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Experience of Burnout Among Psychiatric Hospital Staff

Cindy Cisneros
Walden University

Walden University

College of Psychology and Community Services

This is to certify that the doctoral dissertation by

Cindy J. Cisneros

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Review Committee
Dr. Susana Verdinelli, Committee Chairperson, Psychology Faculty
Dr. Lisa Scharff, Committee Member, Psychology Faculty
Dr. Alethea Baker, University Reviewer, Psychology Faculty

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Sue Subocz, Ph.D.

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Abstract

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MA, La Sierra University 2008

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Proposal Submitted in Partial Fulfillment

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Abstract

Negative experiences at work are common at inpatient psychiatric hospitals and can result in burnout. This is especially the case for psychiatric hospital staff, as they are commonly the first and most frequent line of contact for patients in acute psychiatric care. This study provided relevant insight into the factors that influence the experience of burnout among psychiatric hospital staff that care for patients in inpatient psychiatric hospitals. Research on how burnout affects psychiatric hospital staff apart from other medical professionals is not robust and lacking in qualitative analysis. The transactional model of stress and coping framework constituted the theoretical framework for this study. Through semi-structured interviews, 10 participants were able to elaborate on their unique experiences with burnout. Results of this study indicated participants experienced burnout at work, which resulted in symptoms of anxiety and depression and impacted their interpersonal and social relationships. They expressed that safety concerns related to patient aggression, excessive workload, unpredictability in daily work tasks, and an uncooperative workplace culture contributed to their experience of burnout. The results of this study have the potential to be used for positive social change in understanding the burnout experience among psychiatric hospital staff and increasing facility preparedness to address issues at work that contribute to burnout.

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Dedication

Psychiatric hospital staff were in mind at every point of this project. Their dedication to such an important and challenging profession shows their desire to make a difference. I hope this study can encourage them to know that their voices can be heard and that improvements are possible for their unique role in improving lives.

Acknowledgments

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Chapter 1: Introduction to the Study

Introduction

Burnout among staff working in psychiatric hospitals is a problem that has received widespread attention from empirical researchers (Sprang et al., 2019; Turgoose & Maddox, 2017). Some researchers have attempted to unearth the contributing factors that lead to burnout among healthcare providers to find evidence-based interventions to help deal with the problem (Sprang et al., 2019; Turgoose & Maddox, 2017). The works of these researchers have resulted in the discussion of various factors that could be categorized as work factors, personal characteristics factors, and organizational factors. For example, long working hours, excessive workloads, and frequent call duties (weekend or night calls) contributed to physician burnout, while personal factors included age, gender, and marital status (West, 2018).

An additional layer of stress observed at inpatient psychiatric hospitals is the negative patient-staff dynamics presented in the form of aggression, hostility, and assault (Giménez Lozano et al., 2021; Kelly et al., 2016). This is especially the case for psychiatric hospital staff as they are commonly the first and most frequent line of contact for acute psychiatric care patients (Jacobowitz, 2018). Psychiatric hospital staff refers to nursing auxiliaries who are responsible for patient safety, participation in daily activities, and therapeutic care (Kelly et al., 2015). According to the U.S. Bureau of Labor Statistics, psychiatric hospital staff experience seven times more the number of violent events than other occupations (Ezeobele, 2020). Exposure to a milieu with the potential for physical and verbal assault leaves psychiatric hospital staff vulnerable to burnout

(Giménez Lozano et al., 2021). Research on the burnout experienced by mental health staff at inpatient psychiatric units has rarely included the experience of psychiatric hospital staff. Still, outcomes and implications from these studies are implied to impact individuals in the unique psychiatric hospital staff role (Aguglia et al., 2020; Ezeobele et al., 2020; Hensel et al., 2015).

This chapter explores an in-depth understanding of psychiatric hospital workers in the acute setting, identifies the problem that was investigated, and discusses this study's purpose as well as the research questions. This chapter also presents the theoretical framework that helps to explain the burnout phenomenon and the nature of burnout as a construct. Terms used in this study are defined in addition to its assumptions, scope, limitations, and delimitations. These topics elucidate the significance of this study for the purpose of optimal social change for psychiatric hospital staff who experience burnout.

Background

Researchers have addressed environmental factors that may contribute to burnout among mental health professionals. Such factors include inpatient aggression (Hunsaker et al., 2015; Ridenour, et al., 2015), lack of management support (Hamid et al., 2017), lack of support from other staff members (Giménez Lozano et al., 2021), coping with work challenges (Schadenhofer et al., 2018), and demographic ones such as years of experience in the mental health field (Giménez Lozano et al., 2021). However, the samples in these predictive studies did not include psychiatric hospital staff. The degree to which psychiatric hospital staff experience burnout should also be considered, due to

their critical role as the patient's initial, more direct and frequent line of contact at the hospital (Jacobowitz, 2018).

A patient recovering at an acute psychiatric unit receives services and directives from a multi-disciplinary team, of which psychiatric hospital staff is just one (Ezeobele, 2020). Typically, patients encounter direct contact with a psychiatrist, case manager, nursing, and psychiatric hospital staff. On some occasions, a patient will receive auxiliary treatments such as art, recreation, or vocational rehab (O'Conner et al., 2018). The environmental factors that psychiatric hospital staff face at inpatient hospital units are different from other disciplines. The psychiatric hospital staff is at the bottom of the psychiatric unit hierarchy regarding pay and education level and have the responsibility of maintaining a therapeutic environment for the serious mentally ill (Ezeobele, 2020). All these factors place them in an increased exposure to negative reactions from patients. Psychiatrists and case managers are not required to monitor the safety and daily routine of patients but instead rely on the psychiatric hospital staff to observe, respond, and report patient behavior. While the role of the psychiatric hospital staff is integral to patient treatment, it comes at an increased risk for burnout (Ezeobele, 2020). Research on burnout experienced by mental health staff at inpatient psychiatric units has rarely included the experience of psychiatric hospital staff independent from other roles in the hospital setting (Aguglia et al., 2020; Ezeobele et al., 2020; Hensel et al., 2015).

Problem Statement

Negative patient-staff dynamics in the form of aggression, hostility, and assault are commonly experienced at inpatient psychiatric hospitals (Aguglia, 2020; Kelly et al.,

2021). This is especially the case for psychiatric hospital staff, as they are commonly the first and most frequent line of contact for acute psychiatric care patients (Jacobowitz, 2018). These and other factors have been attributed to the increase in burnout symptoms (Ezeobele, 2020). The term "psychiatric hospital staff" refers to nursing auxiliaries who are responsible for patient safety, participation in daily activities, and therapeutic care (Giménez Lozano et al., 2021; Kelly et al., 2015). According to the U.S. Bureau of Labor Statistics, psychiatric hospital staff experiences seven times the number of violent events compared to other occupations (Ezeobele, 2020). Violence by patients is the number one cause for injury and illness and psychiatric hospital staff are 38 times more likely to be harmed in this way than the national average (Bureau of Labor Statistics, 2015). Exposure to a milieu with the potential for physical and verbal assault leaves psychiatric hospital staff vulnerable to burnout (Kelly et al., 2021; Turgoose & Maddox, 2017). Burnout is defined as an employee's response to job demands, such as an inability to access resources proportionate to the stress that they experience (Maslach et al., 2001; Pines & Maslach, 1978). Burnout can lead to emotional exhaustion, depersonalization, and lack of perceived personal accomplishment (Maslach et al., 1996).

Factors that may contribute to burnout among mental health professionals have been found in academic studies. These include inpatient aggression (Aguglia, 2020; Hunsaker et al., 2015; Ridenour et al., 2015), poor support from peers in the workplace (Gimenez Lozano et al., 2021), a lack of support from managerial staff (Hamid et al., 2017), and work challenges that exceed coping behavior (Schadenhofer et al., 2018). Demographic factors have also been identified, such as years of experience in the mental

health field (Gimenez Lozano et al., 2021). These findings did not isolate the effects of burnout among psychiatric hospital staff. The experience and its result of burnout among psychiatric hospital staff is critical to the literature, due to the critical role of this position as the patient's initial, direct, and most frequent line of contact at the hospital (Jacobwitz, 2018).

Psychiatric hospital staff is part of a multi-disciplinary team established to support the recovery of patients hospitalized for psychiatric care (O'Conner et al., 2018). Support professionals include psychiatrists, case managers, nurses, psychiatric hospital staff and often rehabilitation staff in the areas of art, vocation, and recreation (O'Conner et al., 2018). The psychiatric hospital staff position is unique, as it is the bottom of the hospital unit hierarchy regarding pay and education. All the while, the job expectations are high, requiring regulation of the milieu to be therapeutic and supportive for the serious mentally ill (Ezeobele, 2020). Such qualifiers and expectations place psychiatric hospital staff at increased risk for exposure to negative reactions from patients in the recovery process, and for burnout as a result.

Research on burnout in inpatient hospital units has rarely looked at this setting's impact on psychiatric hospital staff in particular. The scholarly presence of burnout on this profession is even more scant in qualitative studies. This is why a study is long overdue to examine burnout factors as are experienced by psychiatric hospital staff.

Purpose of the Study

The purpose of this descriptive qualitative study was to explore how psychiatric hospital staff working at inpatient psychiatric units describe experiences of burnout and

what factors they identify as contributing to burnout in the acute hospital setting. Ten staff members who have experienced burnout were interviewed using a semi-structured interview to explore the lived experience of this phenomenon.

Research on the burnout experienced by mental health staff at inpatient psychiatric units has rarely included the experience of psychiatric hospital staff alone. It would be remiss to assume that effects of burnout are experienced by psychiatric hospital staff in the same way as other mental health professionals. There is a need to explore how mental health staff at inpatient psychiatric setting experience burnout and what sources they identify as contributing to their burnout (Aguglia et al., 2020; Ezeobele et al., 2020; Hensel et al., 2015), and this is especially true for psychiatric hospital staff.

Research Question

The following questions guided this study:

Qualitative – RQ1. How do psychiatric hospital staff working at inpatient psychiatric units describe experiences of burnout?

Qualitative – RQ2. What factors do psychiatric hospital staff working at inpatient psychiatric units identify as contributing to burnout?

Theoretical Framework

The theoretical framework for this study was based on the transactional model of stress and coping (Lazarus & Folkman, 1987). This model provided a useful framework to explore occupational burnout. Evidence of burnout can be observed by emotional detachment from the job, feeling exhausted, and feeling a lack of personal accomplishment (Maslach & Jackson, 1982; Maslach & Leiter, 1997). The

transactional model of stress and coping explains burnout as a process between an individual and their environment (Lazarus & Folkman, 1987). This theory assumes that a person has resources to cope with environmental demands. People assess an environmental demand and whether they can cope with it. If the demand exceeds their coping resources, then stress emerges and increases. The transactional model of stress and coping was previously used to assess psychiatric hospital staff and perceived stressful events (Aulsbrook, 2021; Nevill, 2019). This theory applies to this study, as psychiatric hospital staff are likely to use the appraisal processes and coping when confronted with stressful events. This theoretical framework was also used to guide the development of the semi-structured interview guide in part. It was also used to compare the codes and themes that emerged. Coping with stress was also addressed by participants in this study. Chapter 2 will show in detail how this theory presents the different ways a person copes, which also made it a perfect framework for this study.

