	%	3	%	4	%	Total	%	M	Std
	N=		N=		N=		N=		N=			
Watching a patient suffer	7	6.7	24	22.9	20	19.0	54	51.4	105	100	3.15	0.99
The death of a patient with whom you have developed a close relationship	22	21.4	35	34.0	11	10.7	35	34.0	103	100	2.57	1.16
The death of a patient	35	32.7	23	21.5	19	17.8	30	28.0	107	100	2.41	1.21
Feeling helpless in the case of a patients who fail to improve	29	27.1	42	39.3	20	18.7	16	15.0	107	100	2.21	1.00
Listening or talking to a patient about his/her approaching death	48	48.0	17	17.0	15	15.0	20	20.0	100	100	2.07	1.19
Physician not being present when a patient dies	51	52.6	13	13.4	11	11.3	22	22.7	97	100	2.04	1.24
Performing processes that bother patients	29	27.1	50	46.7	24	22.4	4	3.7	107	100	2.02	0.80

"(For individual scale items 1 = 'never stressful'; 2 = 'occasionally stressful'; 3 = 'frequently stressful'; 4 = 'extremely stressful') (M = Subscale Mean, Std = Standard Deviation for Subscale)"

As can be seen from the table above, suffering and death of a patient had the greatest impact on stress. Approximately one half of the participants found watching a patient suffer extremely stressful, and around one third experienced a greater level of stress following the death of a patient with whom they had developed a close relationship, whereas fewer than 5% experienced extreme stress when performing processes that bothered a patient (Table 6)

Factor 2: Conflict with physicians

Table 7: Stress factors related to conflict with physicians

Stress Factors	1	%	2	%	3	%	4	%	Total	%	M	Std
	N=		N=		N=		N=		N=			
Conflict with a physician	47	43.5	34	31.5	19	17.6	8	7.4	108	100	1.88	0.95
Making a decision concerning a patient when the physician is unavailable	47	45.6	34	33.0	9	8.7	13	12.6	103	100	1.88	1.02
Having to organise physicians' work	52	53.1	17	17.3	18	18.4	11	11.2	98	100	1.85	1.08
Criticism by a physician	47	43.5	42	38.9	10	9.3	9	8.3	108	100	1.82	0.91
Disagreement concerning the treatment of a patient	47	44.3	40	37.7	11	10.4	8	7.5	106	100	1.81	0.90

"(For individual scale items 1 = 'never stressful'; 2 = 'occasionally stressful'; 3 = 'frequently stressful'; 4 = 'extremely stressful') (M = Subscale Mean, Std = Standard Deviation for Subscale)"

As shown in the previous table, issues concerning inter-professional teamwork seemed to contribute to the stressful experience HSWs experience through when practising their roles. For the majority of these stress factors, the distribution of scores was similar and indicated a lower degree of stress compared to factors associated with Death and Dying. In general, around 45- 50% found these factors to never be stressful, and roughly one third reported them to be only occasionally stressful (see Table 7).

Factor 3: Inadequate emotional preparation

Table 8: Stress factors related to inadequate emotional preparation

Stress Factors	1	%	2	%	3	%	4	%	Total	%	M	Std
	N=		N=		N=		N=		N=			
Feeling inadequately prepared to help meet the emotional needs of a patient's family	62	56.4	27	24.5	11	10.0	8	7.3	108	100	1.67	0.93
Being asked a question by a patient for which I do not have a satisfactory answer	60	54.5	32	29.1	6	5.5	8	7.3	106	100	1.64	0.89
Feeling inadequately prepared to meet the emotional needs of a patient	65	59.1	23	20.9	14	12.7	1	.9	103	100	1.52	0.76

"(For individual scale items 1 = 'never stressful'; 2 = 'occasionally stressful'; 3 = 'frequently stressful'; 4 = 'extremely stressful') (M = Subscale Mean, Std = Standard Deviation for Subscale)"

According to Table (8), more than half of those surveyed identified ‘Feeling inadequately prepared to help with the emotional needs of a patient’s family’, ‘Being asked a question by a patient for which I do not have a satisfactory answer’; and ‘Feeling inadequately prepared to help with the emotional need of a patient’ are factors that are never stressful.

Factor 4: Problems relating to peers

Table 9: Stress factors related to problems with peers

Stress Factors	1		2		3		4		Total		M	Std
	N=	%	N=	%	N=	%	N=	%	N=	%		
Lack of opportunity to share experiences and feelings with other personnel in the work setting	38	39.1	27	27.8	14	14.4	18	18.55	97	100	2.12	1.12
Lack of opportunity to talk openly with other unit personnel about problems in the work setting	48	52.7	26	28.5	9	9.8	8	8.7	91	100	1.74	0.96
Lack of opportunity to express to other personnel on the unit my negative feelings toward patients	54	51.9	31	29.8	12	11.5	7	6.7	104	100	1.73	0.91
Difficulty in working with social workers of the opposite sex	63	58.8	22	20.5	9	8.4	10	9.3	107	100	1.62	1.01
Difficulty in working with a particular social worker inside my immediate work setting	66	65.3	22	21.7	6	5.9	7	6.9	101	100	1.54	0.88
Difficulty in working with a particular social worker outside my immediate work setting	72	69.9	18	17.4	10	9.7	3	2.9	103	100	1.45	0.78

"(For individual scale items 1 = 'never stressful'; 2 = 'occasionally stressful'; 3 = 'frequently stressful'; 4 = 'extremely stressful') (M = Subscale Mean, Std = Standard Deviation for Subscale)"

The table above indicates that the majority of the respondents do not face significant difficulties associated with their peers (i.e. other HSWs) that add to their stress. The minority of the participants indicated that ‘Lack of opportunity to share experiences and feelings with other personnel in the work setting’ can be an extremely stressful issue. While around half of them found ‘Lack of opportunity to talk openly with other unit personnel about problems in the work

setting' and 'Lack of opportunity to express to other personnel on the unit my negative feelings toward patients' to be never stressful. In addition, the majority of the participants reported 'Difficulty in working with social workers of the opposite sex', 'Difficulty in working with a particular social worker inside my immediate work; and 'Difficulty in working with a particular social worker inside my immediate work setting' as never a cause of stress at work (see Table 9).

Factor 5: Problems Relating to Supervisors

Table 10: Stress factors related to problems with supervisors

Stress Factors	1	%	2	%	3	%	4	%	Total	%	M	Std
	N=		N=		N=		N=		N=			
Being held accountable for things over which I have no control	40	37.0	24	22.2	16	14.8	28	25.9	108	100	2.29	1.21
Lack of support from social work administration	44	41.5	18	16.9	14	13.2	30	28.3	106	100	2.28	1.27
Lack of support from other health care administrators	43	43	23	23	16	16	18	18	100	100	2.09	1.14
Criticism by social work administration	53	51.9	22	21.5	14	13.7	13	12.7	102	100	1.87	1.07
Lack of support from the head of the social work department in my workplace	59	57.8	16	15.6	9	8.8	18	17.6	102	100	1.86	1.16
Criticism from the head of social work department in my workplace	51	48.5	32	30.4	10	9.5	12	11.4	105	100	1.83	1.01
Conflict with the head of Social Work Department my in workplace	65	60.1	17	15.7	17	15.7	9	8.3	108	100	1.72	1.01

"(For individual scale items 1 = 'never stressful'; 2 = 'occasionally stressful'; 3 = 'frequently stressful'; 4 = 'extremely stressful') (M = Subscale Mean, Std = Standard Deviation for Subscale)"

According to the table above, the limited authority given to the HSWs and the lack of support provided by the Administration of Social Work and other health care administration at the ministerial level seem to contribute to stress. Around one quarter of the participants reported 'Being held accountable for things over which I have no control' as either frequently or extremely stressful. In addition, more than one quarter felt extremely stressful as a result of

‘Lack of support by social work administration’, while less than one quarter of them reported ‘Lack of support from other health care administrators’ stated this as extremely stressful in their workplaces (see Table 10).

Factor 6: Workload

Table 11: Stress factors related to workload

Stress Factors	1	%	2	%	3	%	4	%	Total	%	M	Std
	N=		N=		N=		N=		N=			
Promotion and evaluation system for HSWs	12	10.9	18	16.4	21	19.1	59	53.6	110	100	3.15	1.05
Too many non-social work tasks required, such as clerical work	12	10.9	18	16.4	22	20.0	58	52.7	110	100	3.14	1.05
Working hours and scheduling (e.g. night shift)	22	20.0	18	16.4	13	11.8	57	51.8	110	100	2.95	1.22
Not enough staff to adequately cover social work department's tasks	26	23.6	20	18.2	16	14.5	48	43.6	110	100	2.78	1.23
Having to make decisions under pressure	30	33.7	24	27.0	14	15.7	21	23.6	89	100	2.29	1.16
Not enough time to respond to the needs of patients' families	39	36.8	33	31.1	19	17.9	15	14.2	106	100	2.09	1.05
Not enough time to provide emotional support to the patient	57	54.3	26	24.8	15	14.3	7	6.7	105	100	1.73	0.94
Having to work through breaks	74	67.3	10	9.1	22	20.0	4	3.6	110	100	1.60	0.93
Not enough time to complete all of my tasks as a social worker	76	69.1	19	17.3	9	8.2	6	5.5	110	100	1.50	0.86

"(For individual scale items 1 = 'never stressful'; 2 = 'occasionally stressful'; 3 = 'frequently stressful'; 4 = 'extremely stressful') (M = Subscale Mean, Std = Standard Deviation for Subscale)"

According to the previous table, promotion and evaluation system; being in charge of performing additional clerical work; working hours; and the shortage of staff in social work departments had a significant influence on the experience of stress reported by surveyed HSWs. Over half of the participants reported finding the ‘promotion and evaluation system for HSWs’

and ‘Too many non-social work tasks required, such as clerical work’ to be extremely stressful. Similarly, the majority of the HSWs reported ‘Working hours and scheduling (e.g. night shift)’ as extremely stressful, compared to others who identified ‘Not enough staff to adequately cover social work department's tasks’ as extremely stressful when practising their roles. (see Table 11).

Factor 7: Uncertainty concerning treatment

Table 12: Stress factors related to uncertainty concerning treatment

Stress Factors	1	%	2	%	3	%	4	%	Total	%	M	Std
	N=		N=		N=		N=		N=			
Lack of resources and equipment to facilitate HSWs to perform their tasks with patients	0	0	8	7.3	19	17.3	83	75.5	110	100	3.68	0.60
Being exposed to health and safety hazards	5	4.5	14	12.7	1.6	14.5	75	68.2	110	100	3.46	0.88
Feeling inadequately trained for what I have to do	30	27.8	27	25.0	28	25.9	23	21.3	108	100	2.40	1.11
A physician not being present in a medical emergency	40	42.6	19	20.2	17	18.1	18	19.1	94	100	2.13	1.16
Fear of making a mistake when treating a patient	41	41.8	30	30.6	10	10.2	17	17.3	98	100	2.03	1.10
A physician ordering what appears to be inappropriate treatment for a patient	41	39.4	36	34.6	20	19.2	7	6.7	104	100	1.98	0.90
Being in charge with inadequate experience	47	47.0	24	24.0	16	16.0	13	13.0	100	100	1.95	1.07
Not knowing what a patient or a patient's family should be told about the patient's condition and treatment	49	47.1	23	22.1	22	21.2	10	9.6	104	100	1.93	1.09
Inadequate information from the medical team regarding the medical condition of a patient	44	41.5	36	34.0	19	17.9	7	6.6	106	100	1.89	0.92

"(For individual scale items 1 = 'never stressful'; 2 = 'occasionally stressful'; 3 = 'frequently stressful'; 4 = 'extremely stressful') (M = Subscale Mean, Std = Standard Deviation for Subscale)"

As the table above shows, limited resources to facilitate HSWs to complete their roles, along with the risk of exposure to hazard at their workplaces had a significant effect on their level of

stress. About three quarters of the participants reported 'Lack of resources and equipment that facilitate HSWs to perform their tasks with patients' as extremely stressful, and around two thirds reported a similar level of stress arising from 'Being exposed to health and safety hazards'. On the other hand, only one quarter of the respondents experienced lower level of stress, because of 'feeling inadequately trained for what I have to do' compared to more than a third who reported 'inadequate information from the medical team regarding the medical condition of a patient' as occasionally stressful experience at workplaces (Table 12).

Factor 8: Patients and their families

Table 13: Stress factors related to patients and their families

Stress Factors	1	%	2	%	3	%	4	%	Total	%	M	Std
	N=		N=		N=		N=		N=			
Having to deal with abuse from patients' families	14	12.7	28	25.5	30	27.3	38	34.5	110	100	2.83	1.04
Having to deal with abusive patients	22	20.8	30	28.3	16	15.1	38	35.8	106	100	2.66	1.17
Patients' families making unreasonable demands	16	14.7	39	35.8	32	29.4	22	20.2	109	100	2.55	0.97
Patients making unreasonable demands	24	21.8	28	25.5	36	32.7	19	17.3	107	100	2.44	1.05
Having to deal with violent patients	32	30.2	26	24.5	18	17.0	30	28.3	106	100	2.43	1.19
Being blamed for anything that goes wrong	34	35.4	26	27.1	14	14.6	22	22.9	96	100	2.25	1.16
Being the one that has to deal with patients' families	32	30.2	33	31.1	28	26.4	13	12.3	106	100	2.18	1.02
Not knowing whether patients' families will report you for inadequate care	37	39.8	32	34.4	9	9.7	15	16.1	93	100	2.02	1.07

"(For individual scale items 1 = 'never stressful'; 2 = 'occasionally stressful'; 3 = 'frequently stressful'; 4 = 'extremely stressful') (M = Subscale Mean, Std = Standard Deviation for Subscale)"

According to the previous table, dealing with aggression from patients and their families, and overly demanding patients' families seems to have the greatest impact on work-related stress among HSWs. More than one third of the participants found that 'Having to deal with abuse from patients' families' and 'Having to deal with abusive patients' were extremely stressful events at their workplaces, whereas more than a third reported lower level of stress when

‘Patients’ families making unreasonable demands’, and ‘Patients making unreasonable demands’ (see Table 13).

Factor 9: Discrimination

Table 14: Stress factors related to discrimination

Stress Factors	1	%	2	%	3	%	4	%	Total	%	M	Std
	N=		N=		N=		N=		N=			
Experiencing discrimination on the basis of sex	28	25.7	8	7.3	5	4.6	68	62.4	109	100	3.03	1.31
Being sexually harassed	67	70.5	15	15.8	7	7.4	6	6.3	95	100	1.49	0.88
Experiencing discrimination because of race or ethnicity	77	78.6	10	10.2	4	4.1	7	7.1	98	100	1.37	0.88

"(For individual scale items 1 = 'never stressful'; 2 = 'occasionally stressful'; 3 = 'frequently stressful'; 4 = 'extremely stressful') (M = Subscale Mean, Std = Standard Deviation for Subscale)"

The table above shows the significant impact of gender inequality on the experience of stress in HSWs’ workplaces. More than a half of the participants reported an extreme level of stress resulting from ‘experiencing discrimination on the basis of sex’, compared to a minority of respondents who encountered lower level of stress because of situations in which they found themselves ‘being sexually harassed’ (see Table 14).

Comparison of the qualitative and quantitative findings for the stress factors

Consistent with the main study (i.e. the qualitative findings), the quantitative data identified similar concerns raised by the respondents in relation to several factors contributing to experiences of stress by HSWs in the workplace. This stress arising from direct contact with patients, as this regularly involved vulnerable groups such as children, the elderly, and those suffering from addiction. However, the quantitative data found lower levels of stress related to inter-professional relations than those observed in the main study (i.e. the qualitative phase). The interviewees reported a number of complications associated with other professional groups (e.g. physicians), including marginalisation of the roles of HSWs and a lack of collaboration

when managing patients' cases. This distinction, however, may be explained by the fact that the Expanded Nursing Stress Scale (ENSS) was developed to assess the experience of work-related stress within the nursing profession. Therefore, some items on the Conflict with Physicians sub-scale were unable to accurately reflect the social work field, in particular 'Having to organise physicians' work'. Nevertheless, it is vital to interpret the data with caution, because all other items were identified as occasionally stressful by more than a third of the respondents.

Moreover, although some of the female HSWs interviewed shared similar emotional pressures as a result of handling abuse cases, or dealing with vulnerable groups, they did not raise any concerns in relation to their ability to provide the required emotional support for both patients and their families. Likewise, there were similarities between the responses expressed by the HSWs surveyed and those interviewed when it came to factors associated with emotional preparation, since the statistical results reported that inadequate emotional preparation never arose as a stressful factor. When it came to the relationships between HSWs as a professional group, the respondents did not express significant difficulties associated with their peers (i.e. other HSWs) as adding to their stress. This result was supported by the findings of the qualitative analysis.

In contrast to earlier findings, the HSWs in the current study stated that they experienced a lower level of stress from the absence of support from social work administration at ministerial level, although in the interviews they highlighted a number of issues reflecting such lack of support from MSHGD. This could be due to a lack of clarity in the statement being intended to measure the role played by leaders at ministerial level in work-related stress, particular due to the items not referring directly to either MSHGD or the Directorate of Social Work (DSW). This finding should therefore be approached with caution, with the 'Problems with Supervisors' sub-scale being previously identified as being occasionally stressful according to HSWs ($M= 2.00$) (see Table 10).

Another significant aspect of consistency between qualitative and quantitative findings concerns stress caused by challenges associated with promotion opportunities, long working hours, and night shifts. Moreover, both sets of data suggested difficulties related to job descriptions, due to HSWs being required to perform additional tasks (i.e. administrative roles). Most importantly, respondents within the quantitative phase raised comparable concerns to

those interviewed in relation to staff shortages in SWDs within Saudi hospitals, with the potential to increase the volume of work and potentially expose HSWs to job stress.

In addition, both the qualitative and quantitative findings tended to agree on the lack of funds to facilitate HSWs in their delivery effective social services, as well as an insufficient budget, resources and equipment, along with inadequate SWD staffing. In addition, both the qualitative and quantitative findings suggest work-related stress arising from a lack of perceived working allowance for HSWs, e.g. an infectious diseases allowance. However, the quantitative data does not report identical levels of stress to that identified in the previous stage when it comes to issues linked to an inadequacy of academic preparation or training courses offered to HSWs. Instead, it suggests a form of pressure experienced by participants when they felt inadequately trained to practise their roles. This difference can be attributed to the lack of clarity of the statements provided within ENSS to assess the experience of stress caused by academic preparation. Conversely, the interviews used in the first stage as a tool for data collection enabled both the researcher and the interviewees to undertake an in-depth discussion of the possible influence of the academic programme offered to HSWs, both pre- and post-graduates, on the experience of work-related stress.

The impact of stress on the participants of this study was found to have similarities with the earlier observations in the first phase regarding the pressures faced by HSWs when dealing on a frequent basis with patients and their families, including a lack of collaboration, and incidences of physical and verbal abuse. Moreover, it appears that patients and their families have only a vague understanding of the roles of HSWs, with the statistical data suggesting they tend to make unreasonable demands, thus reflecting a conflict between their expectations and the actual roles played by HSWs within the hospital context. In addition, HSWs can find themselves blamed when there is a failure to address the financial needs of patients, e.g. medical equipment, and other financial support.

Finally, in support of the qualitative results, the statistical data has demonstrated the presence of gender bias in several cases, as discussed further below. This outcome is largely consistent with data obtained from the interviews, particularly in terms of the associated challenges, as almost all of the female interviewees referred to complexities associated with gender inequality in their workplace, i.e. the lack of opportunities for promotion, along with issues related to attendance and working hours.

Coping mechanisms

As was stated earlier in the Methodology Chapter, the Brief COPE Scale by Carver (1997) was chosen to detect the strategies that HSWs typically employ to overcome experiences of work-related stress. This section highlights coping mechanisms according to the fourteen sub-scales identified by the Carver (1997). All sub-scales are presented in Table (15) alongside the means and standard deviations.

