sw&s | Social Work and Society International Online Journal

The Relationship between Organisational Factors and Job Frustration among Saudi Social Workers

Abdulaziz Albrithen, *United Arab Emirates University*

Nadir A. Yalli, *Umm Al-Qura University*

1 Introduction

Social work in the Saudi medical sector has been contributed to the national health and social development plans by providing social services to meet the psychosocial needs of patients. The social workers are working in partnership with other health care professionals to maximise the delivery of quality services by addressing and tackling the psychosocial problems that cause illness and/or hinder effective recovery. On the other hand, hospitals in Saudi Arabia are recognised as highly bureaucratic as public organizations and rigid formal rules and complex labour procedures are common aspects in these organisations. Human service organisations with bureaucratic features are increasingly becoming the workplace for today's professionals. In Saudi Arabia, there are about 415 state hospitals and over 87 private hospitals.

As social work in health care area is seen as one of those needed services in hospitals in Saudi Arabia, availability of both qualified and well-trained practitioners are assured by certified human resources experts and the promise of good financial potentials has also helped in having enough practitioners ready to provide special services to patients and their families, and also show willingness to organize specialized seminars (Albrithen, 2013).

The social work staff are an integral part of the medical system (Al-Qurni, 2003). Internationally, hospital social workers are expected to perform multiple functions in the process of health care delivery. These various functions involve patients, other professionals in the hospital, and the wider community.

In Saudi health workers have to recognize the importance of evidence-based practice strategy, which needs the documentation that supports program effectiveness (Dziegielewski, 2013). The health workers update their knowledge in the field of expertise which leads to the greatest benefit for the patients. The adoption of this practice is linked directly to the success of the program and also contributes to the health worker's learning process. Evidence-based practice strategy indirectly benefits the patient's immediate needs, and also have a tangibly positive effect on the organization in terms of maintenance as well as improving the health profession (Gossett and Weinman, 2007).

The unique nature of Saudi cultural norms necessitates social workers the country to perform specific duties and responsibilities while working at hospitals based on these cultural norms. The roles of the hospital social worker are not that different to those outlined by Dziegielewski (2013). Social workers in Saudi Arabia are most likely to assume certain functions and responsibilities such as (Saleh, 2002):

1. Daily visits to in-patient wards and out-patient areas, and joining physicians' rounds as needed.

2. Gathering information and conducting assessments of the psychosocial aspects of health.

3. Counseling and therapeutic services.

4. Consultation with other professionals about psychosocial factors and their implications for health.

5. Planning services.

6. Advocacy and prevention services.

7. Post-hospitalization follow-up care.

8. Performing other duties (e.g. monitoring and reporting patients' or families' complaints, writing case reports, administrative tasks).

9. Research services and education activities.

2 Methodology

This study aims to contribute to the developing body of knowledge on hospital social work practice by attempting to investigate the following question: What are Saudi hospital social workers' perceptions of the organisational factors that can influence their ability in successfully practising their roles?

The study analyses and discusses the inter-relationships between respondents' perceptions concerning the organisational issues in the workplace and their self-reported attitudes toward the job, particularly job frustration and organisational commitment. The main goal is to develop a model that can best describe the organisational factors that can influence practitioners' behaviour at work in Saudi hospitals and to identify ways that can benefit the development of professional practice in Saudi health care. To accomplish this objective, a further analysis of the findings using correlation and regression was performed. The present study starts by providing a detailed discussion of the findings from the correlation analysis, highlighting the relationships between responses related to organisational aspects, personal frustration and organisational commitment. This is followed by results from the regression analysis which shows the most important organisational factors that contribute to personal frustration and organisational commitment in Saudi hospital social workers.

Descriptive research is usually attempted when the researcher is aware of the questions related to the issue he or she wants to investigate, but not the answers. Many times different kinds of statistical methods are used for this type of research (Babbie, 2020). This design can help in developing careful descriptions of the topic of this study; that is, practitioners' perceptions of the common organisational issues that can impact on their ability to perform their job roles in an effective manner in Saudi hospitals, which were identified in the exploratory research.

A self-administered questionnaire was designed by the researchers using a Likert scale and free response questions organised in three sections (i.e., demographical data, organisational factors, and job frustration). Section 2 inclusive were related to participants' views on the

organisational structure, and organisational resources. The total number of items in this section are 14 and organised on a Five-Point Likert-Scale ranging from (1) 'strongly disagree' to (5) 'strongly agree'. Both positively and negatively worded statements were included. Section 3 aimed at exploring how participants describe their personal experience in the workplace. A total of 19 positive and negative statements were organised on a five-point Likert-Scale, asking participants to indicate the extent to which they agreed or disagreed with each statement. Items in this section considered three work-related reactions, including emotional feeling on the job (e.g. job frustration), job satisfaction and organisational commitment.

The questionnaire was distributed to all available practitioners (i.e. census) (n= 260) within all of the state hospitals in the western region of Saudi Arabia, and a response rate of 219 (84%) useable questionnaires was obtained. The data was collected from January 2019 to March 2019. The state hospitals are more common and widespread, and sure they reflect and represent all health institutions (including private hospitals) in Saudi Arabia. Similarly, the western region of Saudi Arabia will reflects and represents the other regions in the county. The sample is restricted for those who work in the health field and opened for those who hold a position of 'social worker' no matter what their academic backgrounds are.

The questions of the survey were clearly and adequately formulated to satisfy the research inquiry and to ensure their suitability to the nature of the respondents. Questions were formulated after consulting the theoretical framework of the study, previous literature and the study's objectives. Selection of the items was based upon the extent to which they were deemed comprehensible when translated into Arabic, the extent to which they were acceptable in the Saudi cultural context and the extent to which they were broadly applicable to the health care role of social work practitioners.