Nature of the Study

Interpretative phenomenological approach (IPA) was used as the research design in this study (Smith et al., 2009). The IPA approach aims to explore and understand the participants' lived experiences related to the construct of study. For the intents of this research, the core phenomena examined was the experience of burnout among mental health staff working at inpatient psychiatric units. The IPA approach enabled me to identify patterns and the essence of the responses, and to determine common themes that emerged among participants (Irarrazavel, 2020; Larkin & Thompson, 2012; Tomaszewski et al., 2020).

Definitions

Burnout: The term burnout is defined as an outcome from a person's evaluation of an external stressor and their inability to cope with it (Maslach & Leiter, 2016; Pines & Maslach, 1978). Burnout often presents with diminished personal accomplishment, depersonalization with the job role and purpose, and emotional exhaustion (Maslach & Jackson, 1982). For this study, the term burnout refers to occupational burnout, or stimuli that are associated with perceived stressors in a workplace environment (Villarreal-Zegarra et al., 2021). Early workplace burnout was identified and analyzed by Karasek (1979) where stressors result from the degree to which a person has high demands placed on them at work and whether they were able to contribute to their job role (Baillien et al., 2011). The job demand control model can be compared to the accepted understanding of the occupational burnout phenomenon today, which is defined as an employee's response to job demands such as an inability to access resources proportionate to the work stress that they experience (Maslach & Leiter, 2016). For the purpose of this study, I used the term *burnout* when implying occupational burnout and specified settings for burnout when reporting on other literature.

Psychiatric hospital staff: Psychiatric hospital staff refers to nursing auxiliaries who are responsible for patient safety, participation in daily activities, and direct therapeutic care (Giménez Lozano et al., 2021; Kelly et al., 2015). The psychiatric hospital staff is at the bottom of the psychiatric unit hierarchy when it comes down to pay and education, while having a high expectation of maintaining a therapeutic environment

for the serious mentally ill (Ezeobele, 2020). Such qualifiers place them in an increased exposure to high demand events at work including negative responses from patients.

This main term was used interchangeably for different situations. The term *psychiatric hospital staff* was used when reporting on the existing literature on burnout, since this is the most encompassing terms used to describe this population in the literature. *Mental health staff* was used interchangeably with psychiatric hospital staff in the interview questions and when describing results from the interview, since it is used in the general vernacular. The term *mental health technician* (MHT) was also used interchangeably with psychiatric hospital staff when referring to the job role given by the hospitals that employ the participants. This explains why this term is used on the recruitment flyers.

Stress: Stress is defined as an interaction between an external stimulus and internal response to it (Biggs et al., 2017; Fletcher et al., 2008). This transaction focuses less on the stimulus vs the response and more on the interaction that occurs, which Lazarus and Folkman coined as appraisal (Biggs et al., 2017). An appraisal is a person's evaluation of the environment, a process of transaction between the person's internal response to perceived stimulus (Biggs et al., 2017). The term stress is a part of the burnout phenomenon because appraisals determine the likelihood of burnout as it evaluates the importance of stressor and individual resources to cope (Biggs et al., 2017).

Assumptions

It was assumed that psychiatric hospital staff that volunteered to be interviewed were forthcoming with their perceptions and thoughts. It was assumed that they

understood the questions that were asked and were able to communicate understandably so that their responses can be transcribed into the study. It was also assumed that participants understood burnout as a construct as it is conceived and defined in this study. Finally, it was assumed that participants may experience certain degrees of reticence or embarrassment in discussing their experiences. I maintained a professional stance and reassured them that I come from a nonjudgmental position.

Scope

Participants for this study were psychiatric hospital staff selected from two psychiatric hospitals located in Ohio and Nebraska. This research study focused on understanding their experience with burnout at work. Other factors were not the intentional focus of this study such as sources of stress in their personal lives, their current living situations from their personal sources of stress or support in their lives, or their current living situations. Although these factors are relevant to understand stress that could contribute to burnout at work, they were not the focus of this study. This study excluded other hospital staff who are not in psychiatric services or who have other roles within the hospital.

Limitations and Delimitations

While it is assumed that individuals provided honest responses to the questions on the interview, it is plausible that respondents altered their responses in favor of more socially acceptable answers. Therefore, I could only examine answers as their accurate and valid for the purpose of recording data.

The nature of the study was phenomenological and was limited to the collection of narrative data of lived experiences. This study's sample size was small but was still rich and detailed. I did not collect data for quantitative analysis, which requires large sample sizes and operationalized constructs that can be generalized to larger populations of individuals, which is a limitation of the study design.

The exposure that each participant has accumulated in their lifetime may have influenced responses in ways that were unidentified and/or unidentifiable by the researcher. In addition, the participants experienced burnout in the psychiatric setting, but may not account for burnout experienced if they were at a different psychiatric hospital. The participants were assumed to have worked continuously at the same location where they experienced burnout. Staff who continue to work in the same setting where burnout was experienced but who currently hold positions other than psychiatric hospital staff were not included in this study. This was to preclude confounding experiences of burnout as a psychiatric hospital staff compared to burnout in another hospital position.

This study was limited geographically, as all participants who were interviewed in this investigation were in two specific urban areas in the United States. All participants also spoke and understood English well enough to participate in the research. No multilingual interpretation options were offered.

Significance of the Study

This study provided important insight into the factors that influence the experience of burnout among psychiatric hospital staff that care for patients at inpatient psychiatric hospitals. Findings from this study have the potential to inform psychiatric

facilities about factors that contribute to burnout in this population. Organizational quality improvement may also benefit from this study since manager and peer support were shown to affect burnout among psychiatric hospital staff.

Burnout in the hospital setting impacts the lives of professionals as well as patients (Aguglia, 2020). Understanding burnout from those providing front line care give the learning community potential to impact patients for the better. Psychiatric hospital staff like any other mental health workers should be able to interact with patients without an increased likelihood of experiencing burnout. However, the literature demonstrates that psychiatric hospital staff are exposed to patient aggression more than other mental health workers (Aguglia, 2020; Bureau of Labor Statistics, 2015). Since patient aggression affects burnout, it can serve as an impetus for organizational action, since staff burnout contradicts the goal of improving treatment outcome (Aguglia, 2020; Giménez Lozano et al., 2021; Kelly et al., 2015).

This study explored from a qualitative in-depth approach how psychiatric hospital staff experience burnout. The results of this study can inspire social change by suggesting organizational changes that may reduce burnout. This would clearly impact psychiatric hospital staff in a positive manner, translating into better quality relationships with patients and less staff turnover for the organizations that train and employ them.

Summary

This chapter introduced the phenomenon of burnout and provided background on the problem of burnout in the acute hospital setting, which supports the purpose of this study in the population of psychiatric hospital staff. The research questions and the

theoretical framework of this study were detailed as well as the nature of the study and the terms used within to support further discussion in Chapter 2. This chapter also addressed the assumptions, scope, limitations, and delimitations of this study as well as its significance for social change.

Chapter 2: Literature Review

Introduction

Negative patient-staff dynamics in the form of aggression, hostility, and assault are commonly experienced at inpatient psychiatric hospitals (Auguglia, 2020; Kelly et al., 2021). This is especially the case for psychiatric hospital staff as they are commonly the first and most frequent line of contact for acute psychiatric care patients (Jacobowitz, 2018). Psychiatric hospital staff experience seven times the number of violent events compared to other occupations (Ezeobele, 2020). Exposure to a milieu with the potential for physical and verbal assault leaves psychiatric hospital staff vulnerable to burnout (Kelly et al., 2016; Turgoose & Maddox, 2017). Burnout is defined as an employee's response to job demands, such as an inability to access resources proportionate to the stress that they experience (Maslach & Leiter, 2016; Pines & Maslach, 1978). Burnout can lead to emotional exhaustion, depersonalization, and lack of perceived personal accomplishment (Maslach et al., 1996).

Factors that predict burnout in psychiatric health providers include inpatient aggression (Hunsaker et al., 2015; Ridenour, et al., 2015), lack of management support (Hamid et al., 2017), lack of support from other staff members (Kelly et al., 2015), not coping with work related challenges (Schadenhofer, et al., 2018), and demographic factors such as years of experience in the mental health field (Kelly et al., 2015). However, the samples that were recruited for studies focused on burnout factors in psychiatric providers did not include psychiatric hospital staff. The factors that lead to burnout among psychiatric hospital staff should also be explored given their critical role

as the patient's initial, more direct and frequent line of contact at the hospital (Jacobowitz, 2018).

In this chapter, the literature review search strategy that was used to examine the existing literature is presented. Then, the theoretical framework used in this study, the transactional model of stress, is discussed. Finally, a synopsis of the current literature related to factors associated to burnout, with a focus on how they relate to psychiatric hospital staff, is presented. Overall, this literature review establishes the need for additional research concerning factors that influence burnout among psychiatric hospital staff (Greenwood & Braham, 2018; Jacobowitz, 2018; Kerr et al., 2017).

Literature Search Strategy

I employed a search of many different sources and topics to yield an inclusive and thorough acknowledgement of the literature on this topic. Specific psychological and educational databases used included PsycINFO, PsycARTICLES, SAGE psychology database, and Education Resources Information Center (ERIC). Literature that was reviewed included peer-reviewed articles, early publications, and just one dissertation that were scanned into PDF format. The use of Google Scholar supplemented this search. The extensive search in the databases revealed that most articles that presented evidence for burnout in mental health settings did not focus on psychiatric hospital staff. It was important to identify the literature terminology on burnout that consisted of direct care staff that work in the psychiatric hospital setting. To find studies specific to these variables, the literature on burnout that was found from the databases was reviewed for terms associated with these variables. Once the

terminology was identified, a new search was performed using terms acute hospital setting and psychiatric hospital staff.

The search criteria used included the main construct of *burnout* and other related topics and constructs such as *inpatient, acute, hospital staff, stressors, transactional model of stress, coping, psychiatric, hospital, factors*, as well as many combinations of these terms. When a prominent article was found but outdated, a Google Scholar search for other peer reviewed articles that referenced the hallmark article since 2018 was conducted to see if another article was available in full text and whether it showed more recent or remarkable findings. Reference lists within chosen articles were also used to identify current findings and foundational literature.

Theoretical Framework

The theoretical basis that guided this study was the transactional model of stress and coping (Lazarus & Folkman, 1987). This model served as the lens to explore burnout. In simple terms, feelings and behaviors have a direct effect on bodies and minds. Anger, fear, and other difficult emotions associated with healthcare providers' stress and burnout could be explained well by the transactional model of stress and coping.