Table 15: Coping Strategies scores (Brief COPE-28) among HSWs

Coping Scales	<u>N</u>	<u>M</u>	<u>Std</u>
Religion	110	7.3	0.988
Planning	110	6.88	1.29
Acceptance	110	6.58	1.42
Positive Reframing	110	6.55	1.58
Active Coping	110	6.51	1.46
Use of Instrumental Support	110	6.09	1.58
Self-distraction	110	5.3	1.49
Use of Emotional Support	110	5.2	1.47
Self-blame	110	4.9	1.93
Venting	110	4.8	1.80
Humour	110	4.0	1.43
Denial	110	3.6	1.62
Behavioural Disengagement	110	3.2	1.47
Substance Use	110	3.0	1.90

"(For individual scale items M (1-2) = 'I've been doing this at all'; M (3-4)= 'I've been doing this a little bit'; M (5-6)= 'I've been doing this a medium amount'; M (7-8)= 'I've been doing this alot) (M = Subscale Mean, Std = Standard Deviation for Subscale)"

The table above summarises the fourteen-coping styles used by the surveyed HSWs. The most frequently used strategies were Religion, Acceptance, and Positive Reframing, with the least being Venting and Behavioural Disengagement. It appears that strategies implemented to assist in looking at things positively (e.g. Religion) is the most used strategies than other techniques (see Table 15).

Table 16: Coping Strategies

Coping Scale	Item	1 N=	%	2 N=	%	3 N=	%	4 N=	%	Total N=	%	M	Std
Religion	I've been trying to find comfort in my religion or spiritual beliefs	0	0	7	6.4	24	21.8	79	71.8	110	100	3.65	0.59
	I've been praying or mediating	1	.9	4	3.6	24	21.8	81	73.6	110	100	3.68	0.58
Planning	I've been trying to come up with a strategy about what to do	3	2.7	16	14.5	32	29.1	59	53.6	110	100	3.33	0.82
	I've been thinking hard about what steps to take	1	.9	9	8.2	29	26.4	71	64.5	110	100	3.54	0.68
Acceptance	I've been accepting the reality of the fact that it has been happened	5	4.5	15	13.6	39	35.5	51	46.4	110	100	3.23	0.85
	I've been learning to live with it	2	1.8	15	13.6	36	32.7	57	51.8	110	100	3.34	0.78
Positive Reframing	I've been trying to see it in a different light, to make it seem more positive	9	8.2	14	12.7	30	27.3	57	51.8	110	100	3.22	0.96
	I've been looking for something good in what is happening	6	5.5	9	8.2	38	34.5	57	51.8	110	100	3.32	0.84
Active Coping	I've been concentrating my efforts on doing something about the situation I'm in	11	10	22	20	29	26.4	48	43.6	110	100	3.03	1.02
	I've been taking action to try to make the situation better	5	4.5	8	7.3	26	23.6	71	65.5	110	100	3.48	0.82
Use of Instrumental Support	I've been getting help and advice from other people	9	8.2	23	20.9	45	40.9	33	30	110	100	2.92	0.91
	I've been trying to get advice or help from other people about what to do	4	3.6	20	18.2	40	36.4	46	41.8	110	100	3.16	0.85
Self- distraction	I've been turning to work or other activities to take my mind of things	20	18.2	28	25.5	41	37.3	21	19.1	110	100	2.57	0.99
	I've been doing something to think about it less, such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping	20	18.2	22	20	35	31.8	33	30	110	100	2.73	1.8
Use of Emotional Support	I've been getting emotional support from others	37	33.6	37	33.6	19	17.3	17	15.5	110	100	2.14	1.05
	I've been getting comfort and understanding from someone	6	5.5	21	19.1	37	33.6	46	41.8	110	100	3.11	0.90
Self- blame	I've been criticizing myself	19	17.3	30	27.3	33	30	28	25.5	110	100	2.36	1.04
	I've been blaming myself for things that happened	34	30.9	33	30	21	19.1	22	20	110	100	2.28	1.10
Venting	I've been saying things to let my unpleasant feelings escape	41	37.3	24	21.8	32	21.9	13	11.8	110	100	2.15	1.05
	I've been expressing my negative feelings	15	13.6	36	32.7	25	22.7	34	30.9	110	100	2.70	1.05
Humour	I've been making jokes about it	70	63.6	22	20	15	13.6	3	2.7	110	100	2.51	1.01
	I've been making fun of the situation	23	20.9	26	23.6	42	38.2	19	17.3	110	100	1.57	0.84
Denial	I've been saying to myself (this isn't real)	62	56.4	24	21.8	15	13.6	9	8.2	110	100	1.73	0.98
	I've been refusing to believe that it has happened	43	39.1	39	35.5	19	17.3	9	8.2	110	100	1.94	0.94
Behavioural Disengagement	I've been giving up trying to deal with it	73	66.4	22	20	11	10	4	3.6	110	100	1.50	0.82
	I've been giving up the attempt to cope	52	47.3	36	32.7	17	15.5	5	4.5	110	100	1.77	0.87
Substance Use	I've been smoking to make myself feel better	83	75.5	7	6.4	10	9.1	10	9.1	110	100	1.51	0.99
	I've been using cigarette or Shisha to help me get through it	79	71.8	14	12.7	5	4.5	12	10.9	110	100	1.54	1.00

"(For individual scale items 1= 'I haven't doing this at all'; 2= 'I've been doing this a little bit'; 3 = 'I've been doing this a medium amount'; 4= 'I've been doing this a lot') (M = Subscale Mean, Std = Standard Deviation for Subscale)"

Table (16) details the statistics for coping strategies that HSWs employ to address work-related stress. Overall, the data reveals the respondents utilise forms of ‘problem focused’ and ‘emotional focused’ techniques when experiencing stress in their workplaces. Significantly, around three quarters of the respondents reported using techniques linked to the Religion subscale, these being ‘I’ve been trying to find comfort in my religion or spiritual beliefs’ and ‘I’ve been praying or mediating’. While more than half of the respondents selected coping mechanisms related to Planning ‘I’ve been trying to come up with a strategy about what to do’, and ‘I’ve been thinking hard about what steps to take’; Acceptance ‘I’ve been accepting the reality of the fact that it has been happened’ and ‘I’ve been learning to live with it’; Positive Reframing ‘I’ve been trying to see it in a different light, to make it seem more positive’ and ‘I’ve been looking for something good in what is happening’; and Active coping ‘I’ve been concentrating my efforts on doing something about the situation I’m in’ and ‘I’ve been taking action to try to make the situation better’(see Table 16).

Another interesting result was concluded from the statistical data in relation to the effectiveness of Using Instrumental Support techniques to handle occupational stress. Nearly half the HSWs surveyed stated ‘I’ve been trying to get advice or help from other people about what to do’ occurs at high frequency. In contrast, more than one third of the participants stated that Emotional Support mechanisms, including ‘I’ve been getting emotional support from others’ were used a little, whereas almost half the participants reported ‘I’ve been getting comfort and understanding from someone’ is used frequently to cope with work-related stress. (see Table 16).

It can also be seen from the data in the Table (16) that one third of the respondents reported that they use self-distraction strategies regularly, such as ‘I’ve been doing some things to think about it less, such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping’. The participants additionally reported strategies linked to venting, including ‘I’ve been saying things to let my unpleasant feelings escape’, and ‘I’ve been expressing my negative feelings’ (see Table 16).

Comparison of the qualitative and quantitative findings for the coping mechanisms

This research found a number of similarities between the main study (i.e. the qualitative findings) and the quantitative data when it came to strategies employed to cope with work-related stress. Furthermore, as stated within the findings of both phases, spiritual beliefs played a major role in enabling the HSWs to overcome stressful experiences arising from their work.

It is also beneficial to note potential similarities between the themes emerging from the qualitative findings and the figures within the quantitative findings regarding the use of positive reframing strategies to deal with stress. For example, some of the interviewees viewed their jobs, despite the challenges, as being purely humanitarian, thus enabling them to achieve job satisfaction, particularly when patients and their families expressed their appreciation. Furthermore, both the qualitative and quantitative findings suggested the use of planning, and active coping strategies to develop alternative approaches to address the current limitations concerning HSWs' personal skills, in particular when it came to negotiating budgetary difficulties. Similarly, data obtained from both the HSWs interviewed and those surveyed emphasises the employment of strategies potentially linked to acceptance mechanisms. Thus, while a strong theme emerged regarding HSWs' attempts to address difficulties associated with financial issues in the workplace, the statistical findings reported strategies linked to acceptance as widely employed to cope with work-related stress.

Moreover, both phases emphasised the effectiveness of emotional support techniques when handling occupational stress. For instance, the quantitative result broadly supports the data obtained from the HSWs interviewed during the first phase, referring to the significance of such support from family and friends. In addition, as established within the qualitative section, and confirmed by the statistical data, this study identified instrumental support as an effective technique when facing stress at work with interviewees acknowledging its importance for minimising the experience of work-related stress, particularly professional advice from line managers (i.e. SWDs' managers), colleagues, or friends working in the same field (i.e. HSWs in other hospitals).

In addition, the quantitative result accorded with the earlier observations (i.e. the qualitative findings) in relation to the employment of self-distraction strategies to overcome workplace stress. Likewise, the female HSWs found activities such as shopping, physical exercise, and

drawing as beneficial for alleviating such stress. On the other hand, the statistical data reported strategies linked to venting as proving an effective mechanism for dealing with occupational stress, thus reflecting the findings from the interviewed HSWs, who also identified the effectiveness of sharing negative experiences with mental health professionals, colleagues, heads of SWDs, or with friends.

Finally, a number of differences were found between the main study (i.e. the qualitative findings) and the quantitative data in relation to the coping techniques reported solely within the survey phase. One of these concerned strategies linked to self-blame, denial, humour, and substance use, which were not established in the qualitative aspect of this study, i.e. by the interviewees. However, since the survey phase was employed to verify the findings the main study phase (i.e. the qualitative part), only the themes that emerged initially have been compared with the current phase findings (i.e. the quantitative data). Thus, any additional statistical results outside the scope of this current study will be recommended as subjects for future areas of research.

Reliability of the scales used

A reliability analysis was carried out on all the subscales designed to measure both stress and coping. For the nine factors that measure stress, we found a satisfactory level of reliability (Bland and Altman, 1997), with around one half of the sub factors using Cronbach's alpha (as seen in Table (17)).

Table 17: Reliability of the ENSS

Stress Subscales	Cronbach's alpha	Number of items within the subscale
Death and Dying	.700	7
Conflict with Physicians	.802	5
Inadequate Preparation	.763	3
Problems with Peers	.680	6
Problems with Supervisors	.830	7
Workload	.593	9
Uncertainty Concerning Treatment	.567	9
Patients and their families	.766	8
Discrimination	.196	3

The “Problems with Supervisors” subscale had the highest reliability ($\alpha = .830$), while “Discrimination” had the lowest reliability ($\alpha = .196$). Most items in all 9 subscales appeared to be worthy of retention, resulting in a decrease in the alpha if deleted. The only exceptions to this were the following three items, which would increase the alpha if removed (see Table 8.15):

1. In the “Death and Dying” subscale, removing of “Performing procedure that patients experience as painful” item would increase the alpha from .593 to .613
2. In the “Workload” subscale, removing “Too many non-social work tasks required, such as clerical work” item would increase the alpha from .700 to .723

3. In the “Patients and their families” subscale, removing “Not knowing whether patients’ families will report you for inadequate care” item would increase the alpha from .766 to .786.

Table 18: Reliability of the Brief COPE Scale

Coping Subscales	Cronbach’s alpha	Number of items within the subscale
Self-Distraction	.059	2
Active Coping	.409	2
Denial	.589	2
Substance Use	.907	2
Use of Emotional Support	.221	2
Use of Instrumental Support	.761	2
Behavioural Disengagement	.673	2
Venting	.630	2
Positive Reframing	.695	2
Planning	.628	2
Humour	.296	2
Acceptance	.683	2
Religion	.560	2
Self-blame	.757	2

From the table above, we can observe some heterogeneity in the alpha value. One subscale “Substance Use” has excellent reliability ($\alpha = .907$), and two subscales have good reliability “Use of Instrumental Support and Self-blame” ($\alpha = .761$ and $\alpha = .757$ respectively). While the other items reported reliability, values close to the threshold (0.7) stated by Bland and Altman including, “Behavioral Disengagement, Venting, Positive Reframing, Planning and

acceptance” ($\alpha = .673$, $\alpha = .630$, $\alpha = .695$, $\alpha = .628$ and $\alpha = .683$ respectively). The remaining six subscales have either poor or questionable reliability, ranging from .589 down to .059, which might require future investigations for the items involved in the scale (see Table 18).

Impacts of HSWs’ demographic characteristics on work-related stress factors

The main study (i.e. the qualitative findings) identified gender as one of the key contributors to ongoing stress experienced at HSWs workplaces, particularly in relation to: (1) evaluation and promotion systems; (2) working hours; (3) attendance registration; (4) staff shortages; and (5) patients’ experiences of suffering. Therefore, since the survey phase has been employed to verify the findings of the qualitative phase, this section focuses on the results reporting the impact of gender on work-related stress. Any additional results that are beyond the scope of the current study will be considered for future areas of research (see Appendix 10).

To answer the research question regarding the impact of HSWs’ demographic background on work-related stress, this study explored univariate associations between stress factors and demographic variables. The variables considered for onward multivariable analyses due to the p-value being less than 0.1 at the univariate stage (p.95) are shown in bold in Table 8.16. The p-values highlighted are for the purposes of the variable selection only and should not be confused with the conventional benchmark $p < 0.05$ for hypothesis rejection.

Table 19: Univariate associations between HSWs' Demographics and Work-related Stress Factors (p-values < 0.1 in bold)

	Death and Dying	Conflict with Physicians	Inadequate Preparation	Problems with Peers	Problems with Supervisors	Workload	Uncertainty Concerning Treatment	Patients and their Families	Discrimination
Gender	0.37	0.067	0.122	0.067	0.61	0.003	0.12	0.12	<0.001
Age	0.07	0.026	0.267	0.34	0.206	0.17	0.11	0.019	0.04
Marital status²⁶	0.4	0.35	0.79	0.37	0.75	0.29	0.237	0.99	0.46
Qualification	0.63	0.81	0.094	0.37	0.8	0.76	0.34	0.96	0.37
Specialization	0.81	0.83	0.73	0.44	0.76	0.11	0.95	0.65	0.37
Job Type²⁷	0.58	0.026	0.519	0.12	0.28	0.417	0.454	0.66	0.47
Experience	0.26	0.64	0.66	0.92	0.94	0.30	0.003	0.115	0.59
Responsibility	0.12	0.17	0.096	0.002	0.13	0.39	0.44	0.923	0.066
Department	0.68	0.97	0.85	0.48	0.57	0.77	0.76	0.65	0.33

Stress Factors associated with Gender

As can be seen from Table 19, the univariate analysis achieved by means of the ANOVA test revealed that gender did not achieve p values of less than 0.05 for: (1) Death and Dying; (2) Inadequate Preparation; (3) Problems with Supervisors; (4) Uncertainty Concerning Treatment; and (5) Patients and their Families. Consequently, no further analyses are required for these stress factors.

However, when it comes to the remainder of the stress factors, the analysis showed that only gender achieved p values of less than 0.05. P= (0.003) for Workload (see Table 8.17). Therefore, after the normality assumption was assessed using the Shapiro-Wilk test, a univariate test is reported, using (unpaired t-test) (see Table 19).

²⁶ Since there is only one participant with marital status given as 'other', that participant was removed from the analysis process.

²⁷ Since only two participants have 'other' as job type rather than 'temporary' or 'permanent', they were removed from the analysis process.

Table 20: Association between Gender and Workload

	Male (n=44)	Female (n=66)	P-value	Shapiro-wilk
Mean (Std)	19 (4.7)	21 (4.6)	0.003	W = 0.984 p = 0.221

The unpaired t-test revealed a statistically significant difference between males and females. Females showed a higher score value with regard to workload (2.77 ± 0.9 , $p = 0.003$). This result corresponds to the first phase and concluded that female interviewees experience a higher level of pressure because of the volume of work they are expected to complete (see Table 20).

Stress Factors associated with Gender and other variables

Multiple linear regressions with the enter method were performed on the remaining stress subscales (i.e. Conflict with Physicians; Problems with Peers; and Discrimination), in order to detect the possible impact of HSWs' demographic information (i.e. gender with other variables) on these work-related stress factors (see Table 19). However, as over 90% of the participants answered these questions, it was unnecessary to estimate any missing values (Woodward, 2014).

Table 21: Multiple Linear Regression for Stress Factors²⁸(p-values < 0.05 in bold)

		Regression Coefficient	95% Confidence interval (CI)		P value	R ²	Df	F
Conflict with Physician (N = 107)	Gender (female)	-1.953	-3.339	-.567	.006			
	Age ³							
	baseline (more than 45):							
	Less than 30							
	From 31-35							
	From 36- 40	-1.193	-1.829	-.558	0.007			
	From 41-45							
	Job Type (temporary)*	-2.906	-4.529	-1.282	0.01			
Model fit				<0.001	0.19	3.104	8.33	
Problems with Peers (N= 110)	Gender (female)	-.655	-2.108	.797	.373			
	Responsibility (No)	-2.026	-3.450	-.602	.006			
	Model fit				0.01	0.083	2.107	4.832
Discrimination (N = 110)	Gender (female)	.485	.367	.603	<0.001			
	Age ³							
	(baseline more than 45)							
	Less than 30							
	From 31-35							
	From 36-40	.033		.086	.216			
	From 41-45							
	Responsibility (No)	.092	-.026	.210	.127			
Model fit				<0.001	0.41	3.105	24.13	

²⁸ NB For each factor, the demographic variables selected were those with (p<0.1) in the univariate analyses. For the regression, the selected demographic variables were entered together.

According to the previous table, the model was statistically significant for Conflict with Physician (i.e. $F(3, 104) = 8.33, P < 0.001$), accounting for 19% of the variance. A statistically significant difference was also observed between males and females, with the latter having a lower score for Conflict with Physician by -1.953 units (95% CI -3.339 to -0.567, $p = 0.006$) after adjustment for age and gender (see Table 21).

In addition, the model was statistically significant when it came to Problems with Peers (i.e. $F(2, 107) = 4.83, P = 0.01$), accounting for 8.3% of variability in the score. Nevertheless, after adjustment for responsibility, no statistically significant difference was identified between males and females regarding Problems with Peers ($p = 0.373$) (see Table 21).

Finally, gender was found to have a statistically significant impact when it came to Discrimination, with females returning higher scores than males at 0.485 units (95% CI 0.367 to 0.603, $p < 0.001$) after adjustment for age and responsibility (See Table 21).

Impacts of HSWs' demographic characteristics on coping mechanisms

As reported by the first phase (i.e. the qualitative findings), key contributors to the ongoing stress at HSWs workplaces consisted of firstly, length of field work experience, and secondly, gender. This mainly concerned strategies associated with Leisure Activities and emotional and instrumental support. Consequently, while the quantitative phase aimed to verify the findings conclude by the qualitative phase, this section focuses on results reporting the impact of experience and gender on selected coping strategies, while any results outside the scope of this study will be recommended as future areas of research (see Appendix 11).

This current study explored univariate associations to establish the possible impact of HSWs' demographic characteristics on selected coping mechanisms. Variables considered for onward multivariable analyses due to the p-value being less than 0.1 at the univariate stage ($p < 0.1$) are shown in bold in Table (22). As with Table 8.17, the p-values highlighted are for the purposes of the variable selection only and should not be confused with the conventional benchmark $p < 0.05$ for hypothesis rejection.

Table 22: Univariate associations between HSWs' Demographics and Coping

(p-values < 0.1 in bold)

	Self-Distractio n	Active Coping	Denial	Substance Use	Emotional Support	Instrumental Support	Behavioural Disengagement
Gender	p=.004	p=.174	p=.851	p=.001	p=.628	p=.901	p=.164
Age	p=.399	p=.928	p=.008	p=.827	p=.455	p=.354	P=.001
Marital status	p=.693	p=.623	p=.239	p=.671	p=.760	p=.709	p=.021
Qualification	p=.115	p=.990	p=.323	p=.12	p=.136	p=.784	p=.540
Specialization	p=.873	p=.259	p=.213	p=.17	p=.32	p=.431	p=.408
Job type	p=.678	p=.378	p=.074	P=.001	p=.029	p=.263	p=.358
Experience	p=.658	p=.034	p=.680	p=.665	p=.247	p=.359	p=.599
Responsibility	p=.440	p=.583	p=.582	p=.907	p=.144	p=.225	p=.047
Department	p=.11	p=.12	p=.640	p=.27	p=.335	p=.224	p=.133
	Venting	Positive Reframing	Planning	Humour	Acceptance	Religion	Self-blame
Gender	p=.005	p=.149	p=.001	p=.383	p=.149	p=.13	p=.017
Age	p=.41	p=.658	p=.384	p=.023	p=.736	p=.271	p=.259
Marital status	p=.591	p=.464	p=.275	p=.714	p=.631	p=.215	p=.006
Qualification	p=.148	p=.100	p=.465	p=.105	p=.493	p=.622	p=.118
Specialization	p=.13	p=.406	p=.636	p=.382	p=.981	p=.102	p=.31
Job type	p=.038	p=.896	p=.768	p=.799	p=.649	p=.332	p=.008
Experience	p=.458	p=.592	p=.414	p=.937	p=.900	p=.922	p=.369
Responsibility	p=.004	p=.828	p=.547	p=.274	p=.527	p=.942	p=.048
Department	p=.317	p=.224	p=.134	p=.215	p=.106	p=.990	p=.410

Coping Mechanisms do not associate with Gender

Since Coping Mechanism forms an ordinal outcome, univariate analysis was performed with either the use of the Mann–Whitney U test or the Kruskal-Wallis test, while the multivariate analysis was performed by ordinal logistic regression. The univariate analysis did not reveal any significant association between HSWs’ gender and the strategies selected for coping with work-related stress in relation to: (1) Active coping; (2) Denial; (3) Emotional support; (4) Instrumental support; (5) Behavioural disengagement; (6) Positive reframing; (7) Humour; (8) Acceptance; and (9) Religion (p-value < 0.1) (see Table 22). It was therefore concluded that no analyses are required for these coping strategies.