The internal reliability method was adopted to measure the instrument's reliability, and Cronbach's Alpha test was employed to measure the reliability of the questionnaires. The Alpha is used with multiple choice tests or a measurement scale. Ethical producers and approval were also applied and conducted.

The Statistical Package of Social Sciences (SPSS) software, version 26 for Windows, was used to calculate the reliability of the instrument. All sections concerning work-related factors and work-related behaviour had a Cronbach's Alpha ranging from 0.86 to 0.94. This score determines that the reliability of the instrument was acceptable.

3 Findings

3.1 General Findings

All participants in this study were Saudi, which is broadly representative of social workers given that most non-indigenous practitioners were replaced by the Saudi government over the past two decades with locally trained professionals in order to effectively deal with community conditions. As larger cities have more hospitals and therefore employ more social workers, as expected the majority of practitioners in this study were from the largest two cities in the research area, namely Jeddah (N=83, 37%) and Makkah (N=63, 28.8%). Forty two (19.2%) respondents were from Taif City and 31 (14.2%) were from Medina.

The age of the respondents (N=215) ranged from 24 to 56 years old, with a mean of 36 (four respondents did not specify their age and/or years of experience). Practitioners' years of

experience working as hospital social workers ranged from less than 1 year (0.2 months) to 30 years, with a mean of 10.64 years and a median of 10.00 years. This indicates the nascent position of the social work profession in Saudi Arabia.

With regard to academic qualifications, the majority of respondents (N=194, 88.6%) held bachelor degrees, 7 (3.2%) held bachelor degrees with a diploma (high-diploma is usually in certain filed like health and gained after graduation), 9 (4.1%) with a masters, and 6 (2.7%) described their educational level as 'other' (three respondents did not specify their qualification). This high number of graduates is to be expected, as the minimum qualification requirement for a social work position in Saudi Arabia is a bachelor degree. The limited number of postgraduate programmes in the country however could explain the limited number of professionals with a higher degree (masters level) qualification.

Responses relating to the major subject of their academic studies highlighted a disparity in educational backgrounds, with nearly half (N=90, 41.1%) qualified in sociology, 81 (37.0%) in social work, 10 (4.6%) in psychology, and 34 (15.5%) with other disciplines (four respondents did not specify). The majority (N=171 out of 200) of participants with a bachelor degree had majored in social work or sociology, while 6 (out of 9) of those who held a masters degree had majored in psychology, further indicating the limited educational provision for postgraduate programmes in social work. A large proportion (N=31) of those participants who specified their educational background as social work were operating in Makkah, while almost half (N=43) of those who stated sociology were in Jeddah, and most (N=15) of those who responded as other were in Taif City. This reflects that jobs for 'social worker' in Saudi Arabia can be occupied by other disciplines, which negatively will affect the professional practice of social work and its outcomes.

Data indicates that social work staff may work on three shifts, up to eight hours per shift per day. More than two thirds (N=151 or 68%) of the participants described their working schedule as a day shift, 14 (6.4%) respondents described it as an evening shift, only one practitioner described it as an early morning shift, 40 (18.3%) indicated that they work on two shifts (day and evening) and 13 respondents (5.9%) reported that they work on rotating shifts (three working-shifts).

Salaries ranged from EUR425 to EUR3,500 per month. The mean salary for respondents was EUR1,842 and median EUR1625. No difference was found in the wage scale of hospital social work staff in the different locations of the research area. The monthly salary of the respondents varied according to age, gender, position, position's classification, employment type and length of service. The salary increases as age increases. The majority of those who stated that they earn a monthly salary of up to EUR1,500 (53 of the 60 respondents) were younger participants (aged 24-35). Fifty (out of the total 63) respondents who earned a monthly salary of EUR1,501 or more were 35 years of age or older. This is to be expected, as most young social work staff were new and/or inexperienced practitioners who were on short-term employment contracts that pay minimal remunerations. Approximately 39% (N=54) of respondents with up to five years experience said they earned a monthly salary below EUR1,500. Of those participants with 18 and more years of experience (N=28), 18 earned EUR2,500 or over.

Although the wage scale of employment in state hospitals is standardised according to position, qualification, years of experience and employment type rather than personal characteristics (e.g. gender), data indicates a variation in salary between male and female

participants. The majority of respondents who earned a monthly salary of up to SR6,000 were female (N=31), while most of those participants who earned SR6,001 or over were male (N=49). A large number of female participants were younger, working in administrative positions (i.e. not working as professional practitioners) and/or on short-term employment contracts. According to the results, respondents in permanent employment received higher payments than those on short-term contracts. Of those participants who were on short-term contracts (N=46), 43 indicated that they earned up to SR6,000 per month. For those respondents in permanent employment (N=79), 61 reported that they earned SR6,001 or more. The monthly salary for most of those participants who were in administrative positions (N=24) was up to SR6,000, while over half of the participants in professional positions (N=61) earned SR6,001 or more. The largest proportion of participants who indicated that they earned a monthly salary of SR6,000 or less (N=24) described their employment position (job title) as either a 'sociologist' or an 'assistant sociologist', while most of those respondents who stated that they earned a monthly salary of SR6,001 or more specified their position as 'social worker'.

Although the majority of participants held similar qualifications (e.g. a bachelor degree), all participants at master's level (N=3) reported that they earned a monthly salary of at least SR8,001. A large proportion (N=37) of respondents who indicated that they received a monthly salary under SR6,000 held a qualification in social work, while most of those respondents who stated that they earned above SR6,000 had majored in sociology and/or psychology (N=37). The majority of participants who majored in sociology and psychology were more experienced, had a higher educational level, were in professional positions and were in permanent long-term employment.

3.2 Job Responsibilities

Participants' responses to questions regarding their current job responsibilities are summarised in Table 1 (higher mean scores indicating frequent performance of the task). The table illustrates that social workers are involved to a great degree in the provision of many services in the hospital. The statement 'Undertaking daily rounds in hospital areas as needed' was identified as a key task, with the highest mean score of 4.38 (S.D = 1.070).