Lazarus and Folkman (1984) first introduced the stress adaptation model as they attempted to understand all the components associated with the experience of a stressful situation. Lazarus was influenced by stressful situations he experienced in his life and determined that stress involves an encounter (transaction) between the external environment and an individual. He contended that a stress response depends on a

person's interpretation of the stressor and their ability to cope with it (Lazarus & Folkman, 1984).

Major Tenets

The transactional model of stress and coping (Lazarus & Folkman, 1984) is a widely applied theoretical framework used to understand burnout (Biggs et al., 2017). The major tenets of this model involve the meaning a person gives to an event and their perceived ability to cope with it. An environmental event is considered a stressor when it negatively impacts an individual's wellbeing. Central to this theory is the appraisal process, which is three-fold. The first appraisal occurs by the individual assessing whether an event is perceived as a stressor. If so, the second appraisal occurs when the individual determines whether they can circumvent the stressor using personal resources, such as coping. A person's ability to cope can present physiologically and psychologically (Bodenmann et al., 2016). If the individual does not have the resources to manage the stressor, then burnout may result from the experience (Gonçalves et al., 2019). The final appraisal occurs after the coping resources have been determined (Goh et al., 2010). This interaction represents a transaction between a person's perception of their experience and their resulting behavior (Lazarus & Folkman, 1984). In many cases, positive stress is something that many people respond to with coping skills. However, when an individual assesses the stressor and determines that it is difficult to cope with the situation, then the model recommends adopting interventions that could prevent stress from developing to a deeper psychiatric problem (Lazarus & Folkman, 1987). Personal history of responding to stress influences later responses to similar

stressful factors. As an example, the history of stressful college life will make an individual susceptible or may predispose the individual to a stressor such as burnout in career endeavors if it reflects the past stressor in college. If the student developed successful coping strategies such as mindfulness and compassion formation skills, the student may be better guarded from burnout later in life as compared with an individual without a history of stressful college life (Koropets et al., 2020).

Appraisal

Appraisal is one of the key terms used frequently in the model, and this entails a person's interpretation of stressors and their ability to cope with them (Lazarus & Folkman, 1984). Applying different appraisal methods to the same stressor (in this case, burnout) results in varying stress response. The model advances the idea that when there is a balance between a person’s appraisal and the demands of the situation as well as their estimation of their ability to meet those demands, they will experience a positive stress response (Lazarus & Folkman, 1984). For instance, a nurse could balance their assessment of stressors in the workplace with the demands of the situation (such as when there is a surge in the number of patients such as the case with the COVID-19 pandemic) and their estimation with their ability to meet those demands to successfully respond to the stress.

It is also worth noting that appraisal is not a conscious process, but a highly personal and subjective activity that depends on one's ability to cope with stressors (Lazarus & Folkman, 1984). Hence, to reduce burnout among their staff, human resource departments need to conduct personalized assessments to determine the individual needs

of their staff. Some providers may experience burnouts due to work violence, while others may attribute difficulties in work-life balance as the source of their burnout (De Oliveira et al., 2019).

There are two types of appraisals, primary and secondary appraisal (re-appraisal). Honey et al. (2016) discussed the various types of appraisals that clients may use. In primary appraisal, clients are advised to evaluate or "judge" the significance of the situation (Honey et al., 2016). Therefore, when a healthcare provider encounters a challenging situation during their operations, they may ask questions such as "Am I in trouble?" or "Is there something that I have to deal with?" The outcomes of primary appraisal might be irrelevant, stressful, or benign-positive (Honey et al., 2016). If the response is irrelevant, then there is no need to worry about the worrying situation. If the outcome is benign-positive, that is also not a stressful situation. However, if the appraisal determines the situation is stressful, then there is a need for additional appraisals (Honey et al., 2016).

Those additional responses could come in three forms: harm/loss, threat, or challenge. If the additional appraisal is harmless, then there is a need to determine what is lost already (such as productivity, happiness; Honey et al., 2016). If it is a threat, the focus of the assessment is determining what type of harm or loss could occur in the future (such as loss of enthusiasm in the job, medical errors). Finally, if the additional appraisal is a challenge, then one should assess the potential growth from the situation (Honey et al., 2016).

Secondary appraisal entails evaluating the resources and coping options that was useful when offsetting the stressful situation (Honey et al., 2016). These resources and coping options might be internal (such as the desire to gain promotion in the workplace or be rewarded for exemplary service in the workplace) or external (such as access to additional vacation options or increase in salary/compensation terms). Re-appraisal, on the other hand, involves reconsidering the additional resources that could further improve the situation (Honey et al., 2016). The main activity during the re-appraisal phase is examining the current situation while considering the available coping resources. Additionally, re-appraisal involves assessing the coping resources while considering the reappraised threat (Honey et al., 2016). For example, healthcare providers may re-assess factors such as availability of better working conditions or the need to hire a house help at home to ensure work-life balance, or any other additional resources that could help them deal with burnout.

Coping

The transactional model of stress also focuses on the concept of coping. The basic idea here is that when one fails to escape a stress response, they engage in further learning on how they could effectively cope (Lazarus & Folkman, 1984). For some stressors such as burnout, the appraisal applied may either make it an acute stressor or a chronic stressor. In this case, burnout has the potential to become chronic stress, but when a healthcare provider fails to escape the situation, they should learn how to cope with it effectively. Coping is the process of constantly changing the behavioral and

cognitive efforts to manage specific external and internal stressors that are appraised as exceeding the capabilities and resources of a person (Lazarus & Folkman, 1984).

Cooper and Quick (2017) identified two viable coping strategies that could help people facing a stressful situation: problem-focused coping and emotion-focused coping. Emotion-focused coping is useful for chronic stressors, where there is little to be done to alter the stress levels. Typically, emotion-focused coping involves behavioral or cognitive responses to emotions resulting from stress (Cooper & Quick, 2017). Avoidance is another emotion-focused coping strategy but is considered problematic, especially when it prevents effective behavioral responses. For example, one way that may help reduce the effects of burnout is to avoid implementing the duties and responsibilities of a healthcare professional in a psychiatric setting; this is problematic since it is going to make the stressor worse.

Several strategies could be beneficial when using emotion-based coping. For instance, engaging in positive emotions could be useful in dealing with stressors such as burnout. Positive emotions involve finding the positive amid negative, and people that engage in this tend to be more optimistic (Cooper & Quick, 2017). Finding benefits or meaning in something is another emotion-focused coping. Here, the people affected by a stressor such as burnout may find a way to transform the stressor into a lesson that could help them grow or mature, such as considering excessive workload to increase experience in undertaking their assigned roles and responsibilities (Cooper & Quick, 2017). Post-traumatic growth is cited in academic literature as a useful emotional coping strategy for people who have post-traumatic stress disorder (PTSD). After people experience a

difficult stressor that resulted in PTSD, they are encouraged to go back to those events and realize how they have grown importantly, resulting in clients seeing some positive in that experience (Cooper & Quick, 2017).

Engaging in an emotional approach is another effective emotion-focused coping strategy whereby instead of avoiding or suppressing the emotions, one is encouraged to express those emotions (Cooper & Quick, 2017). For example, a physician facing burnout may be encouraged to cry or express some emotion instead of suppressing the need to cry. Finally, accommodating the stressor is another coping strategy and entails accepting the reality and incorporating it into the identity and lifestyle (Cooper & Quick, 2017). Healthcare workers need to accept that their occupations are demanding and stressful and incorporate that fact into their job identity.

Problem-focused coping, on the other hand, seeks to deal with the stressors head-on (Cooper & Quick, 2017). For example, healthcare providers facing burnout may be encouraged to seek assistance or solicit help from experts, seek out information and more education, use logic or reason to avoid over exaggerating the stressor, engage in problem-solving activities to make a plan of action, and act on steps that could be taken to reduce burnout.

Prior Application of the Transactional Model of Stress Theory

This theory has been applied to burnout studies in occupational settings. Brough et al. (2018) assessed two types (cognitive and emotional) of job demands among police service workers using the transactional model of stress and coping. They found coping styles (accommodation and avoidance) assisted in the job demands and appraisal

outcome over time. Similarly, a cross-sectional survey of nurses in China assessed their job performance considering their coping strategies alongside their work stress. Li et al. (2017) found that positive coping strategies decreased negative effects of work stress, while negative coping strategies increased the negative effects of work stress. Caponnetto et al. (2018) also used the transactional model of stress and coping to assess the effect of a stress management training intervention among healthcare workers in the high-stress emergency room setting where organizational factors were shown to be a strong influence on burnout. Results showed that this intervention was successful among emergency room staff with a decrease in emotional exhaustion and depersonalization subscales of the Maslach burnout inventory (Coponnetto et al., 2018; Maslach et al., 1996).

Several other studies have utilized the transactional model of stress to define how people could handle stress. Gerich and Weber (2020) used the model to confirm that stressful situations such as stigmatization and discrimination could be reduced if people build social support groups and connect with other individuals or groups. Conversely, Mazloomy and Mohammadi (2014) applied the model to determine that stress could be reduced if people engage in exercise and develop a healthy lifestyle. Hocking and Lochman (2015) applied the model in the study to confirm that stressful situations could be offset by finding environments with less stress and preparing for anticipated stress. Overall, this theory permits us to better understand and predict the various responses that people show when encountering stressful situations (Lazarus & Folkman, 1984).

Relevance of the Transactional Model of Stress to the Current Research

The transactional model of stress was used to explore burnout experiences among psychiatric hospital staff. Studies within the past forty years have relied on theories to explain burnout (Lazarus & Folkman, 1987; Maslach & Leiter, 2016) and the past decades have seen an increase in utilizing sustained theories to examine burnout in the human services workplace The transactional model of stress has been used to understand burnout as it occurs in domains that range from the individual to society at large (Maslach et al., 2001).

The burnout phenomenon was acknowledged in the 1970's when burnout began to be observed as a common occurrence. Identifying a theoretical framework to apply to this newly recognized phenomenon did not occur quickly. As the burnout phenomenon gained attention by practitioners in the early 1980's, the scientific community was slow to accept burnout as a construct to study using established theoretical frameworks. This is evidenced by a lack of applying foundational psychological theory to explain burnout; and thus, the lack of published articles concerning burnout, even with practitioners writing thousands of articles on the prevalence and consequences of burnout on individual and societal scales (Cox & Griffiths, 1998). The lack of this early recognition of burnout within the social scientific community caused theorists to adopt different concepts from psychological theories, but lacked a comprehensive, foundational theory.