Coping Mechanisms associate with Gender

As can be seen from Table 20, a univariate analyses performed using one-way analysis of variance (ANOVA) revealed that only gender achieved a p value of less than 0.1 for Self-Distraction, and Planning, as discussed below.

Table 23: Association between Gender and Self-distraction

	Male (n= 44)	Female (n= 66)	P-value
Median (IQR)	5 (4-6)	6 (5-7)	0.004

The Mann-Whitney-U Test showed a statistically significant association between gender and Self-distraction. Females achieved a higher score 6 (5-7) than males 5 (4-6); (P=.004) (see Table 23). This result might reflect the same conclusion as that arrived at for the qualitative findings regarding the increased probability that females engage in a variety of activities, and practice particular hobbies (e.g. drawing, shopping, and performing physical exercise); in an attempt to reduce the effect of stress in their workplaces (see Table 23).

Table 24: Association between Gender and Planning

	Male (n= 44)	Female (n= 66)	P-value
Median (IQR)	6 (5-8)	7 (8-8)	0.001

The Mann-Whitney-U Test showed a statistically significant association between gender and Planning. Females reported a higher score 7 (8-8) than males 6 (5-8); (P=.001). In this regard, it would be important to note that the researcher had not noted any kind of association between HSWs' gender and planning techniques affecting the qualitative data analysis process. Therefore, other research would be valuable so as to gain further clarification about the situation (see Table 24).

Coping Mechanisms associated with Gender and other variables

Coping mechanisms were associated ($p < 0.1$) with gender and other demographic variables (Substance Use, Self-blame, and Venting), were analysed according to ordinal logistic regression using the enter method. The findings are shown below in Table (25). As more than 90% of the participants answered these questions it was unnecessary to estimate missing values (Woodward, 2014).

Table 25: Ordinal Logistic Regression for Coping Mechanisms

Non-normally Distributed Coping Mechanisms		Odds ratio (OR)	95% CI OR		P value Less than 0.05	X ²	Df
Substance Use (N = 108)	Gender (male)	5	1.9	12.7	.001		1
	Job type (permanent)	.15	0.06	0.39	.001		1
	Model fit				<0.001	25.431	2
Self-Blame (N = 107)	Responsibility (No)	2.4	1.17	5.35	0.02		1
	Gender (male)	.5	.24	1.05	0.07		1
	Job type (permanent)	.28	.12	.64	0.003		1
	Marital status: Baseline (Divorced)						
	Single	.15	0.03	.83			1
	Engaged	3	.18	50	.447		1
	Married	.213	.045	1.01	.051		1
	Divorced	0	.	.	.		0
Model fit				< 0.001	29.3	6	
Venting (N = 108)	Gender (female)	4	1.8	9	0.001		1
	Job type (temporary)	3.2	1.4	6.6	0.005		1
	Responsibility (No)	2.25	1.08	4.6	0.03		1
	Model fit				< 0.001	24.4	6

According to Table (25), gender showed a significant association with substance use, with males being five times more likely to resort to substance misuse than females (95% CI 1.9 to 12.7, p=0.001), adjusting for job type. However, it important to note that the qualitative phase did not establish any strategies related to substance use in relation to participants' demographic

backgrounds. However, this result may suggest the need to undertake further empirical work to understand the influence of gender on techniques associated with substance use to handle job stress.

Furthermore, following adjustment for responsibility and job type, gender was not found to show a statistically significant association with self-blame (OR = 0.5, 95% CI 0.24 to 1.05, $p=0.07$). In addition, self-blame had not been previously established (i.e. within the qualitative phase), along with its association with participants' demographic background. However, this statistical result may suggest the need for further empirical work to understand the influence of responsibility, gender, job type and marital status on the selection of strategies linked to the use of self-blame for coping with occupational stress.

When it came to the use of venting, the odds of females venting was 4 (95% CI 1.8 to 9, $p=0.001$) times higher compared to males, adjusting for job type and responsibility. Nonetheless, these results did not emerge during the first phase, as the interviewees with different demographic backgrounds identified a number of methods of venting related to work-related stress. Consequently, the current researcher suggests that further studies should evaluate these associations, utilising additional data.

Coping Mechanisms do not associate with Experience

Table (22) demonstrates that none of the coping mechanisms (apart from active coping) showed any significant association between HSWs' length of experience and strategies selected for coping with work-related stress. It was therefore concluded that no analyses are required for these coping strategies.

Coping Mechanisms associate with Experience

Table (22) reveals that univariate analyses performed using one-way analysis of variance (ANOVA) found that only experience achieved a p value of less than 0.1 for Active Coping. This relationship is discussed in detail below.

Table 26: Association between Experience and Active Coping

	Less than 5 (n=26)	5-10 (n=45)	11-15 (n=25)	More than 16 (n=14)	P- value
Median (IQR)	7 (6-8)	7 (6-8)	6 (4-7)	8 (5-8)	0.034

The Kruskal-Wallis test showed a significant association between fieldwork experience and active coping outcomes ($p=.034$). Post-hoc analysis showed the group with more than 16 years of experience has higher scores 8 (5-8) than the group with fewer than 5 years 7 (6-8), 5-10 years 7 (6-8) and 11-15 years of experience 6 (4-7); $P=.034$ (see Table 26).

Coping Mechanisms associate with Experience and other variables

As can be seen from Table (22), the univariate analysis did not show any significant impact of HSWs' demographic characteristics and length of experience on the strategies selected for coping with work-related stress. As a result, no multivariable logistic regression analyses have been performed for experience and coping mechanisms.

Summary

In conclusion, this chapter described rich quantitative data concerning the experience of work-related stress in HSWs' workplaces, including the identification of work-related stress factors and coping strategies. Several statistical tests have been employed to explore the association between stress factors and coping strategies, and the participants' demographic data, along with checking the reliability of the data obtained utilising the scales used (i.e. ENSS and Brief COPE). The findings obtained point to a certain level of consistency with earlier qualitative work, despite a few differences concerning how HSWs' stress factors, coping mechanisms and demographic characteristics interact. The next chapter, therefore, moves on to discuss the findings obtained from both data collection phases in light of existing literature concerning the experience of work-related stress in the health care domain; in particular from HSWs' perspectives.

Chapter Eight: Discussion

Overview

As discussed previously, the initial objective of this project was to explore the experience of work-related stress from the perspective of Health Social Workers (HSWs) in Saudi Arabia (SA), by investigating the factors thought to contribute to stress in the workplace. It also explored the potential strategies HSWs might adopt to manage stressful experiences, considering HSWs' demographic characteristics as variables relative to both stressors and selected coping strategies. For the purpose of this study, a Constructivist Grounded Theory Methodology (CGTM) was selected to inform the research design. This involved two phases of data collection and two main methods (i.e. semi-structured interviews first, followed by a survey). This research design enabled the researcher to answer the research questions, delivering an in depth and understanding of the issues under exploration.

This chapter presents a detailed discussion and interpretation of the findings obtained using the methods detailed above, highlighting work-related stress factors and coping strategies employed by HSWs working in public hospitals within the Western province of SA (Makkah and Jeddah cities). The chapter also evaluates the findings by comparing them with evidence presented in existing international literature concerning the experiences of work-related stress in health organisations, and in the health social work domain in particular, as a means to understanding how employees manage it. Finally, the possible influence of the pandemic in the position of social work practice at health care sector is briefly discussed at the end of this chapter.

Work-related Stress Factors in Saudi HSWs' workplaces

Globally, work-related stress appears to be potentially a key challenge encountered by many workers in different domains and organisations, including the health care domain (Schaufeli and Peeters, 2000; Palmer et al., 2004; Johnson et al., 2005; Ahsan et al., 2009; Coffey et al., 2009; Xirui Li et al., 2015; Fink, 2017). Crucially, several scholars have suggested there is an increased probability of job stress occurrence among professionals in direct contact with vulnerable clients; particularly those responsible for managing and mitigating physical and social problems, including HSWs (Lloyd et al., 2002; Al-Aameri, 2003; Ting et al., 2011;

Blomberg et al., 2015; Caringi, Hardiman, Weldon, Fletcher, Devlin and Stanick, 2017; Choi, 2019; and Prasad et al., 2021).

Despite this study being limited in scope by its focus on HSWs in the public sectors of Makkah and Jeddah Cities, as well as an absence of HSWs' perceptions in other health care sectors (i.e. hospitals located within rural areas and healthcare centres in each neighbourhood in these cities), it is significant that a number of unique sources of stress were reported by the HSWs involved in this research. The overarching thread linking all the findings of the study concerns the identification of prevalent cultural influences on HSWs' perception of work-related stress, as well as gender based issues. This is important in the context of this current study, due to the suggestion that it is the conservative nature characteristic of Saudi society that plays a major role in influencing the status of social work as a profession, as well as HSWs' professional and personal lives.

Thus, this study found that working in a mixed gender job environment related to the prevalent conservative culture at HSWs' workplaces, impacting on the experience of work-related stress (Hamdan, 2012; Alharbi, 2015; Van Geel, 2016). However, it should be noted that, in this study, both sexes expressed similar concerns regarding the negative attitudes of other Saudi individuals with regard to working in a mixed gender setting. This result reflects the perspective of the majority of Saudi families, who disapprove of members of both genders mixing, even for work purposes. In addition, although this outcome is linked specifically to the conservative Saudi context, it should be noted that scholars in Western countries have also noted similar concerns about mixed gender workplaces, particularly in healthcare organisations. For instance, Banovciová and Basková (2014) reported a high level of job stress among health professionals as a result of issues linked to harassment at work. However, the experience of stress in Western workplaces should be perceived as differing from SA, since physical segregation based on gender in public places is no longer practised in Western countries.

Likewise, the influence of Saudi social culture appears to play a part in job-related stress when it comes to issues of work-life imbalance, especially among married HSWs. This was apparent in relation to the negative feelings they expressed concerning the tension between work and domestic duties, particularly when discussing childcare. The present results have been supported by previous studies, and it has been proposed internationally that women working in healthcare organisations tend to encounter difficulties balancing their personal and working life, as identified in previous studies (Al-Aameri, 2003; Adib-Hajbaghery et al., 2012;

Mosadeghrad, 2013). However, it should be noted that, although the majority of the literature refers to females' experience of stress associated with their domestic responsibilities, male HSWs expressed similar stress arising from commitments to their children and wives in relation to transportation. This can be attributed to the fact that, in Saudi culture, some roles are reserved for males (e.g. driving children to and from school every day), which can conflict with a need to be present during agreed working hours.

Furthermore, this study found that a key limitation experienced by HSWs concerned the influence of Saudi culture on the workplace, in particular the lack of recognition of the social work profession within the healthcare domain. For instance, the majority of Saudi citizens are reportedly unclear about the distinction between the role of social worker and that of psychiatrists and psychologists. In addition, the participants referred to the negative attitudes held by governmental organisations (e.g. police and courts) towards HSWs, and that this has been found to maximise occupational stress. Moreover, previous studies undertaken in separate contexts have found that the lack of recognition of the importance of HSWs' roles can prove a source of stress (e.g. Dane and Chachkes, 2001; Lloyd et al., 2002; 2004). It is therefore relevant to consider the relatively late emergence of social work practice in the health domain in Saudi society in comparison to America and Australia. Moreover, similar concerns have also been reported in Western cultures, although this may be due to studies being undertaken over two decades previously. It is therefore possible that the findings of Dane and Chachkes (2001) and Lloyd et al. (2002) may not reflect the current views of American and Australian HSWs.

Moreover, the current study has observed the lack of acknowledgement within Saudi society of the value of the social work profession, along with the vital role played by HSWs within healthcare organisations. This led to a variety of interpretations regarding the issues emerging as stress factors in HSWs' workplaces, particularly a lack of awareness of their role, which can lead to pressure at work. This was demonstrated by HSWs in both phases, who cited a lack of clarity when it came to their job descriptions, while indicating that they felt imposed upon and expected to take on additional administrative roles.

This aspect was reflected in the survey findings (see Table 11), which revealed that approximately one half of the participants were highly stressed as a result of performing non-social work tasks (i.e. clerical work). This finding is consistent with those reported elsewhere (Gellis, 2001; Lloyd et al., 2004; Coyle et al., 2005; Huxley et al., 2005; Willems, 2014) with regard to role ambiguity and additional paperwork becoming a source of stress for social

workers in the mental health domain. A possible explanation for this ambiguity can be the neglect, as discussed above, of the social work profession by officials and decision makers, due to being deemed to play a secondary role. In addition, Saudi citizens' general lack of recognition of the importance of the role played by social workers clearly reflects the prevalent culture (Yalli and Albrithen, 2011; and Albrithen and Yalli, 2012). This finding has important implications for decision makers responsible for deciding specific job descriptions within Saudi hospitals, in particular it highlights that HSWs would be awarded the ability to fulfil the role for which they have trained, in particular by a clear focus on the therapeutic aspects of their work.

Furthermore, this study observed that the dominant conservative culture also appeared to influence the attitudes of patients and their families, creating a potential source of stress at HSWs' workplaces. For example, the interviewees (particularly those working in mental health), reported a lack of cooperation from patients' families, which impeded effective treatment and increased the pressure placed on HSWs. Similar concerns were also identified in the survey phase (see Table 13). This issue can be interpreted in light of Saudi citizen's lack of awareness of the support HSWs can provide within the treatment process, particularly as some families continue to misunderstand, and attach a stigma to, mental illness (Albrithen and Yalli, 2012; and Attum et al., 2019). Moreover, some families can refuse HSWs' intervention, due to their conservative attitude, which does not accept the involvement of strangers (i.e. other than physicians) in patients' treatment (Albrithen and Yalli, 2012). However, it should be noted that similar concerns have been expressed by physicians and other healthcare providers, as reported by Lin et al. (2017), whose study observed high levels of stress among Taiwanese nurses, resulting from poor communication with patients' families, including their refusal to provide medical intervention in cases of advanced cancer.

Furthermore, the negative behaviour exhibited by Saudi patients and their families towards HSWs (e.g. verbal and physical aggression) exposed the participants of this study to a considerable level of stress, as demonstrated in both the interviews and the survey. The interviews raised a number of complexities linked to a lack of courtesy from patients and their families, as well as aggressive attitudes. This was also confirmed in the second phase, in which one third of the participants stated that being exposed to abuse from patients and their families was extremely stressful (see Table 13). In addition, this finding has been mirrored in previous academic literature, with Lloyd et al. (2005) referring to difficulties associated with the physical disadvantages to which HSWs can be exposed as arising from their experience of

patients in the mental health setting. Likewise, these findings have been supported by previous research among physicians in the healthcare domain (e.g. nurses and doctors) (Happell et al., 2013; Itzhaki et al., 2015; Eltarhuni, 2016).

Both phases of the current research indicate a number of issues connected to the pressures experienced by HSWs when they find themselves unable to meet patients' needs, due to: firstly, a lack of resources within HSWs' workplaces; secondly, demands that are unreasonable; and thirdly, patients' assumptions about their role. This finding was supported by Fantus et al. (2017), who claimed a significant contributor to low morale and stress to be responsibility for advocating for patients' right and demands. This can be seen as HSWs working within complex cultural and organisational values, which can obstruct their ability to meet patient demands, particularly in the light of their limited authority and lack of resources (Albrithen and Yalli, 2012).

This study also found that HSWs' experience of stress was increased in response a lack of social recognition of their roles, which impacted on how they are generally perceived by other professionals (e.g. doctors, and nurses), with whom they are required to work in a collaborative manner (see Table 7). As indicated in the main phase of the study, this leads to a negative perspective from other team members and a lack of collaboration, with practitioners routinely underestimating the effectiveness of HSWs as providers of social support, and ignoring their opinions when planning patients' discharge processes.

This finding is consistent with earlier research (e.g. Dane and Chachkes, 2001; Lloyd et al., 2002; Lloyd et al., 2004; Coyle et al., 2005; Huxley et al., 2005; Willems, 2014), and can be seen as due to competitiveness on the part of physician practitioners, which potentially threatens the effectiveness of partnerships within HSWs workplaces. This suggestion was put forward by Albrithen and Yalli (2015), who observed that poor relationships between practitioners in HSWs' workplaces can inhibit the performance of their roles. This finding, while preliminary, suggests that it would be effective for officials within HSWs' workplaces to develop additional channels to support inter-professional work, rather than the existing medical dominated setting, in order to create a healthy environment facilitating HSWs' engagement with teamwork (Albrithen and Yalli, 2015).

This current study identified insufficient educational preparation a significant determiner of the stress experienced by Saudi HSWs within their workplaces. This was evidenced during the research for this thesis, particularly at the qualitative stage, which identified a noticeable gap

between the theoretical background provided by Saudi universities and real work demands. For example, while the curriculums taught in SA Universities emphasise the delivery of high-level skills and careful professional preparation, this study has demonstrated that HSWs experience a considerable shock when they embark upon their careers, due to the limited autonomy afforded them in the workplace (Yalli and Albrithen, 2011). Furthermore, training courses for the qualifications HSWs require to practice their roles (which are provided primarily by the Saudi Commission for Health Specialities (SCfHS), tend to be insufficient to meet the demands of the workforce. These findings match those observed in previous research by Lloyd et al. (2002), which identified a discrepancy between philosophy and workplace demands among Australian HSWs working in mental health hospitals. This may be due to their limited power and the organisational facilities needed to apply such theories.

This study therefore suggests that SA universities collaborate with SWDs in SA hospitals to determine the actual requirements of the workforce, so enabling appropriate design of courses to ensure the success of HSWs, including reducing workplace stress. This result questions the level of attention currently being directed towards meeting fieldwork demands, and the capacity of organisations to provide the necessary facilities to enable HSWs to perform their roles in an effective manner.

When it comes to administration, this study has identified leadership (particularly at the ministerial level), as a potential factor in adding stress within the HSW setting, particularly among those having a long period of experience. The qualitative and quantitative sections of this study suggest the absence of transformational and transactional leadership styles, as well as HSWs' limited support from both the Mental and Social Affairs General Departments (MSAGD) and the DSW at MoH (see Table 10). While these results differs from those of Gellis (2001) (primarily due to less experienced HSWs tending to report higher levels of stress than their experienced colleagues), they match those observed in earlier studies (e.g. Lloyd, 2002; Quinn et al., 2019). However, some of the issues emerging from this finding may specifically relate to the status of administrators at ministerial level, which could result in HSWs being overseen by officials who have not been thoroughly vetted before taking on the role of head of SWDs in Saudi hospitals, as previously noted by Yalli and Albrithen (2011) and Albrithen and Yalli (2015). These results are likely to relate to the combination of social work and mental health units under a single administration within MoH, despite disparities in the services provided by each department. This indicates the need for additional attention to be directed towards mental health professionals, rather than focusing on HSWs within Saudi hospitals.

Moreover, this study has identified a lack of support, motivation, and appreciation for HSWs' roles in Saudi hospitals as a source of work-related stress, particularly as a result of the negative attitudes capable of demotivating HSWs, as revealed within the main phase of the study (Yalli and Albrithen, 2011). This current study presents evidence from previous observations (e.g. Dane and Chachkes, 2001; Willems, 2014) detailing one cause of occupational stress as being individuals' feelings of being undervalued within their workplaces. Therefore, support and appreciation received by HSWs can increase their loyalty and feeling of belonging to the workplace, thereby minimising stress.