Most of the respondents reported that they frequently (N=147, 67.1%) or often (N=36, 16.4%) made visits to the wards and out-patients areas, and accompany physicians on their rounds. Participants identified the conducting of assessments in relation to psychosocial aspects of health as the second most frequently performed task. Nearly half of the respondents stated that this task was undertaken on a frequent basis (N=106, 48.4%), while a third reported that it was undertaken often (N=70, 32%).

Table 1: Response to Job Responsibilities Questions

Job responsibility	Mean	S.D.	Frequently/ Often		Sometimes		Rarely/ Never	
			N	%	N	%	N	%
Making daily rounds in hospital units	4.38	1.070	183	83.5	18	8.2	18	8.2
Assessment of the psychosocial aspects of health	4.24	0.884	176	80.4	35	16.0	8	3.6
Administrative duties	4.20	1.073	174	79.5	27	12.3	18	8.2
Counselling and therapeutic services	4.15	1.019	157	71.7	48	21.9	13	5.9
Information gathering & referral	3.98	1.004	148	67.6	51	23.3	17	7.8
Research services	3.77	1.170	141	64.4	48	21.9	30	13.7
Advocacy services	3.72	1.210	132	60.3	41	18.4	45	20.6
Preventative services (e.g. contribute to health education activities)	3.72	1.202	132	60.2	54	24.7	32	14.6
Training in psychosocial aspects	3.56	1.350	130	59.4	39	17.8	49	22.3
Consultation with other care providers	3.25	1.254	90	41.1	64	29.2	66	29.2
Planning services (e.g. discharge planning)	3.2	1.395	98	44.7	44	20.1	75	34.3
Budgeting and fundraising activities	2.59	1.254	50	22.8	62	28.3	107	48.9
Community organising and capacity building	2.41	1.227	38	17.3	56	25.6	121	55.3
Post-hospitalisation follow-up	2.37	1.158	37	16.9	63	28.8	118	53.9

While hospital social work professionals may handle some administrative duties (Saleh, 2002), the findings from this study show that Saudi practitioners are frequently involved with administrative activities in the hospital. About 80% of the respondents claimed that they were frequently (N=116, 53%) or often (N=58, 26.5%) involved with administration. Moreover, many respondents commented on this type of work by indicating that they were asked to perform additional administrative duties that had no relation to social work or were part of the responsibilities of other departments in the hospital.

As shown in Table 1, the delivery of psychosocial counselling and therapeutic services was also regarded as one of the main duties for practitioners. Nearly three quarters of the respondents indicated that they provided these services frequently (N=110, 50.2%) or often (N=47, 21.5%). These findings suggest that social workers perceive direct work with patients as their main task, although there is an administrative orientation. The findings also illustrate that there are additional types of activities for social workers in Saudi hospitals, but these were generally viewed as less frequently performed. One of these functions was related to provision of information gathering and referral activities. Over half of the total number of

respondents stated that they undertook information gathering and referral activities frequently (N=83, 37.9%) or often (N=65, 29.7%).

Research is recognised in various international reports as an important component of social worker practice (Davies, 2000; Gossett and Weinman, 2007). As illustrated in Table 1, research work was also perceived by respondents as a common responsibility for social workers in Saudi hospitals. Nearly two-thirds (66%) of the respondents reported that they were involved in studies and surveys (e.g. filling in questionnaires) related to patients and/or service needs in the organisation either frequently (N=72, 32.9%) or often (N=69, 31.5%). It is worth noting, however, that this finding may also mirror respondents' perceptions in relation to the extent to which they are involved with administrative tasks and clerical duties in the hospital, as was previously mentioned.

According to over half of the respondents**,** advocacy services are frequently or often provided and a majority of respondents also indicated that they were frequently or often involved in prevention activities, such as contributing to health education. With regard to the provision of training in psychosocial aspects, the majority of participants (60%) indicated that they were either frequently (N=68, 31.1%) or often (N=62, 28.3%) involved in providing these services. Marginal notes from participants in the study about this item indicate that training was limited to teaching intern students from university social work departments about the profession's involvement with, and contributions to, hospitals.

The responses from participants in relation to the provision of consultation with other care providers were varied. However, approximately 40% of the respondents (N=90) reported that they frequently (N=48, 21.9%) or often (N=42, 19.2%) consulted with care providers. Moreover, less than half were involved in planning services, such as discharge planning, frequently (N=59 or 26.9%) or often (N=39 or 17.8%). These job responsibilities may reflect the nascent position of hospital social work in Saudi Arabia, or that some of social work responsibilities in the hospital setting, such as discharge planning, may be shared with other health care professions who take a lead role (e.g. nursing staff) (Wong *et al.,* 2000).

The findings also indicate that social workers had only limited involvement in the provision of services such as budgeting and planning, community work and post-hospitalisation follow-up. Activities related to financial activities and budgeting may be viewed by participants as main functions of the management system in the hospital. Internationally, community organising and capacity building appear to be major roles for hospital social workers (Wong *et al.*, 2000; Vijay, 2003). For example, social work professionals may operate to promote, coordinate and contribute to the development of networks of support services within the local community to respond to health and social needs; they may also recruit volunteers to meet the needs of patients, families and health agencies (Saleh, 2002). Respondents indicate that community practice is an infrequent part of social workers' responsibilities in Saudi hospitals, as over half of the respondents said that they rarely (N=60, 27.4%) or never (N=61, 27.9%) undertook activities of community organising and capacity building.