In the early 80's Maslach & Jackson (1981) first developed a widely accepted instrument that identified three symptoms of burnout: emotional detachment from the

job, feeling exhausted, and feeling a lack of personal accomplishment (Maslach & Leiter, 2016). Lazarus & Folkman (1984) added to the growing literature of burnout with a more dynamic explanation for burnout, and later adding the concept of coping as part of the transaction. According to the transactional model to explain burnout, it occurs when the environmental stressors exceed a person's capacity to cope (Biggs et al, 2017). This theory identifies the concept of stress as it relates to psychiatric hospital staff and perceived stressful events (Aulsbrook, 2021; Nevill, 2019). In the same way, this theory applies to this study as psychiatric hospital staff are likely to use the appraisal processes and coping when confronted with stressful events. Hence, the transactional model of stress is an adequate theory to examine the factors that may contribute to their burnout experience (Maslach & Leiter, 2016; Nevill, 2019).

Literature Review Related to Key Concepts

Key concepts that contribute to the understanding of burnout among psychiatric hospital staff include factors related to the experience of burnout and the outcomes of such experiences. The key terms that are described below explore central areas of focus across the experience of burnout for psychiatric hospital staff.

Factors Related to Burnout of Psychiatric Hospital Staff

Various factors have been linked to burnout including work and personal characteristics factors. Regarding work factors, West et al. (2018) confirmed that long working hours, excessive workloads, frequent call duties (weekend or night calls), specialty choice, clinical methods used to deal with the illness of clients, and risk of malpractice suits contribute to burnout. A 2014 survey that collected views from

physicians working across all specialties including psychiatric care found out that doctors that use computerized physician order entry (CPOE) and Electronic Health Records (EHRs) were susceptible to the risk of professional exhaustion and were less satisfied with the additional responsibility of clerical work (Shanafelt et al., 2016). Wright and Katz (2018) suggest that for every 60 minutes that a physician spends on patient interaction, the doctor has an extra one to two hours of ordering tests, finishing progress notes, revising test results, and prescribing medications without extra compensation (Wright & Katz, 2018).

Personal characteristics were also identified as contributing to burnout among healthcare providers working across all fields. Shanafelt et al. (2016) identified several personal factors that have a causal relationship with burnout, and this includes engaging in unhelpful coping strategies, being self-critical, over-commitment, sleep deprivation, idealism, perfectionism, inadequate support system outside the work environment (such as having no children, or spouse), and work-life imbalance.

Assault

Patient assault has widely been mentioned in academic publications as a workplace factor that indirectly contribute to burnout of staff working in psychiatric centers (Aguglia, 2020; Gimenez Lozano et al., 2021). For instance, Sun et al. (2017) noted that some staff in psychiatric hospitals experience assault from a patient whose outcomes could include unsuccessful attempts, minor injuries, severe injuries, or death. The disruptions caused by these assaults, as noted by the authors, force healthcare providers to spend more time attending to their patients without additional compensation

(Sun et al., 2017). In the same way, Spector et al. (2014) conducted an international quantitative review of violence experienced by nurses working in psychiatric centers. The findings of the review showed that 55% of these nurses experienced physical assault and were more likely to experience violence as compared to their male counterparts (Spector, et al., 2014).

The role of assaults in increasing burnout among staff in psychiatric settings was examined by Golonka et al. (2019) who noted that providers that experience aggression activate their psychophysiological mechanisms in response to stressors. Some of these mechanisms include high heart rate, high blood pressure, and increases in salivary cortisol and plasma catecholamine, all of which increases tiredness and burnout. Parent-Lamarche et al. (2018) assessed stress reactivity in the workplace and whether personality traits related to salivary cortisol secretion dysregulation effect. They found that cortisol secretion was negatively associated with burnout, while certain personality traits and work conditions showed a significant effect on emotional exhaustion, which, in turn, revealed direct implications for burnout (Parent-Lamarche, et al., 2018).

Demographic and Personal Factors

Variations in age, experience, gender, and job role have been identified as contributing to burnout (Gimenez Lozano et al., 2021). For example, Shanafelt et al. (2016) confirmed that older healthcare providers are less likely to experience burnout as compared to younger colleagues. The onset of burnout based on age may be as early as residency training (Shanafelt et al., 2016). The same findings were replicated in a study by Pantenburg et al. (2016) which confirmed that majority of young physicians often

experience emotional exhaustion as they are still new in the industry and may desire to leave clinical practice and wish to look for other opportunities somewhere (Pantenburg et al., 2016). Further, the study conjectured that young physicians had not experienced superior personal accomplishments as compared to their older colleagues; hence they may experience emotional exhaustion associated with the wish to leave the clinical practice (Pantenburg et al., 2016).

Additionally, West et al., (2018) confirmed that younger physicians working across specialties are highly vulnerable to burnout symptoms, especially those less than 55 years old. Interestingly, the study noted that having a child less than 21 years old is among the personal factors that contribute to burnout by 54% while having a spouse that is not working in the healthcare industry increases burnout risk by 23% among providers working across all specialties (West et al., 2018).

Several authors have also considered the gender of healthcare providers as a predicting factor for burnout. West et al. (2018) noted that there are higher rates of burnout in female physicians and postulated that this may be why the suicide rate among female physicians is 130% higher than women in the general population. McMurray et al., (2000) refuted claims that gender is not a consistent independent predictor of burnout. Still, after adjusting the age factor, it was confirmed that female physicians have a 20-60% chance of burnout. A Norwegian study attempted to decipher the reasons as to why female physicians have high odds of burnout as compared to their male counterparts (Langballe et al., 2017). These researchers were intrigued to find out that women are

susceptible to burnout because of higher disengagements with their male colleagues in the workplace and work-home conflicts.

Kinslow et al. (2020) found that female physicians were more than four times as likely to report burnout symptoms and more than 2.5 times as likely when controlling for demographics like race, age, work hours, etc. Dyrbye et al., (2017) echoed other researchers that conjecture that gender is not an independent predictor of burnout, but after adjustments of other factors such as socioeconomic status, work-life balance, and age, female physicians across all specialties have a 20%-60% increased chances of burnout as compared to men. Houkes et al., (2011) confirmed that the reasons as to why female physicians are highly likely to experience burnout are because of depersonalization and emotional exhaustion whereby these female doctors feel the need to expand their skills and find opportunities in other interesting fields.

Harassment has also been mentioned as a leading cause of burnout among female physicians (Mathews et al., 2019). According to Mathews et al. (2019), sexual harassment in healthcare settings explained why female physicians were more likely to report having suicidal thoughts. Altogether, increased mistreatment in the job serves as evidence that the majority of female doctors experience fatigue in the workplace as compared to their male counterparts (Mathews et al., 2019).

A discussion paper published by the National Academy of Medicine authored by Templeton et al. (2019) reviewed the various issues faced by women physicians and whether these issues lead to burnout. The authors acknowledged the fact that institutional, individual, and societal risk factors associated with burnout differ for men and women

healthcare providers (Templeton et al., 2019). According to these authors, responsibilities at home are a major cause of burnout among female healthcare providers since women are more likely to perform most of the work within the home, resulting in fewer opportunities for self-care and increased time pressures (Templeton et al., 2019). Additionally, the authors noted that gender discrimination contributes to burnout, especially among employees from ethnic minorities like African Americans (Templeton et al., 2019). Sources of discrimination, as stated by the authors, include administrators, other healthcare providers (physicians, nurses, pharmacists), and patients. Most of this discrimination is implicit in nature, meaning that the sources discriminate against female physicians unknowingly, leaving victims feeling disenfranchised and marginalized, adversely impacting their career advancement and self-confidence (Templeton et al., 2019).

Kerr et al. (2021) had mixed concurence with the works of authors' findings on gender differences and the relationship with burnout. In the psychiatric hospital setting, gender roles were found to be a factor in burnout symptoms, but not on the mental health and allostatic load among professionals (Kerr et al., 2021). Similarly, gender studies among the general population found significantly less depressive symptoms in person who idenfify as androgynous, while identifying as undifferentiated leads to depression susceptibility (Lin et al., 2021).

Organizational

Risk factors for burnout have been categorized as organizational, such as social supports, authoritarian leadership style, poor autonomy, poor working conditions, and

working many hours in one day (Gimenez Lozano et al., 2021). Academic researchers have also cited organizational factors as a major cause of burnout among healthcare providers working across all specialties. The use of certain eectronic medical records documentation by healthcare organizations, as posited by Chen et al. (2019), causes burnout among healthcare providers. Healthcare providers that use electronic documentation often document longer notes and spend more time analyzing these documents, which contributes to burnout (Chen et al., 2019). Melnick et al. (2020) found that physicians experience burnout when utilizing electronic documentation databases because of the high volumes of organizational data they have to work with. This means that in order to work effectively, documenting using electronic medical records are difficult to use compared to other common technologies for healthcare providers (Melnick et al., 2020).

Negative leadership behaviors, lack of opportunities for advancement and social support for physicians, and inadequate interprofessional collaboration have been cited as organizational factors that cause burnout among healthcare providers across all specialties (Shanafelt et al., 2015). Further, Shanafelt et al. (2015) noted that burnout is less common in healthcare organizations where leaders mentor, inform and seek input from all stakeholders regardless of their rank and type of work (Shanafelt et al., 2015). A longitudinal study suggested that healthcare organizations that provide physicians and their fellow providers with increased control over workplace issues experienced less burnout and had higher career satisfaction (Williams et al., 2012).

Adverse Outcomes of Workplace Burnout

After the discussion of academic evidence that assessed sources of burnout among healthcare providers across all specialties, this section of the literature review will present studies that have examined the adverse outcomes associated with workplace burnout. These outcomes could be classified into two broad categories: psychological and physical. Both these categories can present itself as symptoms that can range from a case-by-case basis to severe. Grover et al. (2019) argued that burnout causes healthcare providers to complain of feeling exhausted, tired, irritable, inattentive, and fatigued. The researchers further determined that burnout is correlated with depression, mood disorders, stress, and disruptive behavior (Grover et al., 2019). Houkes et al. (2011) established a causal relationship between burnout and risk of near-miss events and accidents, even after recovering from burnout.

Disruptive Behavior

In an attempt to determine the associations between disruptive behaviors, patient safety, depression, and burnout, Rehder et al. (2020) conducted a cross-sectional survey of healthcare workers in a large U.S. healthcare system. The findings showed that disruptive behavior climate was significantly correlated with increased burnout levels, low work-life balance, and poor job satisfaction (Rehder et al., 2020). Further, the researchers confirmed that burnout among healthcare providers is associated with behaviors that may be harmful to patients, including verbal abuse, physical aggression, unnecessary discontinuation of communication such as turning one's back before a conversation is over or hanging up a phone, and humiliating others publicly (Rehder et

al., 2020). These disruptive behaviors, according to the authors, undermines the ability to provide holistic care to patients in a manner that they could heal physically, emotionally, and spiritually (Rehder et al., 2020).