Correspondingly, this study found evidence of a failure to provide HSWs with sufficient and fair remuneration relative to their colleagues from other professional groups within the workplace. According to MoH regulations, the majority of practitioners in the health field are entitled to receive an additional allowance, due to their contact with patients potentially suffering from dangerous transferrable illnesses. However, the fact that this does not currently apply to HSWs can be seen as amplifying the probability of job stress. This result is in line with data recorded in other studies concerning job stress in healthcare organisations (e.g. Santo et al., 2010; Fiabane et al., 2012 and Happell et al., 2013).

This study also observed that the majority of governmental Saudi workplaces appear to be characterised by a prevalence of bureaucratic systems (Yalli and Cooper, 2008; and Albrithen and Yalli, 2012). Likewise, it identified the limited autonomy accorded to HSWs as a contributor to work-related stress. These issues have been reported within the main phase of this research as preventing HSWs from enacting their roles expediently. The study also demonstrated (see Table 10) that one quarter of the respondents stated that they found it highly stressful to be held accountable for aspects over which they have no control. This finding supports the work of relevant studies of Western workplaces, which have also related a lack of professional autonomy and bureaucratic systems to workplace stress (e.g. Gellis, 2001; Lloyd et al., 2002). These relationships can be partially explained by HSWs being secondary service providers, and so with limited authority compared to physicians. This has also been frequently observed in international studies, and therefore this thesis suggests that HSWs would greatly benefit from being empowered in their roles, so positively reflecting their position as professionals and high quality service providers.

Finally, this study identified a lack of resources within Saudi hospitals (i.e. lack of equipment and devices, as well as a shortage of staff (including HSWs), and other budgetary limitations,

as significantly contributing to work-related stress. Both phases of the research indicated a number of difficulties due to the lack of facilities scaffolding HSWs in the performance of their tasks, i.e. the survey identified that three quarters of participants had experienced extreme levels of stress caused by the lack of facilities and equipment in their workplaces (see Table 12). However, this finding can be seen as due to the context of this study, since Albrithen and Yalli (2012) indicated that that HSWs are not generally involved in planning and decisions related to funding. However, this study supports the evidence from the academic literature, as almost all studies undertaken at HSWs' workplaces tend to identify a lack of resources and staff shortages as potential stress factors (Lloyd et al., 2002; Acker and Lawrence, 2009; Coyle et al., 2005; Huxely et al., 2005; Fantus et al., 2017; Yi et al., 2018). The reason for this is unclear, particularly as these studies were undertaken within different cultures, and both developed and developing countries. One possibility is the fact that social work is viewed as a supportive profession, including in the health field, and therefore decision makers pay less attention to their financial requirements. This study therefore suggests that MoH needs to specify and prioritise sufficient resources to enable HSWs to practice their roles to the required standard.

This discussion now considers the influence of gender on HSWs' work-related stress. The research highlighted the impact of the conservative and religious nature of Saudi society as having a considerable influence on current social work practices and work-related stress, particularly among female HSWs. Henderson (2011) stated that the development of Saudi society is considered evolutionary rather than revolutionary, with progress being gradual and consistent. However, although there has been some improvement in the status of women, with social reforms now having granted them additional rights, these remain diversely applied (Hamdan, 2012; Van Geel, 2016).

The current study therefore suggests that this causes a higher level of work-related stress among female HSWs than their male colleagues, partially due to the priority extended to men over women within the workplace. This includes evaluation criteria (i.e. performance and commitment to working hours) representing an enhanced source of stress for the female employees in this study. This can be seen as due to the dominance of men in Saudi workplaces, in particular when it comes to administrative positions (RajKhan, 2014). Thus, despite their physical segregation, males are in a position to evaluate female performance, which impacts on the validity of the assessment process. A further imbalance is that male employees can more readily build strong relationships with administrative staff, due to these being of the same

gender, while the same is not open to female employees, due to physical gender segregation in Saudi workplaces.

However, it should be noted that gender inequality in the workplace is recognised as a global issue, with similar concerns found elsewhere in the literature in relation to different contexts (Adib-Hajbaghery, 2012; Ariza-Montes et al., 2013; Spector et al., 2014; Yad et al., 2014; Hertzberg et al., 2016).

The prevalent culture in SA also raises concerns in relation to time keeping, in particular for female HSWs. Biometric technology (i.e. a finger scanner) is used to register daily attendance, with previous studies suggesting this approach causes stress for professionals in many domains (Oloyede et al., 2013; Adewole et al., 2014). This is particularly relevant to female HSWs who, during the period of the first phase of data collection, were not permitted to drive, and so were reliant on drivers, husbands, or brothers. This result reflects the influence of culture and norms on increasing work-related stress among female HSWs (Alharbi, 2015; Alfasi, 2018).

Likewise, this study found gender played a major role when it came to stress caused by HSWs' workload. As mentioned above, the lack of clarity concerning job descriptions was a point frequently raised by HSWs during both phases. The interviews indicated that the HSWs felt they were being imposed upon by being expected to play additional administrative roles. This was also reflected in the survey findings (see Table 11), which revealed that approximately one half of the participants experienced high levels of stress as a result of being required to perform non-social work tasks (i.e. clerical work). As indicated in both the interviews and the survey phase, this added to their volume of work (see Table 20).

Moreover, a further source of stress related to gender was found to be the process of career advancement, with the dominant culture dictating the promotional processes obligated by SCfHS. This finding is consistent with those of Gellis (2001), Huxley et al. (2005), and Coyle et al. (2005), who observed limited opportunities for personal advancement as a contributing stress factor for both male and female HSWs, particularly in the domain of mental health. However, it is vital to acknowledge the cultural differences between the West and SA, as these inform how social workers perceive personal advancement as a contributory factor to job stress. For example, in this current study, only the female HSWs mentioned experiencing stress as a consequence of the imbalance in the promotional structure, partially due to the conservative culture, as women are not permitted to easily travel to fulfil the requirement of 100 hours of

training sessions per year, as demanded for professional advancement by SCfHS. Therefore, the female HSWs did not see any potential for career progression.

In a similar vein, this study found that, due to the need to undertake night shifts, the issue of working hours placed greater pressure on female HSWs than their male counterparts. The results support evidence from previous observations (e.g. Happell et al., 2013; Lin et al., 2017), stressing the impact of shift work on marital and social life. The reason women are more affected can be linked to the expectation that they take responsibility for domestic tasks and childcare, although in SA it is also assumed that a woman does not leave her house in the evening without a 'Mahram', unless there is an emergency. This study therefore suggests that, in view of Saudi cultural norms, decision makers need to consider the limitations imposed by society on female HSWs by assigning them fewer night shifts.

In addition, this study has postulated that the nature of HSWs' roles as frequently interacting with vulnerable groups may have an additional emotional impact on female HSWs, particularly those working in the fields of mental health or addiction and in children's hospitals. This issue was raised in the interviews by female HSWs, and also reflected on the survey (see Table 6), revealing that half of the HSWs reported watching patients suffer as among their most stressful experiences. This finding supports evidence from previous literature investigating occupational stress among other healthcare professionals (e.g. Wallbank and Roberson, 2013; Pezaro et al., 2016; Lin et al., 2017). Various studies have proposed an association between empathetic feelings prompted by clients' problems and the level of emotional stress experienced by physicians (i.e. doctors, nurses and midwives). This result is also consistent with Lloyd et al. (2002) and Acker and Lawrence (2009), who cited high levels of stress among social workers in mental health settings, as a result of consistently working with vulnerable clients suffering from severe mental illness.

This data also supports Ting et al. (2011), who reported higher levels of Secondary Traumatic Stress (STS) among HSWs having recently worked with suicidal clients. Furthermore, Quinn et al. (2019) found that dealing with traumatised patients as a significant cause of STS. Moreover, Yi et al. (2018) referred to emotional stress arising from being in regular contact with cancer patients, as well as emphasising the influence of inadequate emotional capacity in maximising work-related stress in the context of medical social work. While Yi et al. (2018) identified an association between inadequate emotional preparation and occupational stress, this current study has not raised concerns regarding the ability of HSWs to deal with the

emotional complexities caused by dealing with vulnerable patients, including those in Oncology sections.

Coping Mechanisms

This study has acknowledged several strategies drawn from the literature in response to stressors found within workplaces in different domains (Gyllensten and Palmer, 2005; Howard, 2008; Panigrahi, 2016). However, according to Collins et al. (2010), job stress can vary according to organisational and structural contexts. This study has therefore identified a number of coping approaches associated with problem-focused and emotion-focused techniques, corresponding to those discussed in previous studies. It has found that spiritual characteristics appeared to pervade the ways HSWs tend to combat job stress. This was revealed in the interviews, which indicated that HSWs' spiritual beliefs offered them significant support when experiencing stress at work. This included techniques such as believing they were helping patients for the sake of Allah, and that they will be rewarded by Almighty God for their endurance in the face of difficulties encountered at work. Moreover, they reported that work pressures were mitigated when patients' and their families' offered their prayers, appreciation and acknowledgment. This was also reflected in the survey findings (see tables 8.13 and 8.14), which showed religious techniques being used frequently by more than two thirds of the HSWs. This can be seen as due to most aspects of life in SA being influenced by religious beliefs (Moghadam, 1988; Sidani, 2005). In addition, there remain a number of similarities between the attitudes expressed by the HSWs in the current study and those identified in previous studies (e.g. Dane and Chachkes, 2001; Ting et al., 2008; Hernandez, 2017) in relation to the effectiveness of spiritual beliefs for managing occupational stress. This can be seen as due to spiritual considerations also playing role in managing work-related stress in other societies, including Western communities. However, this could be associated with the lack of acknowledgment and respect generally encountered by HSWs in their workplace. Therefore, while the benefits of spiritual impact cannot be ruled out, they also have the potential to be exploited as a strategy to overcome stressful experiences in HSWs' workplaces.

Furthermore, the current study also identified HSWs' interactions with patients as crucial mechanisms in managing HSWs' suffering. This was indicated in the main phase of the study, as the entertainment activities they organised as an aspect of treatment plans were reported to

enable HSWs to spend an enjoyable time with their patients in different settings. This enabled them to experience a sense of satisfaction, as they were subsequently able to implement positive experiences for their patients. This finding accords with Dane and Chachkes (2001), who highlighted the benefits of an interactional strategy, particularly as appreciation from patients can help minimise HSWs' perceptions of work pressure. These findings therefore have the potential to assist in understanding the potential benefits of MoH considering a specific budget for SWDs in Saudi hospitals, in order to enhance their ability to conduct regular activities to benefit both patients and HSWs.

Likewise, this study identified engaging in adequate communication and enhancing relationships with colleagues and professionals within the workplace as a means of assisting HSWs to manage job stress. This point was raised in both phases of the study, with the qualitative aspect emphasising the importance of building a strong relationship with colleagues and other professionals as a means to share both negative and positive work experiences and exchange advice. The same result was also reported within the survey phase, with instrumental support being utilised by almost half of the HSWs (see Table 16). This finding supports the propositions set out by Ben-Zur and Michael (2007), who indicated instrumental support within workplaces as being potentially more effective than emotional support, since it provides opportunities for employees to listen and counsel one another in a supportive manner when working within the same environment and sharing similar experiences. This also enables HSWs to seek practical advice for performing their tasks efficiently.

These findings have important implications, highlighting the benefits of regular social activities among staff, in order to establish strong relationships capable of reflecting on HSWs' performance and providing opportunities for professionals to recognise the importance of each other's roles within the hospital setting. This in turn can be an effective method of reducing HSWs' levels of stress.

In a similar vein, and with reference to SWDs' managers, this study acknowledges the roles played by line managers in minimising work-related stress among HSWs. This was demonstrated from the qualitative findings and reflected in the survey, with the application of instrumental strategies including seeking support from the managers of SWDs. This is particularly important because the majority of line managers are graduates of social work schools, rendering them more qualified than MSAGD and hospital managers to supervise HSWs. Moreover, SWD managers play mediating roles between HSWs and hospital managers,

as well as communicating with MSAGDs ultimately responsible for SWDs within Saudi hospitals. This indicates that HSWs may feel more comfortable approaching authorised individuals with the skills and abilities to support them instrumentally and emotionally. This confirms Kraemer (2013), Hernandez (2017), and Yi et al. (2018), who acknowledged the role of supervisory support in workplaces as underpinning coping strategies capable of providing both emotional and instrumental provision for employees. Furthermore, it is in accord with Gellis (2001), who reported a positive correlation between applying social support strategies and transformational leadership strategies within HSWs' workplaces. This information can benefit the appointment of SWDs' managers, as it enriches understanding of the complex roles they may be required to play in managing work outcomes, in order to ensure expectations are met.

On the other hand, this study agrees that HSWs' stress, both at work and at home, can be reduced by emotional support from those around them (e.g. family members and friends). The interviews emphasised that sharing stressful experiences with family members helped HSWs overcome their negative feelings, while also maintaining the confidentiality of their patients. This was confirmed by the quantitative data, which reported a number of strategies linked to emotional support and venting as used by HSWs (see Table 16). This study supports evidence from previous observations (e.g. Gellis, 2000; Dane and Chachkes, 2001; Smith, 2006; Kraemer, 2013; Hernandez, 2017; Yi et al., 2018), which concluded that the effectiveness of the emotional support offered to HSWs tends to be influenced by their family members and close friends.

Moreover, this study identified the support of mental health professionals within HSWs' workplaces (e.g. psychologists and psychiatrists) as helpful when dealing with work-related stress (see Table 16). This can also link to venting, as well as the emotional and instrumental advice to address HSWs' negative feelings caused by work. This result was unexpected, due to the study being undertaken in Saudi society, in which the majority tend to stigmatise those consulting mental health professionals (Qureshi et al., 2009; Attum et al., 2019). However, it should be recognised that the views of HSWs may diverge from wider society, due to being highly educated, and understanding the importance of mental health from a professional perspective. Moreover, both HSWs and mental health workers work closely in a professional capacity, and are supervised by the same administration at the ministerial level (i.e. MSAGD). Therefore, this study recommends the value of routinely providing counselling sessions within

HSWs' workplaces, in accordance with the recommendations of mental health experts, as HSWs are subject to emotional challenges caused by the nature of their work.

This research has indicated the different ways in which job stress informs the personal skills possessed by HSWs. Both the qualitative and quantitative findings emphasised the significance of applying the techniques related to planning, positive reframing, and active coping as a means of maintaining emotional stability and calm in the context of fieldwork (see Table 8.18). For example, the interviews showed that planning enabling HSWs to avoid thinking about workplace pressures during their free time (including when at home), were found to be helpful mechanisms in controlling the pressure caused by work. This result corroborates Yi et al. (2018), who suggested that HSWs prefer to separate their personal and professional lives, in order to maintain a stable routine. Also consistent with the findings of Yi et al. (2018), a number of HSWs in the current study considered taking a break away from work as a way of coping with stress. Moreover, the HSWs tended to use skills they had acquired from training sessions to improve their capacity to handle workplace challenges. This result correlates with the view expressed by Trowbridge et al. (2017) concerning the benefits of offering training courses (i.e. a Mindfulness Based Stress Reduction course) to enable HSWs in paediatric sections to minimise stress.

Notably, this study revealed the role of gender as a moderator of stress among HSWs. For example, both phases of the study detected a number of mechanisms related to self-distraction, particularly among the female HSWs, as a means of handling work-related stress. In addition, female HSWs were found to prefer incorporating entertaining activities into their daily life to help them manage their stress levels, e.g. physical exercise, drawing, and shopping. This was confirmed by the results of the survey, with approximately a third of the participants reporting techniques such as watching TV, reading, and shopping. This result further supports the findings of Ting et al. (2008), Hernandez (2017) and Yi et al. (2018), who reported the engagement of HSWs in various activities as an effective means of minimising the impact of occupational stress, e.g. physical exercise; eating tasty food; drinking coffee; going to the gym; reading books; and watching TV.

Another important finding was that HSWs, and in particular females, tended to adapt to the limitations in the workplace environment, specifically with regard to the availability of resources and other policies and regulations (e.g. workload). Female HSWs appeared to rely on this approach to control stress, particularly that caused by organisational factors, e.g. a lack

of resources and an applied administrative system. This finding can be seen as being related to acceptance techniques (i.e. situational coping), particularly when individuals wish to adjust to the constraints of their workplace. However, another possible explanation when it comes to female employees concerns their limited authority within the workplace (Al-Hamdan, 2012) leading to an acceptance of the situation as a method of countering job stress. These results reflect those of Hernandez (2017), who also found that HSWs in paediatric and neonatal intensive care units familiarised themselves with organisational limitations in order to manage primary and STS.

Furthermore, when examining the techniques used by HSWs to cope with work-related stress, this study found that their fieldwork experience played a major role as a moderator of stress. This is evident in the qualitative data, with the interviews indicating that HSWs who had been working for over ten years were more able to deal with tension at work, due to feeling more confident in their ability to survive the conflicting challenges embodied in their roles. Similarly, the second phase reported an association between active coping mechanisms and length of field work experience (see Table 26). This can be seen as due to HSWs' increased capacity to draw on their personal skills to manage work-related stress, due to familiarising themselves with the most appropriate ways of dealing with these issues at work. This result reflects the conclusion of Ting et al. (2008) concerning a correlation between older American HSWs being able to use more positive coping strategies in mental health settings.

It should be noted that there were also a number of diverse findings between the main phase (i.e. the qualitative aspect) and the quantitative result, partially due to differences between each method in terms of the depth of the information gained. For example, the interviews offered in-depth and detailed information about issues relating to leadership as a source of pressure, as perceived from the perspective of HSWs, while the questionnaire gave only limited response options. A further possible explanation for inconsistencies between the findings of the two phases can be seen as arising from the fact that the interviews lacked the anonymity of the questionnaire, and so the responses from the interviewees may have been influenced by an unwillingness to share information having potential implications for their career. This was particularly true of the coping strategies associated with substance misuse, with only the statistical analysis reporting HSWs resorting to such a negative mechanism.

Finally, although a standardised tool, ENSS was adapted within the second phase to serve the purposes of this study. This was due to the impossibility of exploring within the main

qualitative phase every aspect associated with the issues raised in the main qualitative phase. This resulted in the questionnaire phase omitting a number of aspects, mainly with respect to factors linked to the lack of social recognition of HSWs roles and the distinguishing cultural issues associated with Saudi society. This study therefore recommends the need for further research to take these variables into account, in order to address this gap.

The potential impact of COVID-19 on the positionality of HSW in Saudi

The current COVID-19 global pandemic has had a profound influence on different aspects of life throughout the world (Lemieux, Milligan, Schirle, and Skuterud, 2020). Rana, Mukhtar, and Mukhtar (2020) argued that the pandemic has not only increased the mortality rate as a result of viral infection, but also the prevalence of psychological disorders. In addition, Chaturvedi, Vishwakarma, and Singh (2021) reported recognition of several psychological and social problems arising from the self-quarantine imposed internationally to prevent the spread of the virus, e.g. frustration, stress, depression, and isolation. This has resulted in an urgent need for integrated healthcare teams to deal with the resulting physical, mental, and social complications (Alqahtani, 2021; Pietromonaco and Overall, 2022; Long, Patterson, Maxwell, Blake, Pérez, Lewis, and Mitchell, 2022).

In addition, it should be recognised that the pandemic has also had a considerable impact on the workforce, particularly frontline healthcare professionals (Sim, 2020; Monitor, 2020; Cudjoe, and Abdullah, 2020; Ghareeb, El-Shafei, and Eladl, 2021; Doan, Tran, Than, Nguyen, Bui, Nguyen, and Otsu, 2022). Piščalkaitė (2021) claimed that healthcare professionals were a vulnerable group during the pandemic, due to being constantly exposed to physical and psychological pressures. In this regard, Al-Rabiaah, Tamsah, Al-Eyadhy, Hasan, Al-Zamil, Al-Subaie, and Somily (2020) stated that healthcare workers are now experiencing higher level of distress in comparison to other professions. This is partially due to frontline health care professionals being directly engaged in the diagnosis, treatment, and care of patients with COVID-19 (Lai, Ma, Wang, Cai, Hu, Wei, and Hu, 2020). Furthermore, Mhango, Dzobo, Chitungo, and Dzinamarira (2020) concluded that key factors capable of increasing the impact of the pandemic on workers in healthcare settings included: 'lack of personal protective equipment, exposure to infected patients, work overload, poor infection control, and pre-existing medical conditions' (p. 263).