Post-discharge follow-up for patients, particularly for those in high-risk groups (e.g. elderly patients), is a crucial function of social work professionals in hospitals. Post-discharge follow-up for patients is important, not only because it ensures that patients' needs are met, but also because it can allow medical professionals and hospitals to administer early intervention to prevent relapse or unnecessary future re-admissions, leading to effective and cost-efficient health care services (Masiriri, 2008). Hospital social work staff in Saudi Arabia have a

relatively limited role with regard to discharged patients, as this aspect scored the lowest mean of 2.37 (S.D. = 1.158), with the majority of respondents reporting that they rarely (N=53, 24.2%) or never (N=65 or 29.7) followed up patients after discharge. One explanation for these findings may be related to the limited number of social work staff and the consequent time constraints to perform such tasks. Eleven participants cited that they frequently performed additional activities. Most of these responsibilities were perceived as non-social work tasks or as aspects of the responsibilities of other units in the hospital, such as supervising nursery units, checking and verifying IDs of service users, assisting in collecting service fees from patients and/or generally serving as public relations agents.

3.3 Correlation Results

The data analyse and discuss the inter-relationships between respondents' perceptions concerning the organisational issues in the workplace and their self-reported attitudes toward the job, particularly job frustration.

A correlation analysis was performed first by examining the relationship between respondents' views on the aspects of the organisational structure and resources in their workplace and their responses concerning job attitudes. A correlation analysis is a statistical procedure to measure the association between two variables (Babbie, 2020). The value of a correlation (or r) may range from -1.0 to +1.0, with a correlation of 0 indicating absolutely no association. In other words, a correlation of 0 means the variables are completely independent of each other. A positive correlation indicates that as one variable changes in one direction, the other variable changes in the same direction. A negative correlation indicates that as one variable changes in one direction, the corresponding variable changes in the opposite direction (McQueen and Knussen, 2004; Monette *et al.*, 2013; Babbie, 2020; Howitt and Cramer, 2005).

For the purpose of this study, specific items on the organisational structural scale, the organisational resources scale and the personal experience scale (e.g. job frustration) were selected for correlation analysis. Items with high variations and/or contradictions in responses were selected from each of the above-mentioned scales. Statements with a high level of agreement or disagreement in responses and/or with a greater consistency of information were excluded from each scale because it was felt that they may not clearly explain the relationship between respondents' perceptions of their workplace and their job-related behaviour. For instance, a high level of disagreement with the statement concerning participation in the internal governance of the organisation could represent the participants' views of a negative aspect of the structural conditions in the workplace, but may not necessarily highlight frustration with the job and/or indicate a poor working relationship within the organisation.

A review of the frequency findings concerning the organisational structural aspects, organisational resources and the reported personal experiences in the workplace highlighted a number of items that appeared to be useful for further exploration through correlation analysis. Selected items from the organisational structure scale were related to perceptions of job clarity ('In my job, I have clearly defined responsibilities and goals', and 'I feel that the existing job guidelines of social work in the hospital are very vague'); perceptions of job autonomy ('My current job is mainly concerned with routine matters', 'I feel that what I am mostly doing here is following orders', and 'Even small matters have to be referred to someone higher up'); and perceptions of professional embodiment and linkages in of social work the hospital system ('The hospital treats social workers as professionals important to patient care', 'My department is well connected to other units in the hospital'). Only one item

was selected from the organisational resources scale that is related to workload ('Inadequate staffing levels within our department confine me to simple tasks'). Only two items were selected from the personal experience scale that appear to contain high variations and contradictions in responses, which were related to job frustration ('I feel frustrated by my job') and organisational commitment ('I am proud to work for this institution'). The results from the correlation analysis are summarised in Table 2 below:

Table 2: Correlation Results Concerning Organisational Structure, Resources, and Job Frustration

Questionnaire Item	*Job Frustration*
Organisational Structure	
Job Clarity:	
In my job, I have clearly defined responsibilities and goals.	-.37(**)
I feel that the existing job guidelines of social work in the hospital are very vague.	.36(**)
Job Autonomy:	
My current job is mainly concerned with routine matters.	.37(**)
I feel that what I am mostly doing here is following orders.	.38(**)
Even small matters have to be referred to someone higher up.	.38(**)
Professional Linkages:	
The hospital treats social workers as professionals important to patient care.	-.46(**)
My department is well connected to other units in the hospital.	-.51(**)
Organisational Resources	
Workload:	
Inadequate staffing levels within our department confine me to simple tasks [R].	.29(**)
Working Experience	
Job Frustration.	1.00

*Correlation is significant at the 0.05 level (2-tailed)
**Correlation is significant at the 0.01 level (2-tailed).

The above table indicates that the organisational structural and resources aspects in the hospital setting are significant correlations of participants' self-reported personal experiences

in the workplace. The following is a detailed discussion of the findings presented in Table 2, which is organised into four sub-sections: organisational structures and job frustration, and organisational resources and frustration.

3.4 Organisational Structure and Job Frustration

Organisational structure refers to how an organisation arranges, manages, guides and operates itself, and includes elements such as job specifications and definitions, formalisation, centralisation, coordination and legitimacy (Albrithen & Yalli, 2012). International practice research illustrates a statistical relationship between social workers' perceptions of the quality of structural aspects in the workplace and job frustration (Albrithen & Yalli, 2011). Structural aspects were investigated in relation to job aspects such as job clarity, role consistency, job autonomy and decision latitude, and job communication. Empirical studies from several countries show that a practitioner's emotional state and health can be affected by each of these characteristics on their own, or by interaction between them (Lewandowski, 2003; Acker, 2004).

Practitioners are normally assigned and follow certain roles in their work setting. It has been suggested that if practitioners perceive inadequate information and understanding in relation to their work, they are more likely to experience frustration and other emotional health-related problems (Lait & Wallace, 2002). Role ambiguity (Wong *et al*., 2000) represents one of the common concepts that have been frequently cited in the international literature to describe the lack of clarity on job information and its consequences on practitioners' emotional reactions toward the job.