Substance Abuse

West et al. (2018) designed a study to understand why alcohol abuse is rampant among surgeons in the United States. The findings of their study confirmed that high levels of burnout might cause an increased incidence of substance abuse, especially alcohol dependence (West et al., 2018). The reliance on drugs as a gateway from burnout resulted in disrupted personal life and decreased professional efficiency. Similarly, Farrell et al. (2019) were interested in determining why there is a high substance abuse rate in medical students in New Zealand. After collecting data from surveys distributed to 220 students, the authors concluded that medical students face increased pressures compared to their peers (Farrell et al., 2019). This increased pressure results in burnout, consequently encouraging students to engage in substance use as a way to cope. Both burnout and substance abuse impeded a smooth transition of these students into the health workforce (Farrell et al., 2019). The researchers highlighted the importance of improving medical students' wellbeing, including reducing pressures such as tight deadlines on assignments (Farrell et al., 2019).

Suicide

Most healthcare providers across specialties do not acknowledge their burnout symptoms or admit that burnout could affect their performance and refuse help (Shanafelt et al., 2016). As a consequence, healthcare providers that do not seek help increase their

vulnerability to suicide (Shanafelt et al., 2016). Busireddy et al. (2017) reported that physicians whose specialties comprise of demanding care such as primary, emergency, and preventative medicine are at increased risk of suicide (28-40 per 100,000) as compared to the general population (12.3 per 100,000). Although the risk for suicide is high among healthcare providers in the front line of care, Mathews et al. (2019) wondered why there are high suicide rates among women providers as compared to their male counterparts. In particular, the study established that the suicide rate among female physicians is 2.27 times higher as compared to females in the general population. Conversely, the suicide rates among male physicians are 1.41 times higher compared to males in the general population (Mathews et al., 2019).

Dutheil et al. (2019) conducted a meta-analysis and systematic review of the literature to develop an understanding of suicide cases among healthcare providers across all specialties. Findings showed that the physicians are at risk of suicide, especially women and those that work in specialties such as psychiatry, anesthesiology, general surgery, and general practice (Dutheil et al., 2019). The high-risk of suicides among these specialties could be explained by the prevalence of burnout and easy access to potentially lethal drugs. Suicide also has been studied by Stehman et al. (2019), who found out that suicide can be a consequence of burnout. Nonetheless, the authors noted that burnout alone could not lead to suicide, arguing that suicide is a complex condition that is caused by many factors (Stehman et al., 2019).

Medical Error and Quality Care

The professional consequences of burnout were poor delivery of care and increased instances of medical error (Hall et al., 2016). More than 70% of the studies reviewed by the literature supported the hypothesis that burnout caused errors. However, an article by Lawson (2020) challenged the idea that burnout is a contributing factor to medical errors. The reason for this supposition, as stated by Lawson, is that providers with burnout are honest, self-critical, and more likely to report having made medical errors as compared to providers who did not experience burnout.

Dewa et al. (2019) reviewed the current state of peer-reviewed literature related to physician burnout. The objective of the literature review was to determine whether physician burnout affects the quality of healthcare delivery and the safety of clients. Results of the systematic review of the literature suggested that there is moderate evidence that burnout of healthcare providers is associated with the quality of care delivery and safety of patients (Dewa et al., 2019). A cross-sectional study evaluated the link between burnout and medical error (Tsiga et al., 2017). The results of the study highlighted the importance of organizational leaders to create an ample working environment that prevents burnout in order to prevent the occurrence of medical errors.

Summary

In this chapter, I have provided an overview of the current pertinent research on factors contributing to burnout in mental health settings. There is a limited amount of research that discusses psychiatric hospital staff sources of burnout. Environmental factors that psychiatric hospital staff face at inpatient hospital units are different from other disciplines or health settings. Psychiatric hospital staff have substantially different

salaries, education levels, and the job expectations in caring for the serious mentally ill in comparison with physicians (Ezeobele, 2020). Psychiatric hospital staff also face increased exposure to patients' negative reactions compared to physicians. While the psychiatric hospital staff role is integral to patient treatment, it comes at an increased risk for burnout (Ezeobele, 2020). Research on the burnout experienced by mental health staff at inpatient psychiatric units has rarely included the experience of psychiatric hospital staff. As a result, the focal point of my study is to explore how mental health staff working at inpatient psychiatric units describe experiences of burnout and what factors they identify as contributing to burnout.

There is substantial research that explore burnout among professions other than psychiatric hospital staff. Factors related to burnout among hospital and mental health professionals shed light on what psychiatric hospital staff may experience. However, it would be presumptious to attribute a similar understanding of burnout to psychiatric hospital staff, a position that is exposed to higher stressors with less compensation (Ezeobele, 2020). The negligence of exploring burnout among psychiatric hospital staff prompts further study. The review provided in this chapter showed there is lack of qualitative data around this topic. As a result, the focal point of my study brough attention to how psychiatric hospital staff personally express their burnout experience. This provides groundwork for future research in the mental health field and in psychiatric hospital settings in particular.

In the next chapter, the rationale and design choice for this study is presented. The sampling strategy and target population is described. I also discuss the

method for recruiting participants and introduce the use of IPA to guide the reader to understand the ways in which meaning was ascertained to address the research questions. An examination of the trustworthiness of this project is also provided, along with ethical considerations and the steps that were taken to uphold optimal ethical integrity at each point in the study.

Chapter 3: Research Method

Introduction

The purpose of this qualitative IPA study was to explore how psychiatric hospital staff working at inpatient psychiatric units describe their lived experiences of burnout and what factors they identify as contributing to burnout. This chapter outlines the research approach and design used for this study and the specific methods used to present the findings through how participants were selected, how data was handled, and the analysis process. This was accomplished through adherence to guidelines of trustworthiness and ethics, which is also discussed.

Research Design and Rationale

The findings of the study provided explanations of the factors associated with burnout in psychiatric hospital staff. The central phenomenon of this study is burnout, which is considered a common psychosocial problem among healthcare providers in psychiatric units. It is a significant predictor of fatigue, absenteeism, and decrease in the quality-of-service delivery (De Oliveira et al., 2019). Burnout is an occupational phenomenon that is typified by chronic workplace stress that has not been successfully managed. Employees experiencing burnout often showcase symptoms that may include feelings of exhaustion or energy depletion, feelings of cynicism, negativism, and increased mental distance from one's job, and reduced professional efficacy (WHO, 2020). Mental health, on the other hand, includes a person's social, psychological, and emotional wellbeing that affects how people act, feel, and think. Mental health is of critical importance to healthcare providers since it allows them to concentrate on their

assigned duties and provide evidence-based holistic care. Early warning signs that a person may be having mental health issues including having low or no energy, eating too little or too much, having unexplained pains and aches, feeling hopeless or helpless, and using drugs more than usual (De Oliveira et al., 2019).

The research questions that guided the research process were:

RQ1: How do psychiatric hospital staff working at inpatient psychiatric units describe experiences of burnout?

RQ2: What factors do psychiatric hospital staff working at inpatient psychiatric units identify as contributing to burnout?

Through this study, a qualitative research design called IPA was used to understand the factors associated with burnout among psychiatric hospital staff. IPA is a qualitative approach to social research to extrapolate data that represent a person's view of a phenomenon. By definition, a phenomenological approach is preferred by researchers interested in understanding a phenomenon under study through the way they are perceived by people in that situation (Qutoshi, 2018). In this case, researchers can apply the inductive method of inquiry to develop a deeper understanding of the research question through methods that include focus group discussions, interviews, and participant observation. For this reason, methods from IPA were used to explore the social construct of burnout.

Through a phenomenological approach, researchers can answer research questions based on the perspective of the subjects featured in the study (Neubauer et al., 2019).. It was expected that results of this study would show an understanding of the

subjective experience of respondents. Interviews were used to gain insight into people's actions and motivations. A notable advantage of a phenomenological approach to social research is that it can be applied to either single or multiple cases (Neubauer et al., 2019). Interviews can generate large quantity of data. The analysis of a large quantity of data can be time and resource consuming. Fortunately, this weakness associated with the phenomenological approach can be minimized by organizing data in a manner that can be easy to find key issues and themes in each interview transcript (Qutoshi, 2018).

Due to the nature of the research questions, there was no need to imitate the natural sciences. It is instead advisable to emphasize empathetic understanding. In natural science, "explanation" is widely considered, whereas in social sciences, "understanding" is used. According to Sinclair et al. (2017), understanding involves using empathy as reconstruction and interpretation of the action of others rather than psychological sense as intuitive and non-conscious impression. Researchers in social science need to be concerned with the interpretive understandings of human beings. Meanings could be found in the intentions and goals of the individual (DeJonckheere, 2019). The best way of accessing the experiences of human beings is by simply listening and interacting with them (DeJonckheere, 2019). The experiences of people in this research were context-bound. This means that the participants cannot have the freedom from time, location, or the mind of another human. It was necessary for me to understand the socially constructed nature of the participants' world and realize that their values and interests became a part of the research process (Speziale et al., 2011).

Role of the Researcher

It is the goal of the researcher to understand the world from the participants point of view (Ngamvithayapong-Yanai, 2016). As the main researcher in this study, I designed this IPA study, obtained approval from the institutional review boards (IRB), located and screened potential participants, analyzed the findings of the study, and will present the findings in a final report. The main data collection tool consisted of interviews. I engaged in electronic interviews via Zoom and made every effort to understand participants' perspectives and documented their responses.

My experience as a psychiatric hospital staff brought an interest to the burnout phenomenon, as well as a potential for bias. I experienced burnout as a psychiatric hospital staff early in my mental health career, something that inspired this construct for study. In my burnout experience, I had emotional exhaustion, compassion fatigue, loss of personal accomplishment, and detachment from my work's purpose. These feelings were present for three consecutive months. I considered whether it was a reason to change the direction of my work. I reconsidered when thinking how the work used to make me feel before the burnout experience. I chose to explore taking a break from the work instead of changing my occupation. Taking a break dulled the burnout symptoms and I found satisfaction in going to work again.

As I continued in the same field in the same and different positions, I observed symptoms from others similar to the burnout I experienced. I imagined the symptoms, while similar, may be experienced differently. The potential for my bias to confound this study's outcome was circumvented best by my curiosity in the differences that burnout is

experienced. The differences in presentation and individual impact of burnout on the personal life and career path outcomes is what drives my interest to explore the unique ways burnout is experienced among persons other than myself.

Participants were recruited from adult psychiatric hospital units in Nebraska and Ohio. The reason for these locations is for the proximity and professional familiarity of the researcher. I am acquainted with the general hospital's administrative officers of one location while I am located close the other. For both locations, I am not familiar with psychiatric hospital staff or managerial staff who work there. I was open and honest while establishing a good rapport with each of the participants. This involved reassuring the participants that their participation in the study would remain confidential throughout the research process. After each interview, I secured interview sheets, notes, and other confidential participants' information in electronic communication and transcribing was filed in my computer and is password protected. All data will be destroyed after 5 years of completion of the study.

Once data collection was completed, I analyzed participants' responses following IPA guidelines through analyzing the data. When discussing results, I referenced the literature discussed in the literature review section as well as new citations that the responses invited. This discussion explained how the findings related to the literature.