When it comes to clinical social work as an allied healthcare profession, HSWs can be seen to play an essential role during this current crisis (Levin-Dagan, and Strenfeld-Hever, 2020; Fox, McIlveen, and Murphy, 2021; Azhar, Farina, Alvarez, and Klumpner, 2022). According to Levin-Dagan and Strenfeld-Hever (2020), social workers in hospital setting effectively work with a patient from the time he/she is admitted until the completion of treatment. This includes dealing with patients' emotional trauma as a result of the nature of the disease, and fear of deterioration, as well as feelings of loneliness, and guilt at leaving family members at home (Banks, Cai, De Jonge, Shears, Shum, Sobočan, and Weinberg, 2020). Moreover, HSWs are also in charge of dealing with the instrumental and emotional demands of patients' families, which is undertaken by phone, with social workers responsible for delivering messages between families and patients, as well as conveying information from physicians to update the families on their loved one's condition (Levin-Dagan, and Strenfeld-Hever, 2020).

Nevertheless, scholars have found several limitations that have silenced the profession during the global discourse concerning the pandemic (Amadasun, 2020; Alqahtani, 2021). Fraher, Pittman, Frogner, Spetz, Moore, Beck, and Buerhaus (2020) claimed that outdated internal policies in healthcare organisations (i.e. bureaucratic protocols) can have a considerable impact on workflows and consequently the capacity of organisations to meet patients' needs, as well as impacting on practitioners' wellbeing. Moreover, Ashcroft, Sur, Greenblatt, and Donahue (2021) identified additional sources of HSWs' stress as a result of COVID-19, including: (1) increased working hours; (2) volume of work; (3) fear of losing their job; (4) continuous changes in workplace atmosphere; (5) health and safety risks; and (6) domestic caregiving responsibilities. Such factors appear to greatly influence HSWs as a professional group, as well as the position of social work (Amadasun, 2020; and Alqahtani, 2021).

In the context of this current study, medical social work has, since its emergence in 1973, been awarded significant support from the Saudi government and other decision makers (Yalli, and Albrithen, 2011; Mahmoud, 2020; Alqahtani, 2021). In addition, Balhareth, AlDuhileb, Aldulaijan, and Aldossary (2020) emphasised the importance of support HSWs are able to offer during the COVID-19 global pandemic to patients and families, as well as other health practitioners within the workplace setting. Alqahtani (2021) stated that HSWs in Saudi society are committed to addressing the social influences associated with crises, using the principles and ethics of their profession, along with their personal knowledge and skills. In addition, Alqahtani, (2021) noted that COVID-19 could be viewed as an opportunity for clinical social

workers to leave an indelible imprint on Saudi healthcare, both with the public and other professional groups.

Nonetheless, HSWs are unable to respond to the demands of the pandemic without considering their context. This highlights the need to learn from the past in order to increase the effectiveness of the social work profession during the pandemic. A number of studies have therefore concluded that it is vital to note the influence of Saudi culture as an essential element when considering the social work profession, particularly in relation to healthcare (Yalli, and Cooper, 2008; Albrithen, and Yalli, 2013; Albrithen, and Dziegielewski, 2016). This has also been the conclusion reached by the current exploratory study, particularly due to the number of factors associated with the experience of work-related stress being attributed to the conservative culture of the Saudi community.

This study concludes that HSWs are currently working to the best of their ability to develop the professional practice of clinical social work in SA. In addition, the researcher considers it vital that officials make additional efforts to offer an appropriate working environment in order to facilitate effective clinical social work during this difficult period. Furthermore, it is important training courses are established capable of expanding the knowledge of HSWs and enhancing their skills. Similarly, despite the current increase in research into the impact of COVID-19 on healthcare workers, there remains an urgent need to shed light on the obstacles faced by HSWs during the pandemic. This has the potential to address mental health issues experienced by both HSWs and other professionals within healthcare settings.

Finally, this current study also considers that HSWs are motivated to participate in research determining the needs of their clients, as well as establishing suitable resources to respond to their demands in practice. This would assist in preventing serious psychological impacts and enhancing the well-being of professional healthcare workers during the current pandemic.

Summary

In summary, there appears to be considerable evidence emphasising the role played by the nature of social work profession itself, as well as the prevalence of Saudi culture in the stress HSWs' encounter in the workplace, as well as the techniques used to deal with it. The stressors identified, and the coping strategies discussed within this chapter correspond to those identified in previous literature, regarding the influence of HSWs' demographic characteristics, including gender, and field work experience as moderating the experience of job stress and determining

the selected coping mechanisms. The next chapter concludes the thesis, highlighting the original contribution of the study and its limitations, and proposing recommendations for best practice among HSWs in the workplace.

Chapter Nine: Conclusions

Overview

This chapter appraises the extent to which this research has fulfilled its aims, to establish how the findings have contributed to knowledge in the field of social work, especially within the Saudi context. To accomplish this, it begins by summarising the research process, while considering the research questions and aims. It also provides a summary of the findings from the first and main phase (qualitative) and the second (quantitative) phase of the study. The conclusions presented in this chapter contribute to offering a knowledge-based framework, constructed based in the main findings of the study (perceptions of HSWs), as well as on the researcher's own interpretation, which can potentially further the understanding and development of new practical ways of approaching key issues associated with work-related stress, as perceived by HSWs in SA. This is followed by an outline of the study's original contribution to conceptual and methodological knowledge, as well as key recommendations concerning improvements to the working environment encountered by Health Social Workers' (HSWs), including reduction of job stress among HSWs. Finally, suggestions for future research and the limitations of the study are also presented at the end of the chapter.

Summary of the Research Process

This study aimed to explore the factors associated with work-related stress, as well as the coping strategies implemented by HSWs working in public hospitals in the Western province of Saudi Arabia (SA) in the cities of Makkah and Jeddah, paying particular attention to the impact of demographic characteristics on these factors and strategies, from HSWs' perspectives. The research approach was based on an interpretive perspective using Constructivist Grounded Theory Methodology (CGTM), which allowed the researcher to use two methods for data collection. This design enabled the investigator to gain rich in-depth and accurate information regarding the shared experiences of HSWs at state hospitals in the cities of Makkah and Jeddah, through the application of theoretical sampling and data saturation.

In this study, two main data collection instruments were used in two different phases. In the first main phase, semi-structured interviews were conducted to collect qualitative data. Purposive and theoretical sampling technique were used to recruit a sample population of

HSWs according to gender, experience, job type, marital status, specialisation, and academic qualifications, as well as the domains in which they work (e.g. mental health, addiction, maternity and children), to ensure the study would cover a wide range of experiences from different perspectives. In total, twenty-four HSWs were included in this phase. However, the researcher only conducted eighteen semi-structured interviews (with nine male and nine female HSWs), as data saturation was reached by the sixteenth interview, with no new themes emerging in the HSWs' answers. All the interviews were conducted in Arabic, the native language of both HSWs and the researcher. Participants granted the researcher permission to record the interviews, after it was clarified that the recordings would only be used for the purposes of transcription and analysis.

Following the transcription process, the grounded theory coding process adopted by Charmaz (2006) was applied to the data analysis. This technique enabled the researcher to break down and categorise the data into small units, using NVivo 9 software for organisation and classification, which greatly assisted with achieving the CGTM studies' aims. As the interviews were undertaken and transcribed in Arabic, the analysis was also performed in Arabic, in order to minimise the risk of translation errors, thereby avoiding a time-consuming translation process.

In the second phase, two-hundred self-completion questionnaires were distributed across Makkah and Jeddah public hospitals, supervised by (MoH); one hundred-twenty were returned and only a hundred-ten questionnaires were involved in the analysis process. An expanded Nursing Stress Scale (ENSS) was employed to examine work-related stress factors, along with the Brief COPE scale to detect coping strategies. Using SPSS software (version 23) enabled the investigator to analyse the data obtained from the questionnaires via descriptive statistical analysis (e.g. percentage, means and standard deviations). Several statistical tests (e.g. one-way ANOVA, unpaired t-test, multiple linear regression, Mann-Whitney-U Test, Kruskal-Wallis test, and Ordinal Logistic Regression) were also used to determine the probable influence of HSWs' demographic data on the experience of job stress, as well as the coping strategies selected.

Summary of the Research Findings

The researcher categorised the findings of the data obtained from the main phase of this study into two categories of factors impacting HSWs' workplaces, i.e. 'Saudi culture' and 'gender', as discussed in detail below.

1. Saudi Culture. This study identified several influences relating to the prevalent conservative culture of Saudi society capable of causing HSWs workplace stress. These included: firstly, a mixed gender workplace; secondly, attempting to balance work with other responsibilities (i.e. domestic duties); thirdly a lack of social recognition of the roles of HSWs; and finally, inadequate academic preparation. In addition, the participants identified stress linked to: firstly, other professional groups working in the same setting; secondly, patients and their families; thirdly, a need for effective leadership; fourthly, inadequate working policies and regulations in Saudi hospitals; and finally the availability of resources to enable HSWs to perform their roles effectively.

2. Gender. This study clearly demonstrated the impact of gender on workplace stress, with several issues within both phases being reported as relating solely to the female participants. These focused on gender inequality and male dominance in HSWs' workplaces, including: firstly, difficulties linked to male dominance; secondly, issues concerning professional classification, evaluation and the potential for promotion; thirdly, long working hours; and fourthly, staff shortages. Furthermore, female HSWs also faced challenges related to attendance, workload and working with vulnerable groups as well as a lack of fieldwork experience.

In addition, the qualitative findings identified several mechanisms employed by HSWs to cope with workplace stress. These included personal skills, in addition to the emotional and instrumental support received from families and friends, as well as their colleagues and line managers. The findings revealed that the most frequently used strategies were significantly associated with spiritual tendencies. In addition, the participants stated that they alleviated workplace stress by means of: firstly, daily leisure activities (i.e. physical exercise and shopping); secondly, aspects linked to patients (e.g. their appreciation for HSWs); thirdly, strategies linked to venting (e.g. consulting mental health professionals); and fourthly, taking time away from the workplace. It was notable that extensive experience appeared to reduce

work-related stress among the research participants, while their gender and field work experience also influenced their methods of managing of work-related stress.

In addition, a number of factors associated with work-related stress were identified in the second phase based on ENSS, including: firstly, issues relating to patients and their families; secondly, uncertainty concerning treatment; thirdly, workload; fourthly, death and dying; fifthly, problems relating to supervisors; sixthly, discrimination; seventhly, conflict with physicians; eighthly, problems relating to peers; and finally, inadequate academic preparation. These generally supported the findings gathered from the main study phase.

However, it is important to identify the potential limitations of ENSS when measuring the influence of conflict with physicians on work-related stress within the context of this study, due to ENSS being developed to assess the experience of work-related stress within the nursing domain. Therefore, some items used in the sub-scales discussed above might not accurately reflect the field of social work. Moreover, this current research identified considerable differences associated with HSWs' gender and fieldwork experiences as playing a major role in controlling job stress among the study participants.

The quantitative findings also noted several techniques used to address experiences of work-related stress, as identified by the Brief COPE scales. These included the following strategies for dealing with stress in Saudi HSWs' workplaces: (1) religion; (2) planning; (3) acceptance; (4) positive reframing; (5) active coping; (6) use of instrumental support; (7) self-distraction; and (8) use of emotional support. When it came to HSWs' demographic characteristics, the study also highlighted differences in coping strategies, according to gender and fieldwork experience. Meanwhile, many factors associated with work-related stress were identified in the second phase based on the ENSS. This includes issues relating to patients and their families, Uncertainty Concerning Treatment, Workload, Death and Dying, Problems Relating to Supervisors, Discrimination, Conflict with Physicians, Problems relating to peers, and Inadequate Academic Preparation, which mostly support the findings gathered from the main study phase. In this regard, it is noteworthy to identify the possible limitations of the ENSS when measuring the influence of conflict with physicians on work-related stress within the context of this study. This could be attributed to the fact that the ENSS was developed to assess the experience of work-related stress within the nursing domain. Therefore, some items used in the mentioned sub-scales might not accurately reflect the social work field. Moreover, pertaining to the impact of HSWs' demographic characteristics on work-related stress, this

study clearly demonstrated remarkable differences associated with HSWs' gender and fieldwork experiences that seem to play a major role in controlling job stress among study participants.

The quantitative findings also noted that several techniques address experiences of work-related stress, as identified by the Brief COPE scales. Strategies linked Religion, Planning, Acceptance, Positive Reframing, Active Coping, Use of Instrumental Support, Self-distraction, Use of Emotional Support,; all of which seem to be valuable when dealing with stress in Saudi HSWs workplaces. In terms of HSWs demographic characteristics, the study also highlighted the differences in the selected coping strategies, according to HSWs' gender and fieldwork experience.

Table 27: Working Framework for Health Social Work Practice in Public Hospitals in Saudi Arabia

Emerging issue	Contributing Factor	Recommendation
<p>Positionality of Social Work Profession in the Saudi Context</p>	<ul style="list-style-type: none"> • Low level recognition about social workers' roles appears to characterise most Saudi individuals, professionals and officials' point of views. • The ambiguity of HSWs' roles in their workplaces, since most of them seem to perform additional tasks that are not directly linked to the social work specialty. 	<ul style="list-style-type: none"> • Greater efforts might be required from all related organisations to increase Saudi society's understanding of the importance of the social work profession, and social workers' roles in the public sector hospitals in the Western province of Saudi Arabia. • Extra efforts seem to be needed from HSWs to approve themselves and the significance of their roles. • Social media could play a major role in familiarising individuals within the social work profession, and its contribution to providing holistic treatment plans that are equally concerned with the physical and social sides of patients' lives. • A key policy priority should be to review the current job description of HSWs to be more consistent with their academic qualifications; and to give them an opportunity to focus on their therapeutic practice, rather than conducting additional administrative tasks.
<p>Patients and their Families</p>	<ul style="list-style-type: none"> • Conflict of interests between HSWs and patients. • Undesirable attitude perceived from patients and their families, which may include verbal and physical aggression. 	<ul style="list-style-type: none"> • Greater efforts are needed from all related organisations to increase Saudi society's awareness about the support that HSWs can offer to the patients and their families. • Clear regulation or punishment is urgently needed to be generalised within health care organisations, to reduce violence towards health professionals.
<p>Leadership</p>	<ul style="list-style-type: none"> • The role of the Directorate of Social Work (DSW) at the MoH does not seem to have been clearly established yet. • Less attention is giving to qualifications when appointing leaders at the ministerial level. • The MSHGD applied centralised decision-making system 	<ul style="list-style-type: none"> • It would be more effective if individuals with sufficient experience and relevant qualifications managed SWDs with an understanding of the actual needs of the field. • More authority is recommended to be given to the DSW at ministerial level to apply more effective supervision at the practical level. • Managers of SWDs need to offer a healthy environment for HSWs to enhance feelings of loyalty in their workplace.

Table 28: Working Framework for Health Social Work Practice in Public Hospitals in Saudi Arabia

Emerging issue	Contributing Factor	Recommendation
Time Scheduling	<ul style="list-style-type: none"> • Strict attendance policy (i.e. biometric scan). • Working hours could contradict with HSWs' domestic responsibilities. • Nightshifts seems to be problematic; particularly for female HSWs. 	<ul style="list-style-type: none"> • The MoH would reconsider a more flexible scheme for attendance registration, taking into consideration the challenges encountered by HSWs, particularly female employees. • Policy priorities might need to be reconsidered by reviewing the regulation related to the commitment to working hours and HSWs' domestic responsibilities. • It might be possible for the MoH to establish roles that enable female HSWs to cope with their responsibilities as wives and mothers outside their workplaces as well as being employees.
Inter-professional Teamwork and Peer Interaction	<ul style="list-style-type: none"> • Strong evidence of limited interaction between HSWs and other professionals (e.g. physicians) within the hospitals' context. • Strong relationships with colleagues and other professional in HSWs' workplaces seem to effectively help in creating positive environment within health care organisation. 	<ul style="list-style-type: none"> • Key policy change is suggested, to be stated in the agenda of the MoH, to advocate for enhancing teamwork between HSWs and physicians as essential component for effective practice in the Saudi hospitals. • Regular meetings involving HSWs from different backgrounds with fieldwork experience might be helpful in order to offer opportunities to exchange ideas that contribute to minimising the potential compaction that occurs in the health care organisations. • Such meeting may also take place between HSWs and professionals from other domains (e.g. psychologists and psychiatrists), who can offer advice that might assist in managing stress at health care workplaces.
Academic Preparation	<ul style="list-style-type: none"> • There is contradiction between theoretical preparation (philosophy) and fieldwork requirements. • The lack of comprehensiveness of training courses provided to HSWs. 	<ul style="list-style-type: none"> • There is an urgent need to establish partnership between SWDs in Saudi Universities, and fieldwork to address the actual demand of social work practice within the Saudi hospitals. • Continued efforts are required to ensure training sessions are effective and updated with the needs of fieldwork. • Great attention should be given to offering training sessions that can develop HSWs' skills to cope with stress caused by their workplaces.

Table 29: Working Framework for Health Social Work Practice in Public Hospitals in Saudi Arabia

Emerging issue	Contributing Factor	Recommendation
Resources	<ul style="list-style-type: none"> • SWDs in Saudi hospitals are not sufficiently funded. • There is a lack of staff, as well as equipment, devices and physical spaces in SWDs within Saudi hospitals. 	<ul style="list-style-type: none"> • There is an urgent need to secure sufficient funds annually to be under the full control of SWDs, in order to cover those expenses or requirements that might help to improve the services and the profession itself. • Ensuring appropriate facilities should be a priority for the MoH to ensure HSWs have greater access to essential equipment, devices, and the spaces that enable them to serve the clients efficiently. • More HSWs need to be hired in SWDs in Saudi Arabia to improve the efficiency of social work practice.
Motivations	<ul style="list-style-type: none"> • Limited perceived appreciation, motivations at HSWs' workplaces • HSWs are not eligible to receive any financial allowance. 	<ul style="list-style-type: none"> • Leaders at both ministerial and central levels should reconsider the motivations provided for HSWs in their workplaces including emotional and administrative supports, as well as treat financial reward. • The MoH might need to reconsider benefit and allowance regulations, and treat HSWs fairly and equally to other health professionals (i.e. physicians).
Career Advancement	<ul style="list-style-type: none"> • Limitations have been stated by females in relation to the availability of training courses, that are obligated to accomplish. 	<ul style="list-style-type: none"> • It would be beneficial if the DSW were to work in collaboration with the SCfHS to facilitate access to development opportunities for females, perhaps by setting out alternative criteria for the promotion of female HSWs wishing to fill senior roles.
Autonomy and Bureaucracy	<ul style="list-style-type: none"> • Limited autonomy is given to HSWs and managers of SWDs. 	<ul style="list-style-type: none"> • The MoH could consider greater flexibility and authority for SWDs' managers, and practitioners, because the current system tends to be ineffective at empowering leaders and practitioners to participate in decision making.
Gender Inequality	<ul style="list-style-type: none"> • There is clear evidence to demonstrate the inequality between male and female HSWs in different aspects within Saudi hospitals (e.g. evaluation criteria). 	<ul style="list-style-type: none"> • It would be helpful if the SWD considered more accurate evaluation criteria based on HSWs' performance to ensure equality between genders in the workplace.
The Nature of Social Workers' Tasks	<ul style="list-style-type: none"> • The role of HSWs requires regular involvement in the social side of patients' lives. This may have emotional dimensions, which might then affect HSWs emotionally. 	<ul style="list-style-type: none"> • Extensive support is to be provided to HSWs in their workplaces, to enable them to release all the negative feeling caused by the nature of their roles.

Research Recommendations

Although the current study is based on small sample of participants, who work in public sectors hospitals, the findings suggest identified many influential factors that appear to negatively affect HSWs in their workplaces in public hospitals within the Western province of SA. These included those associated with stressors present both within Saudi society and internally in HSWs' workplaces. Several coping strategies were also identified, both outside and within HSWs' workplaces, which assist HSWs in overcoming job related stress. Based on the findings obtained, there seems to be an urgent need to put forward recommendations that might contribute to improvements to the social and practical conditions surrounding HSWs, in order to minimise the probability of job stress occurrence, which could impact on HSWs, as well as the work they conduct in Saudi hospitals. Thus, bearing in mind that the situation might be differ in other health care workplaces (i.e. private sectors, hospitals in rural areas, and health care canters), the following recommendations for future practice are advised:

1. There is clear evidence demonstrating the inequality between male and female HSWs, and the dominance of men in different aspects within Saudi workplaces. Therefore, it must be a policy priority to reconsider female HSWs' status by reviewing regulations such as working hours and evaluation criteria. For example, it should be possible for the MoH to establish roles that enable female HSWs to manage with their responsibilities as wives and mothers outside the workplace as well as employees, especially considering the complex position of women within the Saudi context.
2. In terms of evaluating female HSWs' performance, it seems unreasonable that females are assessed by male administrators, as the latter do not have any direct interactions with female practitioners, especially in light of gender segregation, as their evaluations may not be accurate. It can therefore be assumed that it would be helpful for the DSW to consider more accurate evaluation criteria based on HSWs' performance, rather than other considerations, as a way to ensure equality between genders in the workplace.
3. It is advisable that the MoH reconsiders a more flexible scheme for registering attendance (i.e. a strategy other than biometric scan), taking into consideration the challenges that arise as a result of the restrictions female employees encounter in their daily lives, because some women cannot fulfil the current attendance policy, due to government restrictions.