The findings of this study correspond with previous work in international literature and highlight a statistical correlation between aspects concerning clarity of job definitions and job frustration. Table 2 shows a significant statistical correlation between respondents' feelings of frustration and their responses concerning the statement 'In my job, I have clearly defined responsibilities and goals' ($r = -.37$, $p \leq 0.01$) and the statement 'I feel that the existing job guidelines of social work in the hospital are vague' ($r = .36$, $p \leq 0.01$). These findings indicate that participants who perceived a lack of clear information and specifications concerning their roles in the hospital were more likely to feel frustration at work. This may reflect the nascent position of social work in Saudi hospitals, and the fact that there are many inexperienced practitioners performing the job. Additionally, it is important to note that while the minimum qualification for social work employment in Saudi hospitals is a bachelor degree, social work posts in existence are not held exclusively by social work graduates, but can also be filled by graduates from other disciplines, such as general social science or the humanities.

It is not surprising, therefore, to find frustration among Saudi hospital social workers. Two further possible explanations may be considered for this relationship. The first is that most of these practitioners may have not received adequate practical preparation prior to taking the job. The lack of adequate information and job specification means that they may find it difficult to adjust to their work environment and cope with the complicated needs of patient-clients and the changing nature of their job, which has long been recognised as stressful and frustrating (Lewandowski, 2003). Frustration resulting from a lack of clear delineation of their roles can also increase in these practitioners if they perceive a lack of in-service training opportunities and ineffective support from their superior colleagues and co-workers, which were highlighted as major concerns by several participants in this study. The second possible explanation is that as these inexperienced practitioners lack an adequate understanding of their job, they may find it appropriate to create their own definition of their role by

concentrating on performing less professional duties (e.g. clerical tasks). Consequently, this can impact on the social work message and its overall image in the hospital, increasing difficulties and distractions for trained social workers to carry out tasks that lie in the therapeutic arena, which in turn may escalate the proportion of those who perceive frustration in their job. High ambiguity about the job can also adversely affect the workers' sense of job security, especially for those with short-term employment contracts (Coulshed *et al*., 2006; Al-Qurni, 2003). This may occur when practitioners feel they have little say in the organisation with respect to how they do their job and related activities, which, in turn, can contribute to job frustration (Huxley *et al.*, 2005).

Autonomy is an important aspect of the job that is related to organisational structure. Autonomy reflects the independence of individuals to make decisions according to their own abilities, rather than taking an organisational position (Eby, 2000). Autonomy includes the concept of self-direction, that is the ability individuals have to direct their own life, even in the workplace (Eby, 2000). Social work practitioners are said not to be 'autonomous', like members of well-established professions such as doctors, who are relatively 'free' to make their own professional judgements regarding the needs and requirements of their patients without reference to outside hierarchies and bureaucrats (Banks, 2012). Autonomy issues can occur when practitioners are employed in bureaucratic organisations where there is a tension between the ideal of their professional autonomy and the reality of a rule-governed, hierarchical structure (Banks, 2012).

Lymbery and Bulter (2004) concur that such bureaucratic systems infringe on professionals' autonomy and their time spent with clients, leading to an unfavourable emotional experience on the job such as frustration (Acker, 2004; Lewandowski, 2003).

In this study, participants' views in relation to aspects of job autonomy in the workplace were related to their responses concerning job frustration. The findings of this study highlight a statistically significant relationship between participants' perceptions of organisational structural aspects concerning the extent to which they feel control and discretion over their job and their feelings of frustration. According to Table 2, there is a significant correlation between job frustration and feeling an obligation to refer even small matters to higher authorities within the hospital for a final decision ($r = .38$, $p \leq 0.01$), feeling under pressure to follow orders ($r = .38$, $p \leq 0.01$) and a perception of the job as being mainly concerned with routine matters ($r = .37$, $p \leq 0.01$). These positive relationships indicate that participants who perceive limited autonomy to perform their job in the hospital are more likely to report frustration. An explanation of these findings may again relate to the high number of young practitioners who operate in Saudi hospitals. Most of these newcomers may not have received preparation during their academic training to work in such bureaucratic/formalised organisational conditions that may contradict their freedom and professional expectations (e.g. professional judgment and discretion). In this study, it was noted that practitioners were not only expected to perform formalities and paperwork related to their job, but also to carry out administrative duties that are outside of their professional perimeters, leaving little time for practice, and thus hindering the creativity and innovation necessary for professional development and growth (Lymbery and Bulter, 2004). This situation, however, can vary from one setting to another, depending on issues such as the variation in the hospital's management system and in the amount of administrative support for practitioners in Saudi health care organisations, a second possible explanation for participants' feelings of frustration concerning job autonomy. The findings of this study, for example, highlight a significant

relationship between participants' views concerning the organisational structural aspects in the workplace and their perceptions concerning the hospital administration.

As previously noted, the above findings have already been documented in international practice research. However, it is essential to note that labour procedures and configurations (e.g. rigid rules, complex formalisation) in Saudi hospitals are derived from the various unique socio-economic and cultural aspects of the country. One example to consider is that Saudi society still adheres to most of its traditions and customs, so that the bureaucratic style of its public institutions may frequently reflect the hierarchal structure within families, which in turn is generally compatible with tribal structure. This structure tends to concentrate power and decision-making authority at the apex of the hierarchy based on factors such as seniority and sex. In a similar example from the Saudi health care context, those with the highest professional status and employment positions (e.g. administrators and physicians) can make decisions in the organisation, particularly with respect to patient care and the use of the hospital's resources. They then communicate instructions to those in lower positions in the hierarchy (e.g. nursing staff and social workers). This can make the social workers' job more complicated, especially when those in charge of decision-making in the hospital have a limited understanding of social work and/or hold stereotypical views concerning the contribution of social workers, leading to job frustration in practitioners.