Methodology

Population

The participants for this study were psychiatric hospital staff who work in an acute hospital setting and who have experienced self-perceived burnout as a result of working in that workplace.

Sample

The inclusion criteria for the study were that the participants reported experiencing symptoms of burnout while working in the role of psychiatric hospital staff in the psychiatric hospital setting. They were also willing to participate and able to communicate clearly in English. Individuals in a "psychiatric hospital staff" role often have different titles for their role, but hospitals for the participants in this study gave the title MHT to psychiatric hospital staff hired to provide direct care in the inpatient setting.

Purposeful sampling was used in this study allowing me to choose respondents that have shared the experience with the phenomenon under study (Patton, 2002). This sampling strategy is designed to serve a particular need or purpose by allowing the researcher to recruit a specific group of individuals based on the objective of the study. I also used criterion sampling, which involves selecting cases that meet some predetermined criterion relevant to the study (Patton, 2002). The inclusion criteria for the study were as follows:

1. At least 18 years of age.
2. Psychiatric hospital staff employed from one of two inpatient psychiatric hospitals recruited for this study.

3. Burnout must have been experienced in an inpatient hospital setting as a psychiatric hospital staff, even if burnout was experienced at a different facility than where they were recruited.

The exclusion criteria for the study were as follows:

1. Below 18 years of age.

Hospital staff in positions other than psychiatric hospital staff were excluded from this study. Participants were recruited from adult psychiatric hospital units in Nebraska, and Ohio. Eleven individuals were selected to participate in semi-structured interviews, while only 10 ultimately provided rich data for this study. According to Guest et al. (2006), a sample size of 12 participants is appropriate when using a semi-structured interview guide. They indicated that most variation in the codes occur between the first and twelfth interviews. However, Smith et al. (2009) suggested that IPA studies use smaller samples (five to 10). They indicated that it is only possible to conduct the detailed analysis associated with IPA on a small sample. While there is not a fixed number of participants in IPA studies, what matters is the richness of the data collected. Considering these recommendations for sample size in phenomenological studies, and analyzing the inclusion and exclusion criteria, I expected the saturation was reached with 10 participants acquired for this study.

Sampling Procedures

Participants were recruited from adult inpatient psychiatric hospital units in Nebraska and Ohio. Recruitment methods included flyers posted throughout the two facilities with the intention of recruiting 10 participants. The reason for these locations is

for the professional familiarity and nearness to the researcher. After acquiring participants through the flyers, the word-of-mouth recruiting was used by asking participants to refer other psychiatric hospital staff to the study. The process of the study included making appointments with respondents and carrying out practical interviews to understand their lived experiences. More information on the steps of recruiting participants is presented later in the following sections.

Instrumentation and Materials

The preferred method for collecting data from the 10 respondents was by semi-structured interview. Typically, semi-structured interviews contain several planned questions, but a researcher has the freedom to change the order and wording of the questions as well as ask follow-up questions that are not planned to gather detailed information. According to DeJonckheere (2013), semi-structured interviews are ideal for collecting data from participants with limited time to participate in a study. This was ideal for this study because healthcare providers in psychiatric units are busy professionals, many of whom express burnout symptoms. In addition, semi-structured interviews allowed me in-depth understanding through observation and an informal interview.

The semi-structured interviews contained open-ended questions. Open-ended questions a) permit an unlimited number of possible answers, b) allow participants to answer in detail in order to qualify and clarify responses, c) allow for observation of unanticipated findings, (d) permit adequate answers to complex issues, and e) permit creativity, self-expression, and richness of detail (Guest et al., 2013). Because the semi-

structured interviews contained open-ended questions, it was possible to diverge from the interview guide to give opportunity to openly discuss thoughts and to let participants expand on the topics discussed.

The interview sessions lasted from 30 to 60 minutes per respondent. The interview began by asking participating for demographic information including age, self-identified ethnicity, and years of experience as psychiatric hospital staff among others. The semi-structured interview used in this study was developed to address the research questions using the theoretical framework as a guide. The goal in developing the interview was to compile questions that would adequately evoke the lived experiences that address the research questions regarding burnout. The transactional model of stress and coping was kept in mind when developing the questions and during the interview.

Procedures For Recruitment, Participation, and Data Collection

1. I sent an email to the facility administrator requesting their permission to recruit employees at their facility to become participants for this study. I followed up the initial contact attempt with a phone call to schedule an appointment to present the nature of my study and to obtain consent from the sites.
2. Once the sites agreed to allow employees to participate in the study, I responded to their acceptance by thanking them and reminding them of the steps they can follow: A program director then introduced the study to the employees by providing the study flyer in the main areas where they would be best seen.

3. Potential participants contacted me by email or by text. For those who expressed interest in the study and wish to participate, I invited them to participate in a screening process, which ensured that they met the inclusion criteria for the study.
4. I obtained the participant's personal electronic mailing address so that they could receive the informed consent form, as well available times to meet via Zoom for the study's interview.
5. After I received written consent by replying to the consent form email message, I proceeded to establish a date and time that work for both the participant and my schedule.
6. The interview was conducted via Zoom platform, which was accessible for all the participants. The interview lasted from 30 to 60 minutes and was recorded and transcribed. During the interview, I used the interview guide to pose a series of open-ended questions and record the participants' responses for future analysis. The interview began with questions about the participants demographic information (please refer to Appendix A).
7. Once the interview was finished, the participants were provided with a $20 Amazon gift card via their personal email address to thank them for their participation in the study.

Data Analysis Plan

The goal of IPA is to elicit and preserve thoughtful responses from the participants in order to capture meaningful aspects and then to make sense of what they

share (Larkin & Thomas, 2012). This approach is unique from other phenomenology research because it is based on a dynamic, interactive interview and not on strict empirical observation alone. This approach consists of stages that include contemplating the data and the essence it gives to the participants experience. A second stage determines how to interpret the data as it pertains to understanding how it pertains to understanding the individual's burnout experience (Larkin & Thomas, 2012).

For this study, each lived experience that was shared was carefully examined and involved reading, listening, and writing notes. First, I transferred the transcribed portion of the interviews to immerse myself in the data set. I then read through the interview transcript carefully, line by line, writing first impression notes on a separate document. Then, I read through the transcript again, recapitulating the essence of the participant's responses and its purpose, refining my new or changing impressions along the way so that precision analysis is retained. That is, the notes taken reflected the material accurately (Pietkiewics & Smith, 2014) to identify relevancy to the research questions that guides this study: *How do psychiatric hospital staff working at inpatient psychiatric units describe experiences of burnout and what factors do psychiatric hospital staff working at inpatient psychiatric units identify as contributing to burnout?*

The notes taken assisted me to code the transcript. This involved assigning labels from the information shared to phrases, sentences, or sections of the transcripts that reflected aspects of the burnout experience. Relevancy of terms was determined by what was repeated, emphasized, or deliberately inferred by the participant to be important. Parts of the transcript were also noteworthy to me if something stood out to me as

unexpected, or if it pointed to a theory or concept that was worth assessing further. These methods of data collection aimed to clarify the person's intention based on the context of their lived experience (Pietkiewicz & Smith, 2012).

The coded parts of the transcript were reviewed to conceptualize the data. I reviewed relevant parts again to assess relationships, such as concepts that closely related to or diverged from others. As categories related to burnout began to emerge from all the participant responses, specific themes formed that mirrored present scholarship and that pointed to new information about the burnout phenomenon.

The themes that emerged were compared to each other to address how they might merge into a single theme or whether they seemed to go into a different direction. Subthemes emerged into categories of similar classification within a theme, yet distinct from other subthemes (Larkin & Thomas, 2012).

It was through these themes that new knowledge about burnout from the lived experiences of the participants emerged. What resulted began to show a clearer understanding of burnout from the lived-experience point of view (Pietkiewicz & Smith, 2012). Careful reflection and revisions were performed, and supervisor feedback was elicited and given to validate the codes and themes identified by each participant and collectively (Larkin & Thomas, 2012).

Issues of Trustworthiness

Credibility

Credibility refers to the congruency of the findings as their description reflects reality (Shenton, 2004). To ensure credibility in my study I conducted extensive

interviews. Credibility was guaranteed by using correct operational measures for the phenomenon approach used. In this case, the data-gathering sessions was completed with data from the semi structured interviews. The data that was collected for this study is from a sample of psychiatric hospital staff who self-identify as having experienced burnout. This allowed for an in-depth description of the phenomenon under study from the lens of people that understand it, that is, psychiatric hospital staff employed at inpatient psychiatric hospitals.

I also used prolonged engagement and negative case analysis. Prolonged engagement refers to spending enough time in the field and gaining an understanding of the phenomenon in its context. Negative case analysis relates to taking special consideration of information that did not confirm other resulting data. This requires reviewing information that did not fit the emerging trends and trying to understand why they do not fit. Disconfirming evidence was not reported in this analysis; while I assessed for negative case outcomes, none were found with the data collection in this study. Finally, I used peer debriefing. I consulted with my dissertation committee chair across all major moments of data collection and analysis, and I discussed my reactions and issues related to processing data collection and analysis. This helped the data analysis process by providing another perspective on my own procedures.

Transferability

Transferability refers to the extent to which results of a study can be transferred or applied to similar contexts. To ensure transferability, the researcher should demonstrate enough depth and detail in describing the data (Shenton, 2004). Transferability of the

findings was reinforced by making in-depth and thorough descriptions of the phenomenon under study to enhance external validity and allow the reader to develop an in-depth understanding of the findings. Through this understanding, readers can compare the instances in which the phenomenon described in the study has emerged in similar and different situations.

Dependability

Dependability refers to the stability and consistency of research procedures (Shenton, 2004). Consistency and transparency are needed to ensure that a replication of the study with a similar context, participants, and methods result in similar findings. To ensure dependability in my study I used an audit trail. An audit trail allows others to trace the path of the research step-by-step via the decisions and procedures followed in a research study (Shenton, 2004). I described the planning of the study, reported the details of data gathering, and reflected on the overall research process. I used reflexive journaling using word documents and provided detailed data analysis procedures. This audit trail allowed me to keep track of my research procedures and progress. I also engaged a colleague with an understanding of workplace dynamics to conduct an inquiry audit on the findings of the research study. Also known as an external audit, the colleague examined the data analysis procedures, data collection, and viability of the results.

Confirmability

Confirmability refers to comparable concepts of objectivity in quantitative research and is relevant for the integrity of the data in qualitative studies. It is achieved by demonstrating that the results of the study represent the responses of the participants

as opposed to the subjective preferences and interpretations of the researcher (Shenton, 2004). In my study, I used reflexivity to establish confirmability by keeping a private word document for each interview to make spontaneous notes and to report the decisions, changes, and directions made throughout the research process. The reflexive journal allowed me to capture my thoughts, reactions, and biases. This means of journaling allowed me to identify and set aside my own reactions to the participants' responses, which helped me to avoid researcher bias. I strove to maintain a constant openness to the process of listening to the participants' opinions. In order to do this, I used mindfulness techniques to keep me aware in the moment (Nicholls, 2019).