4. The current study suggests the MoH could consider greater flexibility and authority for SWDs' managers and HSWs, especially in this context, because the current system tends to be ineffective at empowering social workers to make decision.
5. It would be more effective if individuals with sufficient experience and relevant qualifications were selected to manage SWDs at ministerial level, so that they would have an understanding of the actual demands of fieldwork.
6. The results of this study also indicate limitations on perceived motivation in HSWs' workplaces, as HSWs are not eligible to receive a financial allowance. Thus, the MoH might need to reconsider benefits and allowance regulations and treat HSWs fairly and in a manner that is equal to other health professionals (i.e. physicians).
7. Since HSWs are supposed to handle the social side of patients' lives, they are expected to experience the emotional and stressful side effects of their jobs. However, it would be advisable if the Saudi Health Social Work Association (SHSWA) could organise Regular meetings involving HSWs from different backgrounds with fieldwork experience, as this might be helpful in order to offer opportunities to exchange ideas that contribute to minimising the potential compaction that occurs in health care organisations. In doing so, it is more likely that HSWs could release negative attitudes resulting from their jobs.
8. Adequate academic preparation, as well as skills improvement are considered practically important for HSWs, so as to maintain a high-quality of social service provision in Saudi hospitals. Therefore, several improvements in future practice are needed, including collaboration between SWDs in Saudi Universities, as well as fieldwork to identify the existing limitations in the curriculum that cause contradictions between theoretical preparation and fieldwork requirements. Moreover, providing training sessions concerning the possible challenges known to face HSWs in their workplaces will enhance their abilities to deal with such difficulties and reduce the potential risks of work-related stress.
9. On-going efforts are required to make training sessions more accessible, particularly for female HSWs, because the availability of training courses is clearly limited in the context of the conservative Saudi community, as this does not enable women to travel easily to accomplish training requirements. Therefore, it may be of particular benefit

if the MSHGD work in collaboration with the SCfHS to facilitate females to access development opportunities, perhaps by setting out alternative criteria for the promotion of female HSWs wishing to seek promotion.

10. Low level recognition of the position of social work profession and social workers' roles appears to characterise the majority of Saudi individuals, professionals and officials' points of view. Therefore, greater efforts are required to increase Saudi society's understanding of the importance of the social work profession, and HSWs' roles in the health field, including citizens, public organisations, professional groups, and patients and their families. This can be achieved by conducting regular campaigns among different local communities (i.e. workshops, seminars and brochures) to explain SWDs' provision within Saudi hospitals, as well as how to access the services provided if needed.
11. At this point, it is important to refer to the role that the social media could play in familiarising individuals with the social work profession, and its contribution to providing holistic treatment plans that are equally concerned with the physical and social sides of patients' lives. Similarly, it is hoped that the same level of commitment will be given by HSWs to enable them and fight for their profession, especially in the healthcare field. This is because social work practitioners deliver their services in collaboration with other professionals (i.e. doctors and nurses) who are primary service providers within hospitals, while HSWs' roles are secondary. Therefore, extra efforts by HSWs to present themselves within work teams are encouraged. Furthermore, it is believed that developing a formal policy that recommends cooperative work within Saudi hospitals between health practitioners and SWDs could make HSWs' roles more visible. This could be achieved by engaging with activities such as referral strategies. This, in turn, could also build and strengthen social relationships between practitioners from different areas, which are considered a strategy that minimises work-related stress among employees.
12. This study has highlighted the ambiguity of HSWs' tasks in their workplaces, as the majority seem to perform additional tasks that are not directly linked to the social work specialty. As such, a key policy priority should be to review the current job description of HSWs so that it is more consistent with their academic qualifications; and to give them the opportunity to focus on their therapeutic practice rather than on conducting

additional administrative tasks that would expose them to workload, and prevent them from performing their actual roles.

13. One of the more significant issues to emerge from this study is that the SWDs in Saudi hospitals are not sufficiently funded. Notably, there is a lack of HSWs in the field, as well as a low availability of physical spaces and equipment (e.g. offices, computers and communication devices). Consequently, there is an urgent need to secure sufficient annual funding under the full control of SWDs, in order to cover expenses or needs that might assist in improving services and the profession itself.
14. The findings of this study have a number of important implications for future practice.

Contribution to Knowledge

This work contributes to existing knowledge regarding the social work profession, providing strong evidence regarding the key factors that contribute to the experience of job stress among HSWs, as well as the suggested mechanisms to deal with it, specifically in the Saudi context. The study is the first to be undertaken in SA to identify factors causing stress for HSWs in Saudi public hospitals within the Western province (Makkah and Jeddah cities), as well as strategies that could be used to address undesirable experiences. Based on the diversity of the in-depth information obtained, the findings are contributing to the existing body of literature from different perspectives, especially in relation to the role of social work practitioners who play a major role in providing an effective health care system to both the public and private sectors.

Theoretically, this research has assisted in developing a framework for health social work practice in public hospitals in Saudi Arabia to understand one of the most negative practical issues potentially facing workers in their workplaces, by considering different sources that influence HSWs either outside or within their workplaces. The challenges perceived by HSWs in relation to the positionality of social work within Saudi conservative society, have contributed to conceptualising understanding of work-related stress. This is essential to improve the current position of HSWs and the social work profession, since it should prove to be particularly valuable to officials in the health care sector in SA, and even other areas in a similar context. In addition, the proposed framework also provided recommendations to

enhance the environments of Saudi hospitals, as well as increasing public (Saudi citizens') awareness of the importance of HSWs' roles in the medical field.

In terms of the research design and objectives, while the concept of work-related stress has been investigated previously in various studies, the methodology used in this study is being attempted for the first time. The approach implemented in this study proved useful in expanding our understanding, not only of what the factors are that contribute to work-related stress among HSWs and how they cope with it, but also in terms of the influence of HSWs' demographical background and how they manage the experience of occupational stress. Employing both a qualitative and quantitative method with an interpretive approach has enabled this study to acquire in-depth information to construct the meaning of work-related stress in HSWs' workplaces. Moreover, this study was considered the first in terms of its use of the selected validated scale; namely the ENSS. This may raise concerns from other scholars who are interested in health social work practice, as a way to consider the implementation of the mentioned scale as a possible tool to investigate the experience of stress among HSWs. Finally, the theoretical sampling technique that was applied comprehensively ensures the involvement of a wide range of experiences, and has gone some way towards enhancing our understanding of how individuals' experiences can participate socially in constructing knowledge.

Implications for Further Research

This study not only highlighted those factors that contribute to the occurrence of work-related stress among HSWs, but also identified the strategies HSWs use to navigate undesirable experiences. However, there is a definite need for further empirical research to be undertaken in this area. This is because this research topic appears to be underexplored, and there is a growing interest in HSWs and the challenges they might face in practice. Consequently, further studies similar to this one should ideally be conducted in the following areas:

1. What is now needed is a cross-national study involving all provinces of SA, as it could provide a more comprehensive picture of the issues linked to work-related stress in different geographical areas, and may bring additional cultural complications, because of the variation in socioeconomic statuses among Saudi citizens, including HSWs. Thus, the size of the sample is anticipated to be more representative.

2. This research has mainly focused on the perspectives of HSWs. However, it would be interesting to include administrators, decision-makers, other professional groups, and patients and their families in another study, as a way to gain in depth understanding of the experiences of job stress, as perceived by individuals surrounding HSWs in their workplaces.
3. Ethnographic research could also be valuable as a means to closely observe HSWs in their workplaces, as well as any challenges they encountered, and their method of dealing with them.
4. These findings provide insight into future research, as additional studies need to be carried out using feminist approaches to empower female HSWs in the field, and considering the notable influence of the conservative nature of Saudi society, which tends to give relatively less attention to women's issues.
5. Another possible area of future research concerns the effectiveness of coping strategies linked to substance use in minimising work- related stress among HSWs, and as such would be worthwhile.
6. A future study comparing contributors to job stress in HSWs' workplaces, contrasting private and state hospitals would be beneficial to identify the differences between both sectors.
7. Bearing in mind the complications associated with achieving cultural changes with conservative Saudi society, and concerning both the place of women and Saudi attitudes towards social workers, it might be useful to suggest additional research implementing Normalisation Process Theory (NPT), to guide researchers to accomplish change.
8. Although this study suggested the influence of gender and length of fieldwork experience on work- related stress experience, the findings may well have a bearing on other demographic characteristic (e.g. age and fieldwork domain) as factors that may moderate occupational stress experience in HSWs.

Research Limitations

Although this study has provided very interesting findings in relation to influential work-related stress factors, and the suggested strategies for dealing with job stress in HSWs' workplaces, like all research it was subject to a number of limitations which indicate a need for caution when evaluating the claims of the empirical findings.

1. The first limitation relates to generalisation of the obtained findings, based on the research approach and sampling technique. That is, the findings only represent the situation of HSWs working in (Makkah and Jeddah cities) in Western provinces in SA. Even though Saudi society is characterised by a very conservative culture, such conservatism varies according to the geographical region in which individuals live. This means the results of this research might not adequately reflect the experiences of HSWs in areas other than the Western province of SA.
2. A further limitation concerns the conservative nature of the Saudi community. The majority of individuals adopt an approach to physical separation between genders in most aspects of their lives. However, such an arrangement could affect interactions between males and females. From this perspective, being a female researcher conducting a study requiring in-depth involvement with male participants' experiences proved quite challenging. Although detailed experiences were drawn from all the participants in the current study, it is possible that the male participants would have been more open and comfortable about contributing if a male researcher had carried out the work. Therefore, it could be the case that some information was not uncovered as a result.
3. The scope of this study was limited in terms of focusing solely on the perceptions of HWSs working in the public sector and in urban hospitals, while overlooking others located on rural areas, as well as the private sector.
4. This study was limited by the absence of participants other than HSWs (e.g., physician teams, psychological professionals, patients, and officials in the the), whose perspectives are thus not represented, as it was felt that including their voices would require effort and time extending beyond the scope of a PhD thesis. Most importantly, since this study is exploratory in nature, it does not include observations

of HSWs within their workplaces. However, due to the fact that exploratory studies are rare, the current research is valuable and significant as it is.

Final Remarks

Saudi society is currently undergoing dramatic political and cultural changes. Even though this transformation appears to be desired by most Saudi individuals, it also brings about multiple challenges, especially regarding social concerns. At present, a holistic policy has been embraced fostering fundamental changes in Saudi society. Within this process, the notion of improving many governmental sectors to facilitate better and efficient delivery of services, including within the health system, has been listed as a key objective. From this perspective, there seems to be an essential need to develop the social assistant programmes provided by SWDs within Saudi hospitals, in order to navigate the social complications that accompany physical problems.

However, while HSWs' roles are believed to be important in relation to the medical teams at Saudi hospitals, the current study has also identified a considerable number of factors that contribute to work-related stress among HSWs in public hospitals in the Western province of SA. Most of the factors that emerged are associated with low level of recognition of the significance of social work profession, in addition to other cultural views that influence HSWs, both within and outside their workplaces, whether directly or indirectly. The findings show that, although most HSWs tend to find different strategies to minimise job stress, reconsideration of existing policies and regulations by officials and policy-makers remains essential, in order to reduce the occurrence of job stress. The framework developed in this study is expected to contribute to the improvement of HSWs' status, in addition to that of the social work profession in general within the Saudi community, because empirical research is believed to be part of a society's desire to improve, as it focuses on inhabitants' requirements.

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494.

Appendix 1: Summary of Literature Review

Researchers	Date	Area	Sample	Methods and aims	Limitations
Lloyd et al	2002	Mental health		Systematic review	-The study only focused on the experience of work- related stress in mental health. -No field work for data collection
Lloyd et al	2004	Australian public mental health organisation	196 Occupational therapists and 108 clinical social workers	Cross-sectional survey	-The study focused on the area of mental health and ignored stressors that might be exist in other domains within hospitals context. - Relied on one objective method for data collection.
Lloyd et al	2005	Australian public mental health organisation	196 Occupational therapists and 108 clinical social workers	Cross-sectional survey	
Acker and Lawrence	2009	Mental health organisations	140 Social workers in USA	Questionnaire to detect the association between HSWs' self-competence and organisational stress	- The study focused on the area of mental health and ignored stressors that might be exist in other domains within hospitals context. -Issues related to the sample seems to limit generalizability of the findings.
Ting et al	2011	Mental health (with suicidal clients)	245 Social workers in USA	Large- scale survey relied on perceived stress scale to explore the impact of working with suicidal clients on HSWs' psychological and emotional wellbeing and career, taking into account time since incident took place	-The study focuses only on suicidal incident as a source of stress for HSWs. -The exploratory nature of this study and its limitations when interpreting the results.

Researchers	Date	Area	Sample	Methods and aims	Limitations
Badger et al	2008	Secondary Traumatic Stress (STS)	121 HSWs in one of five trauma centres located in the Midwest in USA	Descriptive, cross-sectional survey to explore the predictive contributions of empathy, emotional separation (Maintenance of Emotional Separation Scale), occupational stress (Work-Related Strain Inventory), and social support (Multidimensional Scale of Perceived Social Support), for producing STS in HSWs	<ul style="list-style-type: none"> - The study examined the experience of work-related stress caused only by empathy with patients and their problems. -Issues related to the sample seems to limit generalizability of the findings.
Quinn et al	2019	Secondary Traumatic Stress (STS)	Clinical social workers in the Southeast United State. Out of possible 2383 Licensed Master Social Workers (LMSWs) only 107 were eligible to complete the survey.	Cross-sectional study design consisting of a state-wide, mail based survey to investigate the impact upon STS of risk and protective factors relevant to the experiences of social workers, such as the clinical supervisory relationship, work type, client trauma type, and caseload size	<ul style="list-style-type: none"> -The study only focused on the (STS). -The study attempted to obtain a best subset of predictor variables from a relatively limited number of candidate variables. Whereas, factors which are important to understanding STS may have been overlooked in the survey. -The rate responses (107 HSWs out of 2383) could be unrepresentative.

Researchers	Date	Area	Sample	Methods and aims	Limitations
Yi et al	2018	Oncology	Interviews with Korean medical social workers working in oncology departments	To illuminate the issue of compassion fatigue as a STS disorder among HSWs and how watching cancer patients suffer impacts HSWs emotionally	-The sample is not representative. - The study ignored other organisational challenges (e.g. inadequate support system or heavy workload) which could be another key factor for the psychological well-being of social workers.
Huxley et al	2005	Mental health	Data was collected from 237 mental health social workers in south London, UK	Survey informed by two focus groups involving MHSWs from a South London mental health trust in order to capture the range of different issues for each. The questionnaire includes demographics and satisfaction and some standardized questionnaires including the General Health Questionnaire (GHQ). Each section of the questionnaire permitted open-ended responses. The study aims to investigate the experience of stress and pressures in mental health social work	-Despite the informative data obtained using well-structured questionnaires, the study does not reflect the case of HSWs in health care domains other than mental health services.

Researchers	Date	Area	Sample	Methods and aims	Limitations
Coyle et al	2005	Mental health	19 studies conducted in the UK and USA and the rest of Europe	Based on the stress model developed by Carson and Kuipers (1998), structured systematic review used to establish levels of stress, burnout, coping and more importantly, the factors that ameliorate stress in the workplace for HSWs to reduce stress and enhance coping in mental health workers.	-The study only focused on the experience of work-related stress in mental health. -No field work for data collection
Willems	2014	Mental health	Random sampling of licensed clinical social workers, nurse practitioners, psychologists, psychiatrists, doctors, speech therapists, occupational therapists, physical therapist and Chaplin at a hospital in Minnesota, USA	A cross-sectional research design, to determine the amount of stress using a Perceived Stress Scale (PSS). The study aim to compare stress among professionals in a mental health care setting hypothesising that: 'mental health care social workers experience higher levels of stress in comparison to other mental health care	-The sample is not representative. - The study only focused on the experience of work-related stress in mental health.

Researchers	Date	Area	Sample	Methods and aims	Limitations
Gellis	2001	Health care setting	187 social workers employed in academic health centres (AHC's) and general community hospitals	Job stress survey to examine differences in the perception of job stress and job satisfaction	-Issues related to the sample seems to limit generalizability of the findings. -The study would benefit from integrating qualitative approaches that help to gain in-depth understanding about the experience of work-related stress from HSWs perspectives.
Barcy	2006	Case management	45 HSWs and nurses in USA	Self-reported survey based on Computer Anxiety Rating Scale to explore the association between computer self-efficiency and computer anxiety.	-The sample is not representative. -The study does not reflect the case of other sectors within hospitals setting in relation to other stressors.
Fantus et al	2017	Moral Stress	The study relied purely on library based data and did not involve any fieldwork	investigate those sources that might contribute to conscience pressure among the HSWs by adapting conceptualisation of moral distress from the nursing field across '(i) clinical situations; (ii) working conditions and limited resources; (iii) structural conditions; and (iv) moral sources' to elucidate the concept of moral distress in HSWs and how this transpires in the field of hospital social work	- No fieldwork for data collection.

Researchers	Date	Area	Sample	Methods and aims	Limitations
Ostadhashemi et al	2019	Paediatric Oncology	19 social workers with not less than five years' work experience in paediatric oncology	Qualitative inductive approach using the 5-stage content analysis method as recommended by (Grancheim and Lundmen, 2004) to determine a comprehensive understanding of paediatric oncology social workers' experiences in Iran	-The number of participants was limited.
Yi et al	2018	Pediatric Oncology	27 pediatric oncology social workers	Five focus group interviews, to understand the experience of compassion fatigue among 27 paediatric oncology social workers.	-The number of the participants was limited.
Dima et al	2021	Different areas of intervention including health domain	83 social workers employed in statutory and private social services in Romania, from different areas of intervention	Survey included questions for collecting both qualitative and quantitative data, to explore the changes posed by the new COVID-19 pandemic to the field of social work and its impact on social workers in terms of job stress and burnout in Romania using the theoretical framework of VUCA (Volatility, Uncertainty, Complexity and Ambiguity).	-Although the study has provided significant results regarding the area of job stress, it is limited in terms of not focusing only on health care context. - The sample was relatively small -There were a disproportionate number of social workers in the public compared to the private sector, which does not allow for a more detailed comparison between the two groups of professionals and systems

Researchers	Date	Area	Sample	Methods and aims	Limitations
Seng et al	2021	Various social service sectors across Singapore including health domain	308 Frontline social workers	Self-designed questionnaire comprising 10 items measured “personal” and “work- related” support at the organization, to examine the level of psychological distress among the frontline social workers during the COVID- 19 pandemic and whether resilience and organisational support played a part in mitigating their psychological distress.	<ul style="list-style-type: none"> - The results are not generalizable to the social work population across the whole of Singapore, since the study used convenience sampling. - The study was not able to determine if there was an increase in the distress level following the pandemic or if it was a distressed population to begin with.
Ashcroft et al	2021	A broad range of institutional settings including health care domain	2,470 social workers who are members of Ontario Association of Social Workers (OASW)	Exploratory study using a cross-sectional, online survey disseminated through Survey Monkey, to understand the experiences of social workers during the first-wave of the COVID-19 pandemic.	-Issues related to the sample may affect the generalisability of the data.
Al- Mansour et al	2021	Health care professionals including social workers	1378 HCWs working in primary health centers (regular and fever clinics; clinics specialized in managing patients with COVID-19 symptoms) across Saudi Arabia.	Online questionnaire was applied to collect data on role conflict and ambiguity, self-esteem and social support, to identify certain occupational risk factors for stress among healthcare workers (HCWs) during the COVID-19 pandemic.	-Due to the strict measures of social distancing, we had to access participants via e-mails; therefore, the possibility of non-response bias cannot be excluded since the sociodemographic and occupational characteristics of responders might have differed from non-responders.

Researchers	Date	Area	Sample	Methods and aims	Limitations
Aughterson et al	2021	Health and social care professionals from across the UK including social workers	25 participants from a range of frontline professions in health and social care	Qualitative study deploying in-depth, Individual interviews through phone or video call, which were audio-recorded and transcribed and thematic analysis was used for coding. To explore the psychosocial well-being of health and social care professionals working during the COVID-19 pandemic.	-The study included wide range of professions, which might limit the specificity of findings. -Issues linked to sampling may affect the generalisability of the findings.