The extent to which practitioners feel autonomy on the job can impact upon their feelings as professional members important to the organisation and on their overall sense of embodiment in the workplace, which can also play a significant role in their emotional reactions to the job. Organisations, especially large ones such as hospitals, are composed of different sections and/or departments that are interdependent and influence one another to reach organisational objectives (Saleh, 2002). Effective linkages between the organisation's units can influence the quality of both the personnel and the organisation as a whole (Sabab *et al*., 2005). Given that the social work department and its members represent a part (or system) of the health care setting and considering the fact that the very core of practitioners' work lies in relationships (Saleh, 2002), the extent to which practitioners view their linkages in the workplace is considered as an important predictor in their job-related feelings and behaviour. Various international studies (Neuman, 2003; Huxley *et al.*, 2005) illustrate that work-related disillusionment and frustration in social work practitioners is associated with their perceptions of the organisational structural aspects that impact on their professional connections within the workplace and their sense of being valued, which are referred to in this study as professional linkages.

The findings of this study highlight a significant statistical correlation between participants' views on organisational aspects concerning their linkages in the workplace and their feelings of job frustration. According to Table 2, there is a significant relationship between participants' feelings of frustration with the job and their responses concerning the statement 'The hospital treats social workers as professionals important to patients' care' ($r = -.46$, $p \leq 0.01$), and the statement 'My department is well connected to other units in the hospital' ($r = -.51$, $p \leq 0.01$). These negative correlations indicate that participants who perceive ineffective linkages in the workplace are more likely to report frustration with the job. The above correlations may reflect the fact that social work is not well established as a competent profession in the Saudi health care system (Albrithen, 2019); a situation that could contribute to frustration among the few professionally trained social work practitioners, in particular the newly employed ones. It is appropriate to recall the hierarchal arrangements within Saudi hospitals that can impact on opportunities for practitioners to effectively communicate with

higher levels of the hierarchy; a situation that can minimise opportunities for professional input into the organisation's work and for influencing decisions related to practice and clients, as well as preventing them from seeking clarification and support on difficult work assignments, all of which are considered as responsible factors for frustration. More importantly, the association between job frustration and job linkages may also mirror the fact that there are many practitioners who may not be prepared to work in multi-disciplinary or multi-cultural settings such as hospitals (Reese and Sontag, 2001). For example, it is worth noting that the health care system in Saudi depends heavily on expatriates for providing medical services, most of whom are from non-Arab speaking countries (e.g. Indonesia and Pakistan). This is exacerbated by the fact that the majority of social work personnel are Saudis and native speakers whose academic preparations are mainly from Arabic language institutions. Accordingly, one of the common difficulties that newly employed practitioners may encounter in the workplace is a language barrier which can prevent them from effective communication and interaction with other health care personnel, leading to frustration.

3.5 Organisational Resources and Job Frustration

In this study, organisational resources refer to the workplace assets that are made available to practitioners to do their job, such as money, people and buildings. According to the literature, the adequacy of organisational resources can also influence practitioners' emotional health at work. The adequacy of organisational resources can associate with job satisfaction, while inadequacy of resources can cause frustration.

Inadequacy of organisational resources has been found to influence many aspects of practitioners' jobs, especially workload (McLean and Andrew, 2000; Lymbery and Bulter, 2004), leading to job frustration (Huxley *et al.*, 2005). Workload is often linked to the adequacy of staffing levels. International literature opines that if there is a staff shortage, then some of the priority work replaces normal activities and, presumably, reduces access to professional services (Huxley *et al.*, 2005). Several studies illustrate that shortages in staffing levels (e.g. clerical staff) in the social work department can impact on practitioners' perceptions of excessive workload, such as increased administrative duties, resulting in frustration with the job (United States General Accounting Office, 2003; Huxley *et al.*, 2005).

The findings presented in Table 2 show a significant, although weak, statistical association ($r = .29$, $p \leq 0.01$) between participants' feelings of frustration and their belief that inadequate staffing levels within the social work department constrain them in performing more professional duties. This finding indicates that participants who reported negative perceptions concerning their workload were more likely to be the ones who mentioned frustration with their job. One explanation for this finding is that practitioners in some hospitals, especially in more urbanised cities, are divided to operate on three working-shift/schedules per day (on a 24-hour basis), which can reduce the already small number of available practitioners on each shift, and thus increasing the size of the workload for individual practitioners. It may also reflect the variations among hospital social work departments in staffing levels, as some departments appear to experience high shortages in staffing levels, although the findings of this study may not clearly describe this situation. It is also possible that practitioners in some hospitals may experience high uncertainty and inconsistent demands from the job, which can impact on their perceptions of increased workload and, thus, their feelings of job frustration (Maslach *et al*., 2001).

> "A workload mismatch may also result from the wrong kind of work, as when people lack the skills or inclination for a certain type of work, even when it is required in

> reasonable quantities… Generally, workload is most directly related to the exhaustion aspect of burnout." (Maslach *et al.*, 2001: 414).

The association between participants' feelings of frustration and their perceptions of workload could also be attributable to participants' years of experience on the job (Acker, 2004). For example, participants with more years of experience may have attended more in-service training and developed skills that enable them to manage their workload and adapt to work-related pressures better than their newly employed peers.

In summary, the above findings concerning the linkage between participants' reporting of job frustration and their perceptions concerning organisational structure and resources correspond with previous work in the international literature and highlight that organisational conditions in the workplace, particularly aspects related to job clarity, job autonomy and professional relationships, are responsible for job frustration in practitioners (Lewandowski, 2003) in the Saudi hospital sector.

Several international studies have reached the conclusion that negative feelings about one's work, such as stress and frustration, generally represent an indication of a negative attitude and an ineffective commitment to the organisation (Acker, 2004; Huxley *et al.*, 2005). However, very few studies have taken this a step further to find out whether predictors of workplace frustration can also impact on practitioners' commitment to their employers (McLean and Andrew, 2000; Allen *et al*., 2004).