Ethical Procedures

During the course of the study, I followed the principle of beneficence, which includes protecting the research respondents from any harm and any form of exploitation (Smith et al., 2009). I conducted the study in a manner that respected the principle of human dignity, which includes the right to full disclosure and self-determination. This was done by providing the participants with the ability to voluntarily inquire about the study and the right to refuse to participate in the study completely or in part if they felt uncomfortable at any time. Participants were informed verbally and in writing during the consent process and before the interview that they may quit the study at any time and were not obligated to answer any questions. Although the participants signed consent forms prior to participation, they were informed that consent was a process and could be revoked at any time.

The interview itself included questions about stress and coping, which could have evoked psychological distress; however, the questions provided low risk of distress. During the course of the interview, I monitored emotional expression. I planned to allow a time for a break if the participant appeared distressed. In such a scenario I would reconvene with the participant after the break and remind them of their ability to continue or discontinue the interview depending on their comfort. If the participant wished to discontinue the interview, I would respect their wishes and have available resources in their area to seek therapeutic support. In the end, all participants showed no signs of disturbance or frustration. On the contrary, many messaged me later stating how the interview was a positive experience for them.

Because the interviews took place via videoconference, there is a possibility that the communication could be hacked. This means that privacy cannot be 100 percent guaranteed; however, I made sure that I was in a private office space during the interviews to protect the participants' privacy on my part. I also suggested that the participants be in a private location when preparing for the interview. Privacy was also managed by the way it was stored. Although it is impossible to maintain true anonymity for the participants in a qualitative study, all possible measures were taken in the current study to maintain participant confidentiality (Smith et al., 2009). The raw data that was collected for the purposes of this study was only minimally shared with the dissertation committee chair for this study and was de-identified to protect confidentiality (Smith et al., 2009). To ensure that participants could not be identified based off their transcriptions, each transcription was assigned a number, identifying demographic

information either be removed or generalized (Haverkamp, 2005), and the names of the participants were never mentioned during the recorded interview. The participants were informed of how their experiences would be used to inform scholarly efforts (Smith et al., 2009). The transcripts, notes on word documents by the researcher, and audio was stored and filed in my computer and is password protected. The transcripts and other raw data will be destroyed after five years of completion of the study.

Summary

The purpose of this chapter was to outline the procedures and plans for researching the factors that contribute to burnout among healthcare providers in psychiatric units. In the initial parts of the chapter, the descriptive design and qualitative methodology were identified and explained as to why they fit this study. In simple terms, a qualitative approach was preferred to provide textual findings that was analyzed using IPA. The first part of the chapter also identified semi-structured interviewing as the preferred instrument for garnering personal ideas. A sample of 10 respondents was selected purposively. After outlining the study procedure, the chapter outlined the data collection and analysis tools that were used. In particular, the chapter revealed the use of an open coding process, which is part of the IPA analysis framework that was used to identify key themes related to the research topic. The following chapters will demonstrate how the participant's lived experiences in the psychiatric inpatient hospital setting answered this study's research questions.

Chapter 4: Results

The purpose of this descriptive qualitative study was to explore how psychiatric hospital staff working at inpatient psychiatric units describe experiences of burnout and what factors they identify as contributing to burnout in that setting. The previous research on burnout in psychiatric hospital staff apart is not robust. A qualitative in-depth exploration had been lacking. Hence, the current study filled a much-needed gap in the research literature that was long overdue.

Ten psychiatric hospital staff members volunteered to share their burnout experience and were interviewed using a semi-structured interview. I implemented IPA as an analysis strategy to make sense of the data. IPA allowed me to capture the essence of the lived experiences; and themes and subthemes were generated in response to the research questions. The semi-structured interviews allowed participants to elaborate on their unique experiences with burnout, which enriched the interpretative process. IPA allowed me to capture the essence of the burnout experience for each participant.

The interviews focused on two main research questions:

RQ1: How do mental health staff working at inpatient psychiatric units describe experiences of burnout?

RQ2: What factors do mental health staff working at inpatient psychiatric hospitals identify as contributing to burnout?

Chapter 4 provides description of data collection requirements and procedures, how the data was analyzed and interpreted. This includes the detailed explanation of the

setting, demographics, codes and definitions, and themes and subthemes provided by the participants lived experience.

Setting

After I obtained approval from the Walden University IRB to begin the data collection process, I had flyers distributed to one hospital that did not have their own IRB. After establishing this initial contact, I was contacted by six employees expressing interest in the study. The employees were screened for inclusion criteria during this communication and were found to meet criteria. All six were sent consent forms via their personal email accounts to view and question before acknowledging their consent to participate by replying to the message containing the consent form.

A second hospital required an internal IRB process and took longer than expected to grant my access to recruit employees for the study. Formal approval from this hospital's IRB was given on 10/20/22. Flyers for the study were disseminated throughout the psychiatric units. Five employees expressed interest in the study, appeared to meet criteria, and consented to interviews. After beginning the interview with one participant, they were not able to define burnout or give personal experience of burnout in the hospital setting. The participant was motivated to enter this study due to concurrent experience in a university practicum, although employed for 4 months as a hospital staff. This participant was excluded from the study. Thus, four participants from the second hospital location were included in the study. The final sample comprised of 10 participants who qualified to provide feedback on the phenomenon of the study. Compensation was given to all participants.

Demographics

A total of 10 participants participated in the study. The ages of the participants ranged from 24 to 70, and the average age was 46.2 years old (*SD* =17.65). The average number of years employed as a psychiatric hospital staff was 8.7 years (*SD* =7.51) All 10 participants were MHT currently working in an inpatient psychiatric hospital setting. All other relevant demographic information is presented in Table 1.

Table 1

Study Demographics

Participant	Age	Gender	Race	Duration employed as MHT	Education
1	28	Female	Black	4 years	BA
2	26	Female	White	3 years	BA
3	70	Male	White	29 years	BA
4	61	Male	White	11 years	BA, M.Div.
5	56	Male	White	8 years	BA
6	30	Female	White	2 years	BA
7	64	Female	Black	12 years	Associates
8	38	Female	Black	3 years	BA
9	24	Female	White	8 months	BA in spring
10	65	Male	White	7 years	Certificate

Data Collection

Participants were recruited through the distribution of flyers in areas visible to them and in each psychiatric unit where psychiatric hospital staff were employed. Although three hospital sites were approved by Walden's IRB, only two were used, since

no participants responded from a third facility. Once I obtained permission from these sites, a point of contact person within management distributed flyers at the respective locations.

Snowball sampling was also used to recruit more participants by referrals from participants who expressed interest in the study directly. Three of the 10 participants resulted from this form of sampling. All documents and communication were developed in English, and there was no need for translation. When participants contacted me with interest in the study, they were thanked and then screened to ensure inclusion criteria were met. A personal email was then requested where a consent form could be sent. Prior to scheduling a time to meet for the interview, I provided all participants with details in what to expect if they chose to consent to the study, the consent process, the nature of arranging and then meeting to have a conversation about their burnout experience, and the incentivized compensation for participation. Participants were encouraged to ask questions throughout the process. Once informed consent was obtained, an interview was scheduled via the Zoom platform. Originally the data collection process was estimated to take 3 months, but due to the IRB approval process, data collection process took seven months to complete.

The demographic questionnaires were completed, and then the interviews were conducted. All responses were volunteered and were not prompted with cues other than what was in the interview questions. I noticed certain participants tended to describe responses in third person instead of personalizing their experiences. When appropriate and with care and sensitivity, I would verify whether they were describing what they

experienced personally and would ask for examples. A flow of consciousness was encouraged while ensuring the participant responded to each interview question. Once the interview was completed, the participants were thanked again for their willingness to share their experiences and were given their compensatory gift certificate.

Data Analysis

Data analysis through IPA principles provides an in-depth look at the meaning of participant responses (Alase, 2017). In this stage of interpreting the data, each lived experience was carefully examined using an IPA approach, allowing me to contemplate the essence of the experiences that were shared. After the semi-structured, in-depth interviews, I transcribed the text using closed captioned, time stamped data while rewatching and listening to the interview itself. Each response was given a brief code with a description of the content. The participant's burnout experience was further understood by giving each term a more focused code in an additional column. Each response was then given a code with a description to identify its meaning (See Table 2 for an example of this process). After immersing myself in the data, I re-read through the transcript, reviewing line by line changing impression when necessary to ensure precision analysis was retained.

Table 2

Example of Coding System

Transcription	Line by line coding	Focused coding	Defining codes
P1: Sleep deprived for one, or I just did not sleep at all. So I started in a way becoming like a patient where I'm not sleeping for 2 or 3 days. And then it became an issue with falling asleep sometimes because I was, in a way diabetic.	Participant describes health issues on Night shift: medical needs are an inconvenience.	BURNOUT: PHYSICAL HEALTH ISSUES	This code refers to illness experienced during periods of burnout: Health issues on night shift, not sleeping for 2-3 days, experiencing hallucinations due to lack of sleep.
So I was falling asleep, too, because you know lack of sleep and then I would get written up and then you know you can't get to your food sometimes, or the patient doesn't want you to be eating in their room so your sugar's dropping, so that was an issue.	Participant infers discipline for falling asleep at work.	BURNOUT: PERFORMANCE ISSUES: DISCIPLINED	Needing to eat due to blood sugar but patients not wanting you to eat in front of them. This code refers to stress at work due to falling asleep for not getting a break from others, but then getting in trouble for it.

For the next phase of data analysis, it is important for the researcher to take a step back from reviewing the interview transcript and reflect on repeated phrases or circumstances that may result in themes (Pietkiewics & Smith, 2014). These phrases were color-coded according to temporary themes (e.g., Picking Up Shifts, Expectations, Favoritism, etc.). Using an Excel spreadsheet, the temporary themes were categorized according to the two research questions to meet the purpose of the study: How do

psychiatric hospital staff working at inpatient psychiatric units describe experiences of burnout and what factors do psychiatric hospital staff working at inpatient psychiatric units identify as contributing to burnout? The temporary themes or codes representing the essence of shared phrases that reflected aspects of the burnout experience were further categorized according to the 15 interview questions. The complete participant response was included for each code within the Excel spreadsheet. This met my personal preference of referring back to details of the interview. Associating these codes with interview questions also made it easier to view themes that stood out as unexpected or occurred with any frequency.

The final stage involves a final assessment of what was experienced and how it describes the phenomenon (Alsana, 2017). To meet this final step in the data analysis process, I further contemplated the context of the participants' lived experience before determining whether they were appropriately represented by the pre-existing codes or phrases. These color-coded themes were then placed in an Excel spreadsheet according to participant. This allowed me to view data that were repeated, emphasized, or uniquely inferred by participants. This stage allowed me to consider a theory or concept that was worth assessing further, such as components of burnout represented in the literature like emotional exhaustion, depersonalization, or cynicism, and low personal accomplishment, or inefficacy (Lazarus & Folkman, 1987; Maslach & Leiter, 2016). The categorized codes pointed to themes that represented how participants experienced burnout.