Appendix 2: The Interview Schedule

Introduction

I'll briefly explain the focus of my study, going back over the letter they received from the first phase (participants information sheet). Thanks so much for letting me talk to you today. The focus of this interview is to explore factors related to workplace stress for Health Social Workers (HSWs) experience in their work; in addition to strategies they use to cope with such stress.

a) Stress factors focused questions

(Now I'd like to turn to talk about the factors that can cause work-related stress for you)

1. How do you feel about your workplace environment?
 - *What do you like about your job/ like less?*
 - *Are there any areas of difficulties in your workplace that can lead to job stress for you?*
2. Do you think the roles that allocated to you are the same roles that you supposed to do as a HSW?
 - *How does it contribute in creating job stress for you?*
3. When you work with your patients, do you feel stress?
 - *How satisfied do you think are your patients with your intervention? Why do you think this?*
 - *Do patients and their families' perception toward your roles cause stress for you? Why do you think they have these perceptions? What are the reasons?*
4. How do Saudi community attitudes toward HSWs and HSWs' roles contribute in creating the feeling of stress for you?
 - *How do other professional groups see you in your job? Why do you think they have these attitudes towards you/the HSW role? What do you think the reasons might be?*
 - *How does your family's and friends' perception affect your feeling? Why do you think they have these perception/attitudes towards you/the HSW role? What do you think the reasons might be?*
5. It is unusual to work in mixed place in the conservative Saudi community, does that lead to stress?
 - *What are the reasons for your answer?*
 - *How do you try to deal with such stresses?*

6. Do you have personal circumstances that affect you in your job?
 - *Do you have any responsibilities other than your job?*
 - *In what ways do they affect you/your work?*
7. If you could change one thing that would reduce your stress, what would that be?
8. Are there any other changes you would like to see in your work/relationship with colleagues/support from your agency/personal circumstances to help reduce your stress?

C) Coping mechanism focused questions

(Now I'd like to turn to talk about the strategies you use to cope with work stress)

1. Can you tell me what strategies do you use to cope with job stress?
 - *Do you have any kind of skills to use when you experience job stress?*
2. Could you please describe a difficult situation at work and how you overcame it?
3. Whom does your support system consist of?
 - *Your manager's and colleagues role in reducing stress?*
 - *Your colleagues at work*
 - *Your friends*
 - *Your family*
4. Have you ever sought help from professionals or engaged on stress relief organisations?
 - *Professionals (Psychologist, psychiatrists)?*
 - *The Administration of Mental Health and Social Affairs provide any support for HSWs if needed?*
5. Could you share with me what are the factors that can contribute in reducing the feeling of stress caused by your job?
 - *E.g. Experience*
 - *Job type*
6. Is there anything in your organisation you believe could contribute in reducing stress for HSWs and employee?
7. From your experience, what recommendation would you give to HSWs to help them reduce job stress?

8. From your experience, what recommendation would you give to your employing organisation to help them reduce job stress?

Additional comments:

- Is there anything further you would like to add or discuss?
- Are there any other comments regarding this subject that you may want to add? Please elaborate.

Thank you very much.

I'll obviously be very careful not to write up any of this in a manner by which you can be identified. However, is there anything you've just told me which I should be particularly careful about? Anything I should check with you first before I use it?

Appendix 3: The Questionnaire

Code Number ()

Stress Factors and Coping Mechanisms in Health Social Workers' Workplaces

Dear Health Social Worker,

My name is Sahar Muathen, I am a teaching assistant in the Department of Social Work in Umm Al-Qura University. I am conducting my PhD project at Hertfordshire University in the UK under the supervision of two experienced researchers in Health Social Work field titled ‘Stress Factors and Coping Mechanisms in Health Social Workers’ Workplaces: An Exploratory Study in Saudi Arabian Western Province Hospitals’, I am very interested in having your perspective and experience around these issues of being a Health Social Workers (HSWs).

This is the first ever study of this important issue in Saudi Arabia, and I hope you would be ready to contribute to it.

It would be greatly appreciated if you would complete this questionnaire and return it (in two weeks time from the date you receive it) to the manager of Social Work Department in your workplace in the attached an envelope which you will seal off before giving it to your manager. I have attempted to put to you clear questions, and it will take only about twenty to thirty minutes to complete.

Instruction for completing the questionnaire can be found on the form itself before each question. It will be OK if you feel unable to complete this questionnaire for any reason. Please note that whether you choose to complete the questionnaire or not, this will have no effect on your post and position in the hospital, or your managers’ views- they will not know who has responded, and in any case it will not be possible to identify any information coming from you, as quotes will be anonymised and rephrased.

Please be assured that all information you provide will be kept strictly confidential. You are not asked to provide any identifying information. The obtained information from your study will be written in a way in which individual will not be able to be identified.

Your contribution will greatly support this project, and our knowledge of these key issues for social work.

If you have any queries about the questionnaire, please do contact me on (s-n-4@hotmail.com) or on my mobile (0550600631).

Thank you in advance.

Sahar Muathen

Section A: Personal and Professional Information

-Gender

Male Female

-Age

Less than 25 25-30 31-35 36-40 41-45 46-50 More

-Personal Status

Single Engaged Married Divorced Other

-Academic Qualification

Bachelor Bachelor and Medical Diploma Master PhD Other

-Specialisation

Social Work Sociology Psychology Other

-Job Type

Permanent Contract Other

-Work Experience

Less than 5 years 5-10 years 11-15 years 16-20 years more than 20

-Do you have additional responsibilities outside your workplace that affect you stressfully

Yes No

**-Which department in your workplace do you work in -----
-----**

Section B: Work-related Stress Factors

Below is a list of situations that commonly occur in Health Social Workers (HSWs) workplaces. For each situation that you have encountered in your **PRESENT WORKING SETTING**, please indicate **HOW STRESSFUL** it has been for you:

(Enter the number in the right-hand column that best applies to you. If you have not encountered the situation, write '0'.)

Never happened	Never Stressful	Occasionally Stressful	Frequently Stressful	Extremely Stressful	Does Not Apply
0	1	2	3	4	5

1. Performing processes that bother patients_____
2. Criticism by a medical team _____
3. Feeling inadequately prepared to help with the emotional needs of a patient's family....._____
4. Lack of opportunity to talk openly with other personnel about problems in the work setting....._____
5. Conflict with the head of Social Work Department in my workplace..... _____
6. Inadequate information from medical team regarding the medical condition of a patient....._____
7. Patients making unreasonable demands....._____
8. Being sexually harassed....._____
9. Feeling helpless in the case of a patient who fails to improve....._____
10. Conflict with a medical team _____
11. Being asked a question by a patient for which I do not have a satisfactory answer....._____
12. Lack of opportunity to share experiences and feelings with other personnel in my work setting _____
13. Working hours and scheduling (e.g. night shift)..... _____
14. Medical team ordering what appears to be inappropriate treatment for a patient....._____
15. Patients' families making unreasonable demands....._____

Never happened	Never Stressful	Occasionally Stressful	Frequently Stressful	Extremely Stressful	Does Not Apply
0	1	2	3	4	5

16. Experiencing discrimination because of race or ethnicity.....___
17. Listening or talking to a patient about his/her approaching death.....___
18. Fear of making a mistake in treating a patient.....___
19. Feeling inadequately prepared to help with the emotional needs of a patient.....___
20. Lack of opportunity to express to other personnel on the work sitting my negative feelings towards patients.....___
21. Difficulty in working with a particular health social worker (or HSWs) in my immediate setting.....___
22. Difficulty in working with a particular health social worker (or HSWs) outside my immediate setting.....___
23. Not enough time to provide emotional support to the patient.....___
24. A physician not being present in a medical emergency.....___
25. Being blamed for anything that goes wrong.....___
26. Experiencing gender discrimination.....___
27. The death of a patient.....___
28. Disagreement concerning the treatment of a patient.....___
29. Feeling inadequately trained for what I have to do.....___
30. Lack of support of head of social work department in my workplaces.....___
31. Criticism by the head of social work department in my workplaces.....___
32. Not enough time to complete all of my tasks.....___
33. Not knowing what a patient or a patient's family should be told about the patient's condition and its treatment.....___
34. Being the one that has to deal with the patients' families___

Never happened	Never Stressful	Occasionally Stressful	Frequently Stressful	Extremely Stressful	Does Not Apply
0	1	2	3	4	5

- 35. Having to deal with violent patients.....__
- 36. Being exposed to health and safety hazards.....__
- 37. The death of a patient with whom you developed a close relationship.....__
- 38. Making a decision concerning a patient when medical team is unavailable.....__
- 39. Being in charge with inadequate experience.....__
- 40. Lack of support by social work administration.....__
- 41. Too many non-HSWs' tasks required, such as clerical work__
- 42. Not enough staff to adequately cover social work department's tasks.....__
- 43. Lack of resources and equipment that facilitate HSWs to perform their tasks with patients.....__
- 44. Having to deal with abusive patients.....__
- 45. Not enough time to respond to the needs of patients' families.....__
- 46. Being held accountable for things over which I have no control.....__
- 47. Physician(s) not being present when a patient dies.....__
- 48. Having to organise physicians' work.....__
- 49. Lack of support from other healthcare administrators.....__
- 50. Difficulty in working with HSWs of the opposite gender.....__
- 51. Promotion and evaluation system for HSWs__
- 52. Having to deal with abuse from patients' families.....__
- 53. Watching a patient suffer.....__

Never happened	Never Stressful	Occasionally Stressful	Frequently Stressful	Extremely Stressful	Does Not Apply
0	1	2	3	4	5

54. Criticism from social work administration.....__
55. Having to work through breaks.....__
56. Not knowing whether patients and their families will report you for inadequate care.....__
57. Having to make decisions under pressure.....__

Section C: Coping Strategies

Below is a list of coping strategies that commonly used to deal with stressful situations. For each strategy that you have employed, please indicate **how frequent you have been doing it:**

(Enter the number in the right-hand column that best applies to you).

I haven't been doing this at all	I've been doing this a little bit	I've been doing this a medium amount	I've been doing this a lot
1	2	3	4

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

I haven't been doing this at all	I've been doing this a little bit	I've been doing this a medium amount	I've been doing this a lot
1	2	3	4

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

الإستبارة ()

عوامل الإجهاد الوظيفي وإستراتيجيات التعامل معه في أماكن عمل الأخصائيين
الإجتماعيين و الأخصائيات الإجتماعيات في المجال الطبي



القسم الأول: المعلومات الشخصية والمهنية

							الجنس:
							ذكر
							<input type="radio"/>
							أنثى
							<input type="radio"/>
							العمر:
أقل من 25	30-25	35-31	40-36	45-41	50-46	أكثر من 50	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
							الحالة الشخصية:
							أعزب
							<input type="radio"/>
							مخطوب
							<input type="radio"/>
							متزوج
							<input type="radio"/>
							مطلق
							<input type="radio"/>
							أخرى
							<input type="radio"/>
							المؤهل العلمي:
							بكالوريوس
							<input type="radio"/>
							بكالوريوس ودبلوم طبي
							<input type="radio"/>
							ماجستير
							<input type="radio"/>
							دكتوراه
							<input type="radio"/>
							أخرى
							<input type="radio"/>
							التخصص:
							خدمة إجتماعية
							<input type="radio"/>
							علم الاجتماع
							<input type="radio"/>
							علم نفس
							<input type="radio"/>
							أخرى
							<input type="radio"/>
							نوع الوظيفة:
							حكومية
							<input type="radio"/>
							متعاقد
							<input type="radio"/>
							أخرى
							<input type="radio"/>
							الخبرة العملية:
							أقل من 5 سنوات
							<input type="radio"/>
							5-10 س
							<input type="radio"/>
							11-15 س
							<input type="radio"/>
							16-20 س
							<input type="radio"/>
							أكثر من 20 س
							<input type="radio"/>

- هل لديك مسؤوليات إضافية خارج مكان عملك والتي تؤثر عليك بالتوتر والإجهاد؟

لا

نعم

- في أي قسم في من أقسام المستشفى تعمل



قسم الثاني: عوامل الإجهاد المرتبطة بالعمل

فيما يلي قائمة بالمواقف التي تحدث عادةً في أماكن العمل الخاصة بالأخصائيين الاجتماعيين والأخصائيات الاجتماعيات في المجال الصحي. لكل موقف واجهته خلال عملك ، ارجو الإشارة إلى مدى مساهمة الموقف في أحداث الإجهاد الوظيفي لديك:

(أدخل الرقم الذي ينطبق عليك بشكل أفضل في العمود الأيسر بجانب كل عبارة. إذا لم تكن قد واجهت الموقف ، فاكتب "0")

لم يحدث على الإطلاق	غير مجهد على الإطلاق	مجهد أحياناً	مجهد في كثير من الأحيان	مجهد جداً	غير منطبق
0	1	2	3	4	5

1. تنفيذ العمليات والإجراءات التي تزعج المرضى
2. النقد من قبل الفريق الطبي
3. الشعور بعدم الاستعداد الكافي للمساعدة في الاحتياجات العاطفية لأسرة المريض
4. عدم إتاحة الفرصة للحديث بصراحة مع الموظفين الآخرين عن المشاكل في قسم الخدمة الإجتماعية
5. الصراع مع رئيس قسم الخدمة الاجتماعية في مقر عملي
6. عدم توفر المعلومات الكافية من الفريق الطبي بشأن الحالة الطبية لمريض
7. المرضى الذين يقدمون طلبات غير معقولة
8. التعرض للتحرش الجنسي
9. الشعور بالعجز في حالة المريض الذي لم تتحسن حالته
10. الصراع مع الفريق الطبي
11. عند طرح سؤال من قبل أحد المرضى لا يكون لدي إجابة كافية له
12. عدم وجود فرصة لتبادل الخبرات والآراء مع الموظفين الآخرين في إعداد العمل
13. ساعات العمل والجدولة (على سبيل المثال ، النوبة الليلية)
14. الفريق الطبي يأمر بما يبدو أنه علاج غير مناسب للمريض من وجهة نظر الأخصائي/ة الإجتماعي/ة
15. عائلات المرضى تقدم طلبات غير معقولة

لم يحدث على الإطلاق	غير مجهود على الإطلاق	مجهود أحياناً	مجهود في كثير من الأحيان	مجهود جداً	غير منطبق
0	1	2	3	4	5

16. أعاني من التمييز بسبب العرق أو العنصرية.....
17. الاستماع أو التحدث مع أحد المرضى عن قربه من الموت.....
18. الخوف من ارتكاب خطأ في إعداد الخطة العلاجية للمريض.....
19. الشعور بعدم الاستعداد الكافي للمساعدة في تلبية الاحتياجات العاطفية للمريض.....
20. عدم وجود فرصة للتعبير إلى الموظفين الآخرين في العمل عن مشاعري السلبية تجاه المرضى.....
21. صعوبة في العمل مع أخصائي/ة اجتماعي/ة معين في القسم الذي اعمل فيه.....
22. صعوبة في العمل مع أخصائي/ة اجتماعي/ة معين خارج القسم الذي اعمل فيه.....
23. عدم توفر الوقت الكافي لتقديم الدعم العاطفي للمريض.....
24. عدم تواجد الطبيب أثناء وجود حالة طبية طارئة.....
25. القاء اللوم على الأخصائي/ة الاجتماعي/ة عند حدوث خطأ.....
26. التمييز (عدم المساواة) بين الجنسين في مقر عملي.....
27. وفاة مريض
28. الخلاف بشأن الخطة العلاجية للمريض.....
29. الشعور بعدم كفاية التدريب على الأعمال التي أقوم بها.....
30. عدم وجود دعم من رئيس قسم الخدمة الإجتماعية في مقر عملي.....
31. النقد من رئيس قسم الخدمة الإجتماعية في مقر عملي.....
32. ليس هناك ما يكفي من الوقت لاستكمال جميع المهام الخاصة بي
33. عدم معرفة ما يجب إخبار المريض أو أسرة المريض به عن حالة المريض وعلاجه.....
34. كوني الشخص الذي يتعامل مع عائلات المرضى.....



م يحدث على الإطلاق	غير مجهود على الإطلاق	مجهود أحياناً	مجهود في كثير من الأحيان	مجهود جداً	غير منطبق
0	1	2	3	4	5

35. الاضطرار للتعامل مع المرضى الذين يعانون من حالات العنف.....
36. التعرض لمخاطر الصحة والسلامة في مقر عملي (كالأمراض المعدية).....
37. وفاة مريض طورت معه علاقة وثيقة.....
38. اتخاذ قرار بشأن مريض عندما يكون الفريق الطبي غير متاح.....
39. أن أكون مسئولاً في موقف ما مع عدم توفر الخبرة الكافية.....
40. عدم وجود دعم من قبل إدارة الخدمة الاجتماعية.....
41. القيام بالكثير من المهام غير المتعلقة بالأخصائي/ة الاجتماعي/ة (مثل الأعمال الكتابية).....
42. ليس هناك ما يكفي من الموظفين لتغطية مهام قسم الخدمة الاجتماعية بشكل ملائم.....
43. قلة الموارد والمعدات التي تسهل قيام الأخصائي/ة الاجتماعي/ة بأداء مهامه مع المرضى.....
44. الاضطرار للتعامل مع المرضى المسنين (العنفين).....
45. ليس هناك ما يكفي من الوقت للاستجابة لاحتياجات أسر المرضى.....
46. كوني مسؤول عن أمور ليس لدي صلاحية السيطرة عليها.....
47. عدم تواجد الفريق الطبي عندما يموت المريض.....
48. الاضطرار إلى تنظيم عمل الفريق الطبي.....
49. عدم وجود دعم من مديري الرعاية الصحية الآخرين.....
50. صعوبة في العمل مع الأخصائيين/نيات الاجتماعيين/يات من الجنس الآخر.....
51. نظام ترقية وتقييم أداء الأخصائي/ة الاجتماعي/ة.....
52. الاضطرار للتعامل مع سوء المعاملة والعنف من أسر المرضى.....
53. مشاهدة معاناة المريض.....



غير منطبق	مجهد جدا	مجهد في كثير من الأحيان	مجهد أحيانا	غير مجهد على الإطلاق	لا يحدث على الإطلاق
5	4	3	2	1	0

54. النقد من إدارة الخدمة الاجتماعية.....
55. الاضطرار إلى العمل أثناء فترات الراحة.....
56. عدم معرفة ما إذا كان المرضى وأسرهم سوف يبلغون عن عدم كفاية الرعاية المقدمة اليهم.....
57. الاضطرار إلى اتخاذ القرارات تحت الضغط.....



اسم الثالث: استراتيجيات المواجهة

يما يلي قائمة من استراتيجيات المواجهة التي تستخدم عادة للتعامل مع المواقف العصبية. لكل استراتيجية قمت بتوظيفها ، يرجى توضيح مدى تكرار القيام بذلك:

(أدخل الرقم في العمود الأيمن الذي ينطبق عليك بشكل أفضل).

لم أفعَل هذا على الإطلاق	كنت أفعل ذلك ناعرا	كنت أفعل ذلك ففقدت متوسط	كنت أفعل ذلك كثيرا
1	2	3	4

1. اعود إلى عملي أو ازاول أنشطة أخرى لأبعد ذهني عن التفكير بالموقف.....
2. أركز جهودي على القيام بشيء ما حول الموقف الذي أنا فيه.....
3. أقول لنفسي " هذا ليس حقيقياً".....
4. أقوم بتدخين (السجائر- المعسل- الشيشة) لأشعر نفسي بأنني أفضل.....
5. أحصل على دعم عاطفي من الآخرين.....
6. أياأس من محاولة التعامل مع الموقف.....
7. اتخذ إجراءات في محاولة لجعل الموقف أفضل.....
8. أرفض أن أصدق أن الموقف حدث.....
9. أقول ألفاظ وعبارات تسمح لمشاعري غير السارة بالهرب.....
10. أتلقي المساعدة والمشورة من أشخاص آخرين.....
11. الجأ إلى تدخين (السجائر- المعسل- الشيشة) لتخفيف حدة الموقف.....
12. أحاول رؤية الموقف من زاوية مختلفة ، لجعله يبدو أكثر إيجابية.....
13. أنتقد نفسي.....
14. أحاول وضع إستراتيجية حول ما يجب القيام به.....
15. احصل على الراحة والتفهم من شخص ما.....
16. أياأس من محاولة التأقلم مع ما يحدث.....