3.6 Regression Analysis

The findings from the correlation results were used to inform the further examination of the data using regression analysis to delineate the most important organisational aspects that contribute to practitioners' personal experiences in the hospital environment. For regression analysis purposes, structural and organisational resource items were organised into four independent/predictor categories that were labelled: *job clarity* ('In my job, I have clearly defined responsibilities and goals', and 'I feel that the existing job guidelines of social work in the hospital are very vague'); *job autonomy* ('My current job is mainly concerned with routine matters', 'I feel that what I am mostly doing here is following orders', and 'Even small matters have to be referred to someone higher up'); *professional linkages* ('The hospital treats social workers as professionals important to patient care', and 'My department is well connected to other units in the hospital'); and *workload* ('Inadequate staffing levels within our department confine me to simple tasks'). This is because some of these questionnaire items were similar in meaning and/or had been originally designed to measure certain aspects concerning organisational structure (e.g. role structure) and resources (e.g. staffing) in the workplace. Additionally, this procedure had enabled the computation of the mean scores for variable groups, with two items and more, that were subsequently used for the regression analysis with each of the two dependent variables (job frustration), while controlling the individual-demographic variables (personal/professional characteristics).

Accordingly, two straightforward regression analyses were undertaken to estimate and develop models predicting job frustration in social workers. In the analysis, the following variables were entered as the independent variables: Job autonomy, job clarity, professional linkage, workload, location, age, major, years of experience, and salary.

The results are presented in Tables 3 and illustrate the list of independent (predictor) variables for each dependent variable. Following is a more detailed discussion of the factors that

explain the greatest variance in practitioners' personal experiences in the workplace. The regression findings are discussed into two sub-sections related to predictors of job frustration.

Table 3 below shows that 32% of the variance in job frustration is explained by variance in the set of model predictors, as listed in the lower portion of the table. Note that the predictors are listed in order of weight (*b* coefficient magnitude) or how important they are in the model.

Table 3: Multiple Linear Regression Results for Structural and Resource Organisational Aspects: Predictors of Job Frustration

Model	***R***	***R Square***	**Adjusted R Square**	**Std. Error of the Estimate**	***F***	***P***
	.563	.317	.302	1.12475	21.225	<.001

	Unstandardized Coefficients		Standardised Coefficients		
Model	*B*	Std. Error	Beta	*T*	*Sig.*
(Constant)	6.262	.467		13.402	.000
Job Autonomy	-.329	.094	-.240	-3.499	.001
Job Clarity	-.252	.082	-.209	-3.066	.002
Professional Linkages	-.238	.084	-.200	-2.823	.005
Age	-.026	.010	-.152	-2.604	.010

According to the above table, job autonomy (B = -.329, t = -3.499, p = .001), job clarity (B = -.252, t = -3.066, p = .002) and professional linkages (B = -.238, t = -2.823, p = .005) were highlighted as the most important predictors of respondents' job frustration. These findings indicate that as job autonomy, job clarity and professional linkages in the workplace decrease, job frustration is more likely to increase (Allen *et al.*, 2004; Lewandowski, 2003). It is important to note, however, that the three predictor sets are related to organisational structure aspects in the workplace. Workload size, which is related to the organisation's resources in this study, did not have a significant effect on job frustration. This could be explained by better structural conditions in the organisation which can contribute to improved workload management for practitioners. For example, a clear job description can enable practitioners, especially newly employed ones, to gain a positive understanding of the job's requirements, which can then facilitate the effective management of the workload (Lait & Wallace, 2002). As illustrated in Table 3, age (B = -.026, t = -2.604, p = .010) was the only control variable that had a significant effect on job frustration, suggesting that that as respondents' ages decrease, job frustration increases.

Overall, the above findings seem to correspond with a study conducted by Lewandowski (2003) in which the researcher concurs that certain organisational factors are more critical in explaining workplace frustration. Lewandowski, however, reports that none of the individual characteristics that were investigated in the study (e.g. age and gender) were related to job frustration. The findings of the present study highlight age as one of the responsible factors for workplace frustration. In other words, participants who perceived inadequate freedom on

the job had a lack of job clarity and low professional linkages, and being young were more likely to be frustrated by the job.

4 Conclusion

The study has analysed and discussed the findings concerning the relationship between respondents' perceptions of organisational structure and resource issues in the workplace and participants' self-reported reactions toward the job, especially frustration with the job. Using correlation analysis, the results highlight significant statistical associations between participants' opinions concerning organisational structure and resources that are related to job clarity, job autonomy, professional linkages and workload, and respondents' feelings of frustration with the job.

Using the above-mentioned set of identified variables (i.e. job clarity, job autonomy, professional linkages and workload), a regression analysis was performed to identify the most important predictors of job frustration, while controlling respondents' personal/professional variables. According to the findings, practitioners' job frustration can be determined by the extent to which they perceive clarity in the job and the extent to which they perceive adequate autonomy to carry out their roles. In other words, lack of clarity on the job and decreased job autonomy are responsible factors for increased job frustration among participants in this study. The results also highlight perceived professional linkages and respondents' age as strong predictors of job frustration. Alternatively, the weaker the professional linkages in the workplace and the younger the practitioner, the greater the chance for job frustration. The findings presented in this study are supported by previous work in the international literature. Professional linkages or connections in the workplace have also been documented in various studies as important predictors of job frustration (Yalli & Cooper, 2008). Age was also found, among other socio-demographic variables, to be related to burnout (Maslach and Leiter, 2009).

References

Acker, G. (2004). The effect of organizational conditions (role conflict, role ambiguity, opportunities for professional development, and social support) on job satisfaction and intention to leave among social workers in mental health care. *Community Mental Health Journal, 40*(1), 65-73.

Albrithen, A. (2013). Social work history and features of social security System: Saudi Arabia. In H. Soliman (ed.), Social work in the Middle East (pp. 95–109). New York, NY: Routledge.

Albrithen, A. (2019). "Health Care Social Work in Saudi Arabia. In R. Winnett; R. Furman; D. Epps and G. Lamphear (eds.), Health Care Social Work: A Global Perspective (pp. 162-172). New York: Oxford University Press.

Albrithen, A. & Yalli, N. (2011). "The Perceptions of the Personal and Professional Factors Influencing Social Workers in Saudi Hospitals: A Qualitative Analysis", Journal of Social Work in Health Care, 50(10), 845-862.

Albrithen, A. & Yalli, N. (2012). "The Perception of Organizational Issues of Social Work Practitioners in Saudi Hospitals", Journal of Social Service Research, 38(3), 273-291.

Allen, R., Lambert, E., Pasupuleti, S., Cluse-Tolar, T. and Ventura, L. (2004). The impact of job characteristics on social and human service workers. *Social Work & Society, 2*(2), 173.

Al-Qurni, M. (2003). Role ambiguity and role conflict influence on medical social work practice in Saudi Arabia (Unpublished report). Saudi Arabia: Umm Al-Qura University.

Babbie, E. R. (2020). *The practice of social research* (14th ed.). Boston: Cengage Learning.

Banks, S. (2012). *Ethics and values in social work* (4th ed.). Basingstoke: Red Globe Press.

Lait, J. & Wallace, J. E. (2002). Stress at work: A Study of organizational-professional conflict and unmet expectations. *Industrial Relations, 57*(3), 463-490.

Coulshed, V., Mullender, A., Jones, D. and Thompson, N. (2006). *Management in social work* (3rd ed.). New York: Palgrave Macmillan.

Davies, M. (2000). *The blackwell encyclopaedia of social work*. Oxford: Blackwell Publishing Ltd.

Dziegielewski, S. F. (2013). The changing face of health care practice: Opportunities and challenges for professional practice. New York: Springer.

Eby, M. (2000). The challenge of being accountable. In A. Brechin, H. Brown & M. Eby (Eds.), *Critical practice in health and social care*. London: Sage Publication.

Gossett, M. and Weinman, M. (2007). Evidence-based practice and social work: An illustration of the steps involved. *Health and Social Work, 32*(2), 147-150.

Howitt, D. and Cramer, D. (2005). *Introduction to SPSS in Psychology; for SPSS 10, 11, 12 and 13* (3rd ed.). London: Prentice Hall.

Huxley, P., Evans, S., Gately, C., Webber, M., Mears, A., Pajak, S., Kendall, T., Medina, J. and Katona, C. (2005). Stress and pressures in mental health social work: The worker speaks. *British Journal of Social Work, 35*(7), 1063-1079.

Masiriri, T. (2008). The effects of Managed Care on Social Work Mental Health Practice. *SPNA Review*, 4(1), 82-98.

Lewandowski, C. (2003). Organizational factors contributing to worker frustration: The precursor to burnout. *Journal of Sociology & Social Welfare, 30*(4), 175-185.

Lymbery, M. and Bulter, S. (2004). *Social work ideals and practice realties*. New York: Palgrave Macmillan.

Maslach, C. and Leiter, M. (2009). *The truth about burnout: How organizations cause personal stress and what to do about it.* (1st ed.). San Francisco: Jossey-Bass Publishers.

Maslach, C., Schaufeli, W. and Leiter, M. (2001). Job burnout. *Annual Review of Psychology, 52*, 297-422.

McLean, J. and Andrew, T. (2000). Commitment, satisfaction, stress and control among social services managers and social workers in the UK. *Administration in Social Work, 23*(3/4), 93-117.

McQueen, R. and Knussen, C. (2004). *Introduction to research methods and statistics in psychology*. (1st ed.). London: Pearson Education.

Monette, D. R., Sullivan, T. J. and DeJong, C. R. (2013). *Applied social research: Tool for the human services* (9th ed.). Boston, MA: Cengage Learning.

Neuman, N. (2003). The effect of organizational reengineering on job satisfaction for staff in hospital social work departments. *Social Work in Health Care, 36*(4), 16-33.

Reese, D. and Sontag, M. (2001). Successful interprofessional collaboration on the hospice. *Health & Social Work, 26*(3), 167-173.

Sabab, A., Dyab, A., Maimini, K. and Habeb, S. (2005). *Essentials of modern management*. Jeddah, Saudi Arabia: Khawarizm.

Saleh, A. (2002). *Social work and fields of practice*. Egypt: Darul-Ma'arefah Al Jamaih.

United States General Accounting Office (USAGO). (2003). *Child welfare: HHS could play a greater role in helping child welfare agencies recruit and retain staff.* Washington, DC: USAGO.

Vijay, V. (2003). *Social work in health care: An Indian perspective.* India: Department of Social Work, Bangalore University.

Wong, C., Chan, B. and Tam, V. (2000). Medical social work in Hong Kong hospitals: Expectation, authority Structure and role ambiguity. *International Social Work, 43*(4), 495-516.

Yalli, N. & Cooper, N. (2008). The perceptions of hospital social workers in Saudi Arabia regarding the organisational factors that impact on their role. *International Journal of Social Welfare*, (17), 247–250

Author´s Address:
Abdulaziz Albrithen
Professor of Social Work
United Arab Emirates University
College of Humanities & Social Sciences
Al Ain 15551, UAE
Phone: +971 3 7136493
Fax: +971 3 7134978
aziz88@hotmail.co.uk

Author´s Address:
Nadir A. Yalli, PhD
Assistant Professor
Department of Social Work
Umm Al-Qura University
Makkah, Saudi Arabia
Tel: +966125505388
Fax: +966125531006
nadiryalli@yahoo.com