لم افعل هذا على الإطلاق	كنت افعل ذلك نادرا	كنت افعل ذلك ففقدت متوسط	كنت افعل ذلك كثيرا
1	2	3	4

17. أبحث عن ما هو جيد وإيجابي في الموقف الذي حصل.....
18. اصنع فكاهة من الموقف.....
19. أقوم بفعل أي شيء لأقلل التفكير في الموقف، مثل الذهاب إلى السينما ومشاهدة التلفاز والقراءة ، أو أحلام ليقظة، أو النوم ، أو التسوق.....
20. أقبل الحقيقة والواقع فيما حدث.....
21. أعبر عن مشاعري السلبية.....
22. أحاول أن أجد الراحة في ديني أو معتقداتي الروحية.....
23. أحاول الحصول على نصيحة أو مساعدة من أشخاص آخرين حول ما يجب فعله.....
24. أتعلم التعايش مع الموقف.....
25. أفكر بجدية حول الخطوات التي يجب اتخاذها.....
26. ألقى باللوم على نفسي في الأشياء التي حدثت.....
27. أصلي أو أتأمل في قدرة الخالق.....
28. أسخر من الموقف.....



Code Number ()

Stress Factors and Coping Mechanisms in Health Social Workers' Workplaces



Dear Health Social Worker,

My name is Sahar Muathen, I am a teaching assistant in the Department of Social Work in Umm Al-Qura University. I am conducting my PhD project at Hertfordshire University in the UK under the supervision of two experienced researchers in Health Social Work field titled 'Stress Factors and Coping Mechanisms in Health Social Workers' Workplaces: An Exploratory Study in Saudi Arabian Western Province Hospitals', I am very interested in having your perspective and experience around these issues of being a Health Social Workers (HSWs).

This is the first ever study of this important issue in Saudi Arabia, and I hope you would be ready to contribute to it.

It would be greatly appreciated if you would complete this questionnaire and return it (in a month time from the date you receive it) to the manager of Social Work Department in your workplace in the attached an envelope which you will seal off before giving it to your manager. I have attempted to put to you clear questions, and it will take only about twenty to thirty minutes to complete.

Instruction for completing the questionnaire can be found on the form itself before each question. It will be OK if you feel unable to complete this questionnaire for any reason. Please note that whether you choose to complete the questionnaire or not, this will have no effect on your post and position in the hospital, or your managers' views- they will not know who has responded, and in any case it will not be possible to identify any information coming from you, as quotes will be anonymised and rephrased.

Please be assured that all information you provide will be kept strictly confidential. You are not asked to provide any identifying information. The obtained information from your study will be written in a way in which individual will not be able to be identified.

Your contribution will greatly support this project, and our knowledge of these key issues for social work.

If you have any queries about the questionnaire, please do contact me on (s-n-4@hotmail.com) or on my mobile (0550600631).

Thank you in advance.

Sahar Muathen



Section A: Personal and Professional Information

-Gender

Male Female

-Age

Less than 25 25-30 31-35 36-40 41-45 46-50 More than 50

-Personal Status

Single Engaged Married Divorced Other

-Academic Qualification

Bachelor Bachelor and Medical Diploma Master PhD Other

-Specialisation

Social Work Sociology Psychology Other

-Job Type

Permanent Contract Other

-Work Experience

Less than 5 years 5-10 years 11-15 years 16-20 years more than 20 years

-Do you have additional responsibilities outside your workplace that affect you stressfully

Yes No

Which department in your workplace do you work in _____



Section B: Work-related Stress Factors

Below is a list of situations that commonly occur in Health Social Workers (HSWs) workplaces. For each situation that you have encountered in your **PRESENT WORKING SETTING**, please indicate **HOW STRESSFUL** it has been for you:

(Enter the number in the right-hand column that best applies to you. If you have not encountered the situation, write '0'.)

Never happened	Never Stressful	Occasionally Stressful	Frequently Stressful	Extremely Stressful	Does Not Apply
0	1	2	3	4	5

1. Performing processes that bother patients
2. Criticism by a medical team
3. Feeling inadequately prepared to help with the emotional needs of a patient's family.....
4. Lack of opportunity to talk openly with other personnel about problems in the work setting.....
5. Conflict with the head of Social Work Department in my workplace.....
6. Inadequate information from medical team regarding the medical condition of a patient.....
7. Patients making unreasonable demands.....
8. Being sexually harassed.....
9. Feeling helpless in the case of a patient who fails to improve.....
10. Conflict with a medical team
11. Being asked a question by a patient for which I do not have a satisfactory answer.....
12. Lack of opportunity to share experiences and feelings with other personnel in my work setting
13. Working hours and scheduling (e.g. night shift).....
14. Medical team ordering what appears to be inappropriate treatment for a patient.....
15. Patients' families making unreasonable demands.....



Never happened	Never Stressful	Occasionally Stressful	Frequently Stressful	Extremely Stressful	Does Not Apply
0	1	2	3	4	5

16. Experiencing discrimination because of race or ethnicity.....
17. Listening or talking to a patient about his/her approaching death.....
18. Fear of making a mistake in treating a patient.....
19. Feeling inadequately prepared to help with the emotional needs of a patient.....
20. Lack of opportunity to express to other personnel on the work sitting my negative feelings towards patients.....
21. Difficulty in working with a particular health social worker (or HSWs) in my immediate setting.....
22. Difficulty in working with a particular health social worker (or HSWs) outside my immediate setting.....
23. Not enough time to provide emotional support to the patient.....
24. A physician not being present in a medical emergency.....
25. Being blamed for anything that goes wrong.....
26. Experiencing gender discrimination.....
27. The death of a patient.....
28. Disagreement concerning the treatment of a patient.....
29. Feeling inadequately trained for what I have to do.....
30. Lack of support of head of social work department in my workplaces.....
31. Criticism by the head of social work department in my workplaces.....
32. Not enough time to complete all of my tasks.....
33. Not knowing what a patient or a patient's family should be told about the patient's condition and its treatment.....
34. Being the one that has to deal with the patients' families



Never happened	Never Stressful	Occasionally Stressful	Frequently Stressful	Extremely Stressful	Does Not Apply
0	1	2	3	4	5

35. Having to deal with violent patients.....
36. Being exposed to health and safety hazards.....
37. The death of a patient with whom you developed a close relationship.....
38. Making a decision concerning a patient when medical team is unavailable.....
39. Being in charge with inadequate experience.....
40. Lack of support by social work administration.....
41. Too many non-HSWs' tasks required, such as clerical work
42. Not enough staff to adequately cover social work department's tasks.....
43. Lack of resources and equipment that facilitate HSWs to perform their tasks with patients.....
44. Having to deal with abusive patients.....
45. Not enough time to respond to the needs of patients' families.....
46. Being held accountable for things over which I have no control.....
47. Physician(s) not being present when a patient dies.....
48. Having to organise physicians' work.....
49. Lack of support from other healthcare administrators.....
50. Difficulty in working with HSWs of the opposite gender.....
51. Promotion and evaluation system for HSWs
52. Having to deal with abuse from patients' families.....
53. Watching a patient suffer.....



Never happened	Never Stressful	Occasionally Stressful	Frequently Stressful	Extremely Stressful	Does Not Apply
0	1	2	3	4	5

54. Criticism from social work administration.....
55. Having to work through breaks.....
56. Not knowing whether patients and their families will report you for inadequate care.....
57. Having to make decisions under pressure.....



Section C: Coping Strategies

Below is a list of coping strategies that commonly used to deal with stressful situations. For each strategy that you have employed, please indicate **how frequent you have been doing it:**
(Enter the number in the right-hand column that best applies to you).

I haven't been doing this at all	I've been doing this a little bit	I've been doing this a medium amount	I've been doing this a lot
1	2	3	4

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



I haven't been doing this at all	I've been doing this a little bit	I've been doing this a medium amount	I've been doing this a lot
1	2	3	4

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



Appendix 5: The Questionnaire Piloting Results

Cronbach's Alpha

Reliability Statistics

Cronbach's Alpha	N of Items
.925	57

Split- half coefficient

Case Processing Summary

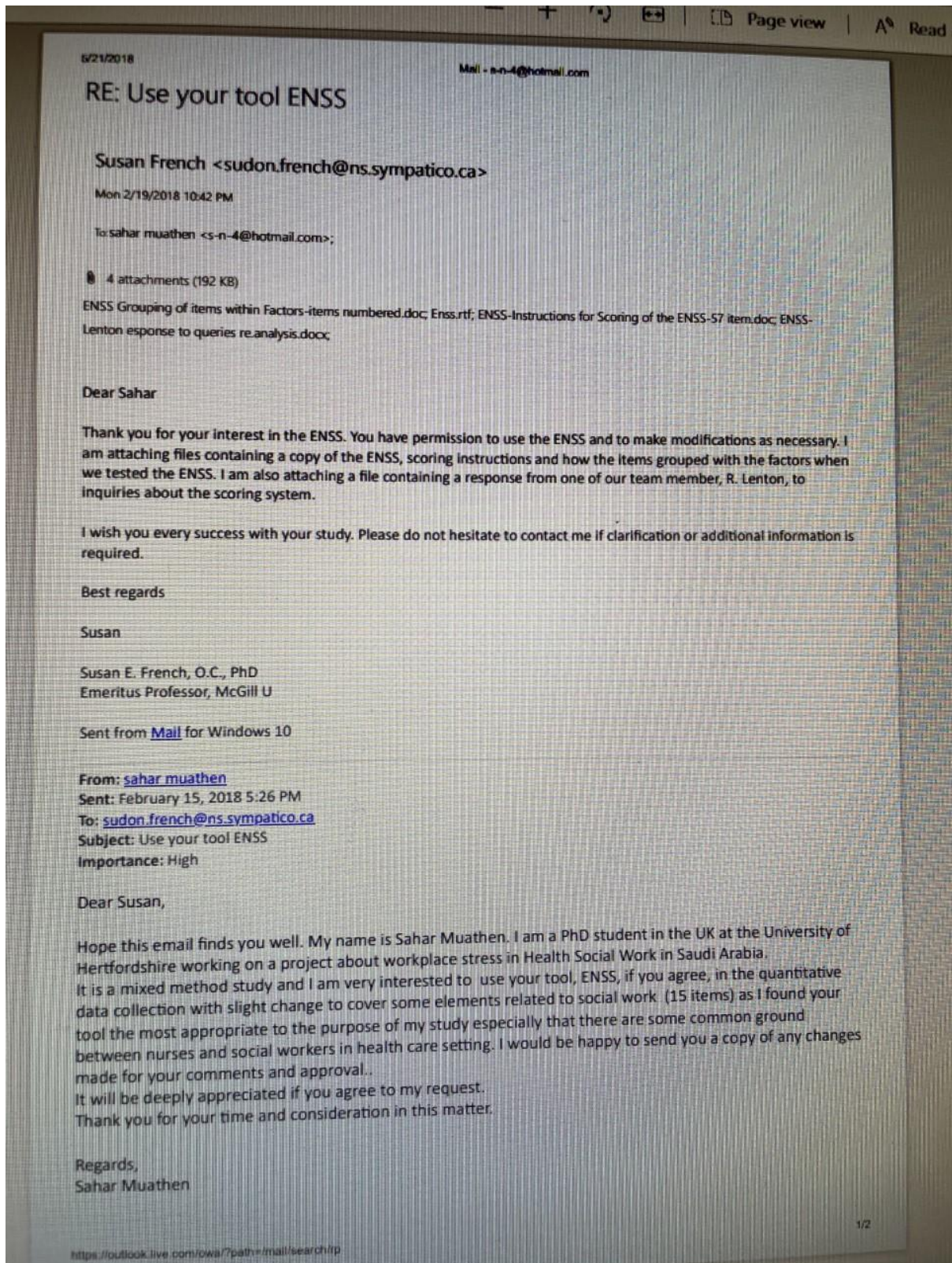
		N	%
Cases	Valid	12	100.0
	Excluded ^a	0	.0
	Total	12	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	Part 1	Value	.900
		N of Items	43 ^a
	Part 2	Value	.826
		N of Items	42 ^b
	Total N of Items		85
Correlation Between Forms			.864
Spearman-Brown Coefficient	Equal Length		.927
	Unequal Length		.927
Guttman Split-Half Coefficient			.875

Appendix 6: The Permission from the Expanded Nursing Stress Scale's Author



Appendix 7: Letter Confirming Ethical Approval for Data Collection



UNIVERSITY OF HERTFORDSHIRE
HEALTH & HUMAN SCIENCES

ETHICS APPROVAL NOTIFICATION

TO Sahar Husni Muathen
CC Brian Littlechild
Shula Ramon
FROM Dr Richard Southern, Health and Human Sciences ECDA Chairman
DATE 04/07/14

Protocol number: **HSK/PG/UH/00163**

Title of study: Stress factors for Health Social Workers and coping mechanisms applied by them in Western province, Saudi Arabia (Makkah and Jeddah cities).

Your application for ethical approval has been accepted and approved by the ECDA for your school.

This approval is valid:

From: 15/08/14

To: 18/12/14

Please note:

Approval applies specifically to the research study/methodology and timings as detailed in your Form EC1. Should you amend any aspect of your research, or wish to apply for an extension to your study, you will need your supervisor's approval and must complete and submit form EC2. In cases where the amendments to the original study are deemed to be substantial, a new Form EC1 may need to be completed prior to the study being undertaken.

Should adverse circumstances arise during this study such as physical reaction/harm, mental/emotional harm, intrusion of privacy or breach of confidentiality this must be reported to the approving Committee immediately. Failure to report adverse circumstance/s would be considered misconduct.

Ensure you quote the UH protocol number and the name of the approving Committee on all paperwork, including recruitment advertisements/online requests, for this study.

Students must include this Approval Notification with their submission.

Appendix 8: Final Thematic Map for Work-related stress Factors in HSWs' Workplaces

Codes	Sub- theme	Final theme
Public perceptions Harassment	Working in a mixed gender workplace	Culture
Children transportation domestic duty	Responsibilities outside workplaces	
Importance of HSWs' roles Governmental organisations' attitude	Lack of social recognition in the Saudi social community	
Academic programmes Theoretical preparation and reality in the field Professional classification	Inadequate academic preparation and training	
Lack of Budget Equipment and resources	Lack of resources in HSWs' workplaces	
Ministerial leaders Central leaders	Leadership in HSWs' workplaces	
Roles and job description Bureaucratic system Lack of incentives	Regulations and policies in HSWs' workplaces	
Uncooperative families Patients and their families' attitudes Patients' expectations	Patients and their families	
Other professional perceptions Lack of collaboration	Other professionals in HSWs' workplaces	

Codes	Sub- theme	Final theme
Commitment to working hours Flexibility in males section Evaluating female performance	Gender inequality	
Requirements for professional classification	Professional classification	
Long daily working hours Disability to perform domestic duties Night shift	Working hours	
Biometric attendance	Attendance	
Employing traditional methods Promotion requirement	Evaluation and promotion	Gender
Shortage of female HSWs in workplaces	Staffing	
Perform intensive work Doing additional administrative tasks	Workload	
Facing emotional complications Handling a very sensitive areas	Patients' problems	

Appendix 9: Final Thematic Map for Coping Mechanisms

Codes	Sub- theme	Final theme
Handling patients' anger Maintain emotional equilibrium when dealing with patients' problems Avoid thinking about workplace pressures during their free time Avoid taking any decision while under pressure Adjust according to the circumstances in the hospital	Self- control Self- adjustment	Personal Skills
Wife Mother Husband Friends Relationships with colleagues (HSWs) Relationships with other professionals	Family and friends support Discussing problems with colleagues (HSWs) and professionals in other departments for advice	Emotional and Instrumental Support
Do the job for the sake of (Allah) almighty God Wait for rewards from almighty God (Allah) Thanking God for the peace HSWs have	Strong spiritual beliefs Gratitude to (Allah) for giving a comfortable life	Religious Strategies
Drawing Go to gym Walking while shopping	Arts activities Physical exercises	Leisure activities

Codes	Sub- theme	Final theme
Relaxation sessions Talking with psychologists Expressing undesirable feelings	Trying to control pressure Releasing negative feelings	Venting
Handling any obstacles Supportive when breaks needed	Managing problems associated with patients and their families Flexibility in controlling complications linked to attendance	Managers of Social Work Departments
Appreciation of patients Patients and families' prays Enjoy organising activities with patients	Feeling of satisfaction caused by helping patients and their families Spending time with patients during activities removes HSWs them from the atmosphere of routine and pressure of work	Patients and their Families' Attitudes
Taking vacation Changing field of work	Stay away from the working environment	Taking a break from the workplace
Length of experience Years of experience made that easier	ability to deal with tension at work improved over time	Fieldwork Experience

Appendix 10: Univariate associations between HSWs' Demographics and Work- related Stress Factors

Association between Age and Death and Dying

	Less than 30 (n= 19)	31-35 (n= 29)	36-40 (n= 41)	41-45 (n= 13)	More than 45 (n= 8)	P-value	Shapiro-wilk
Mean (Std)	18.7 (5.5)	16 (4.8)	15 (4.3)	15 (5.3)	11.7 (4.1)	0.07	W = 0.981 p = 0.119

Association between Experience and Uncertainty Concerning Treatment

	Less than 5 (n=26)	5-10 (n=45)	11-15 (n=25)	More than 16 (n=14)	P-value	Shapiro-wilk
Mean (Std)	22.5 (2.6)	20.9 (4.8)	18.3 (4.5)	18.7 (4.5)	0.003	W = 0.983 p = 0.196

Table (8.21): Association between Age and Patients and their Families

	Less than 30 (n= 19)	31-35 (n= 29)	36-40 (n= 41)	41-45 (n= 13)	More than 45 (n= 8)	P-value	Shapiro-wilk
Mean (Std)	21.2 (6.7)	17.8 (4.9)	19.1 (5.5)	16.8 (4.7)	13.7 (6.6)	0.019	W = 0.982 p = 0.139

Multiple Linear Regression for Stress Factors²⁹(p-values < 0.5 in bold)

		Regression Coefficient	95% Confidence interval (CI)		P value	R²	Df	F
Inadequate Preparation (N = 110)	Qualification³⁰	.592	.152	1.031	.009			
	Responsibility (No)	-.664	-1.483	.154	.110			
	Model fit	-			0.008	0.086	2.107	5.0117

²⁹ NB For each factor, the demographic variables selected were those with (p<0.1) in the univariate analyses. For the regression, the selected demographic variables were entered together.

³⁰ Qualification and age were treated as ordinal independent variables ... See Pasta DJ. Learning when to be discrete: continuous vs. categorical predictors. *In SAS Global Forum 2009 Mar* (Vol. 248).

Appendix 11: Ordinal Logistic Regression for Coping Mechanisms

Non-normally Distributed Coping Mechanisms		Odds ratio (OR)	95% CI OR		P value Less than 0.05	X ²	Df
Denial (N = 108)	Age: (baseline more than 45):						
	less than 30	6.8	1.4	32.5	.016		1
	From 31-35	1.5	.35	6.3	.583		1
	From 36-40	1.15	0.3	4.6	.846		1
	From 41-45	1.4	0.3	3.3	.704		1
	more than 45	0			.		
	Job type (permanent)	0.8	0.34	1.4	.294		1
	Model fit				0.006	16.15	5
Substance Use (N = 108)	Gender (male)	5	1.9	12.7	.001		1
	Job type (permanent)	.15	0.06	0.39	.001		1
	Model fit				<0.001	25.431	2
Self-Blame (N = 107)	Responsibility (No)	2.4	1.17	5.35	0.02		1
	Gender (male)	.5	.24	1.05	0.07		1
	Job type (permanent)	.28	.12	.64	0.003		1
	Marital status: Baseline (Divorced)						
	Single	.15	0.03	.83			1
	Engaged	3	.18	50	.447		1
	Married	.213	.045	1.01	.051		1
	Divorced	0			.		0
Model fit				< 0.001	29.3	6	

Non-normally Distributed Coping Mechanisms		Odds ratio (OR)	95% CI OR		P value	X2	Df
Behavioural Disengagement (N = 110)	Age: (baseline more than 45): less than 30	8.6	2.7	31.5	.006		1
	From 31-35	9	0.82	96	.072		1
	From 36-40	9.2	.9	95	.061		1
	From 41-45	3.23	.25	41	.367		1
	more than 45	0	.	.	.		
	Responsibility (yes)	.76	.35	1.6	.468		1
	Marital status: (baseline Divorced):						
	Single	1.82	0.32	10	.491		1
	Engaged	1.6	.166	17.2	.657		1
	Married	.85	.17	4.2	.850		1
	Divorced	0	.	.	.		0
Model fit				.001	27.72	8	
Venting (N = 108)	Gender (female)	4	1.8	9	0.001		1
	Job type (temporary)	3.2	1.4	6.6	0.005		1
	Responsibility (No)	2.25	1.08	4.6	0.03		1
	Model fit				< 0.001	24.4	6