Once final themes were identified, they were compared to address how different themes might come together or seem to go into a different direction, and whether themes

came together as subthemes. For instance, most participants remarked on patient violence making it seem like an emerging theme. Until lesser expressed safety factors were mentioned, such as staffing ratio, emergency medication decision making, and patient acuity presented a larger umbrella under which patient violence would fit. Patient violence made more sense as a subtheme of the main theme of safety.

Evidence of Trustworthiness

Measures were incorporated to ensure trustworthiness for this study by addressing concerns of credibility, transferability, dependability, and confirmability (Shenton, 2004).

Credibility

To ensure honest, quality data, I conducted extensive interviews using specific yet open-ended questions for psychiatric hospital staff to encourage thoughtful self-reflection. This allowed for an in-depth description of the phenomenon from the lens of the others that understand it, that is, psychiatric hospital staff employed at inpatient psychiatric hospitals. I also met the qualification of prolonged engagement in the position of MHT because I had worked as psychiatric hospital staff in an acute hospital setting. This gave me personal experience in understanding the burnout phenomenon in the context that this study is interested.

I frequently debriefed with my dissertation chair before, during, and after data collection. This provided me with insights into approaches for practices such as probing questions, sampling allowances, and quality confirmation. These meetings also provided me with an experienced perspective for reviewing my own procedures. I reviewed

previous research findings to determine to what degree this study's findings augment or diverge from past studies.

Transferability

The data from this study can only be attributed to psychiatric hospital staff in settings of acute psychiatric care. However, information from this specific group may be compared to findings from other groups as long as the description of the data origin is well preserved and clearly defined. Through this clarity, readers may be able to compare the instances in which the burnout phenomenon described in the study emerges in different situations.

Dependability

The dependability of this study was preserved by detailing the steps of data collection and analysis so that this research may be replicated. These steps were carefully recorded and detailed with transparency showing careful record of my planning for the study, data procedures and processes, and a reflection of the overall research process. I consulted a mentor who is an outpatient clinical psychologist to ensure fidelity throughout the research process. This mentor was assigned by a participating hospital's IRB, a requirement for all researchers for the location where data are collected. Members of my dissertation team examined the procedures of the study and the viability of the results.

Confirmability

Confirmability was ensured by developing interview questions that reflected the true nature of the study. This instrument was scrutinized by my dissertation team, whose

suggestions resulted in its final form. The interview guide was integral in addressing the research questions. The coding process presented themes that reflected participants experience, avoided research bias, and preserved the study's integrity. In addition, I carefully detailed the process of data collection and analysis and followed the research plan as described in the proposal. I kept a reflexive journal to minimize the influence of any potential bias on the data.

Results

Two research questions were used to explore the lived experiences of MHT who experienced burnout.

RQ1: How do mental health staff working at inpatient psychiatric units describe experiences of burnout?

RQ2: What factors do mental health staff working at inpatient psychiatric hospitals identify as contributing to burnout?

Six interview questions addressed the first research question, while three interview questions addressed the second research question. The applicability of each theme and sub-theme as they relate to the research questions are presented in Table 3.

For the first research question, two major themes emerged, which referred to how the burnout experience left its mark in the lives of mental health staff and how participants recognized effects of burnout and ways to mitigate it. The first theme resulted in two subthemes. The second research questions evoked four major themes from the data analysis. The first theme raised the issue of safety in the workplace with subthemes of patient violence and MHT support and teamwork. The second theme was

workload, the third theme focused on workplace culture with subthemes of RN teamwork/support and co-worker attitudes and corporate perception and managerial support. The fourth highlighted the unpredictable aspects of the job. Table 3 lists the themes and subthemes that are described in this section.

Table 3

Emerging Themes and Subthemes Based on Research Questions

Research question	Theme	Subtheme
RQ1: How do mental health staff working at inpatient psychiatric units describe experiences of burnout?	Effects of Burnout	Personal Experiences and Mental Health Coping
	Learning Burnout	
RQ2: What factors do mental health staff working at inpatient psychiatric hospitals identify as contributing to burnout?	Safety	Patient Violence MHT Support and Teamwork
	Workload	
	Culture	RN Teamwork/Support and Co-worker Attitudes Corporate Perception and Managerial Support
	Unpredictability	

Emerging Themes Based on Research Question 1

Theme 1: Effects of Burnout

The first theme that was generated from the data collected was reports of the effects of burnout psychiatric hospital staff experienced. Personal experiences with these effects on mental health and interpersonal relationships were shared by the participants.

Personal Experiences and Mental Health. Participants described how burnout impacted their mindsets, their emotionality, and their interpersonal and social

relationships. Anxiety and depression symptoms were described as well as other changes, such as a growing aversion to interacting with others during time off. Some participants describe perseverating on the negative work experience while away from work, making it difficult to acquire the rest needed to return to work re-energized. They also described mentally "checking out" while at work, their mood affecting the care they provided to the patients they really cared about, nearly quitting several times, and seeing patterns of isolation in their personal life that increased when burnout was first experienced at work. Several of them also expressed feelings of demoralization at recognizing their inability to function in the role like they wanted to. For example:

> I started to feel really anxious about going into work. I was fixating a lot on work when I wasn't there. I was coming home upset and crying and I was just feeling a lot more like neurotic and labile in my personal life. And really just starting to dread going into work as opposed to feeling like I was going to something with purpose… There was a lot more crying, a big uptick in my anxiety. I had a pretty big disturbance in my sleep. I've never been great at sleeping, but instead of switching my schedule when I was off from being up during the day on my off days, I was just staying up always on nights thinking that if I could be better rested, maybe work would be more enjoyable, and I wouldn't dread it so much. And then it was also kind of bleeding into some of my self-care personal stuff. I would plan things with my boyfriend to do over the summer and outside spending time outdoors with him, and I would cancel it because I was dreading being around people. I wasn't able to focus on the

> things I used to enjoy like reading, so I would try and read, and I just couldn't focus, and I would like put down my book and be like what the heck did I just read. Um, yeah. (P2)
>
> I just stopped wanting to go back into work. I don't really know, I just sort of got stuck, not speaking up for myself, just accepting how I was treated. You may think the adult unit is like your go to, it's super easy. It takes a few months and then you realize, man, like this is exhausting. Sometimes you don't even get a lunch break. So, what is that doing to your mental health? I know it affected me. Like in the beginning, if I didn't have lunch or something I really honestly didn't complain, because you can clock out no lunch. But again, almost at about a year a felt like, 'oh, I need a lunch. I need to step away from this place and then come back. Then maybe I can help you somehow.' So, knowing your limits I think is major. I did not know my limits then. So, I think I just, honestly, I just stopped caring, and I knew I needed my paycheck. So yeah, I'll go to work. But I think I was already gone before I actually left the place like I just didn't care anymore. (P8)

Coping. Many of the participants described the strategies they used to cope while experiencing burnout. Three participants reported that they left the field, with one returning soon after, and the other two returning years later. A couple also reported that they sought counseling due to mental health issues around the time that burnout was experienced. Several also described their introversion when talking about their coping needs, with two referencing outcomes from personality typology tests. Some discovered

that connecting with other professionals that understood their experience helped them through burnout. Others reported educating themselves through reading, and utilizing their joy for arts and crafts. A couple also described the harm with attaching to patients too much, bringing patient struggles home after work hours, and wanting to help the patients succeed beyond what they had control of. Some examples of this were:

> I had to leave the field, and I had to really begin to evaluate what is going on at that point. I really didn't understand dysfunctional families and dysfunctional organizations and expectations, and all those things. I really didn't understand my introversion. And I think introverts experience it very differently than extraverts in these intensely relational roles. I just had to pull back and do a lot of understanding myself. A lot of journaling, all that kind of stuff. I had trouble finding people that understood what I was talking about. They did verbally, 'Oh yeah, I've been tired, too,' you know. It's, 'you just push on through,' but to really find people that I could really crash in front of, and just be vulnerable, they just weren't there, you know. The expectation that everybody, that I created, and the organization and the ideals, Christian ideology, you know the extremes of it. There just wasn't… I couldn't find a safe place for me to be broken for me to be that needy, you know. I'm in recovery myself, so that who I used to be, and here I am again. (P10)

> I was trying to spend more time with my boyfriend and my friends, which, like I mentioned wasn't really working out because the introvert in me, was

> really coming out and feeling really burned out on being around people, and kind of dreading that social interaction. And then I was trying to do things like taking baths and sunbathing and reading, and like other just little self-care activities. But I was no longer able to focus and really just relax into those things like I used to do. (P2)

Theme 2: Learning Burnout

Participants recognized effects of burnout at work and what has worked to help them avoid "burnout traps." Some described what has changed for them at work that has helped them mitigate the experience of burnout. A few described that understanding organizations better and letting go of expectations from management and administration helped them find more job satisfaction. Others echoed this sentiment by how letting go of things they cannot control helped to decrease the onset of burnout. Intentionally taking care of personal issues such as emotional needs was mentioned as an important tool to combat burnout. Examples of this theme include:

> Understanding organizations was a big piece for me. And letting go bitterness over my major disappointment that these people really even the best ones that really loved and cared for me and were committed to me. But yeah, they couldn't fix the system to take care of me. That was my responsibility, not theirs. (P10)

> So, three things that helped, one of them was I wasn't facing the unknown anymore, because I gained a set schedule and which units I was going to be on. So, I knew who I was going to work with. I knew what I was walking into,

> I knew what patients I was seeing. I got a lot more support from my on-unit staff, so I gained set nurses that were much more supportive, management was a lot more supportive…. even though I'm spending more time in the hospital and less personal time, I do feel like I am less burnt-out now because I have that set schedule. I have a routine, and I have the support both in my career and private life, now as opposed to then, when everything was up in the air. Yeah, things are not as chaotic as they were. (P2)

Emerging Themes Based on Research Question 2

Theme 3: Safety in the Workplace

The third theme that emerged from the data collected concerned safety in the workplace. The concern for safety in the secure hospital setting is understandable since there is potential for patients to harm staff members. One expectation for psychiatric hospital staff is to be aware of safety risk and milieu safety in general. As a result, the mental health staff needs to have a heightened awareness of what may provoke a dangerous situation to prevent safety. Seven of the ten participants relayed safety concerns related to burnout. These concerns fell into two sub theme categories: Patient Violence and MHT Support and Teamwork.

Patient Violence. Patient violence and aggression refers to a range of behaviors that could lead to harm or injury to another person or to oneself, and this was one of the sub themes that emerged from the data as a factor that contributes to burnout. Typically, there is an intention to harm another person physically or verbally (Greenwood & Braham, 2018). Many participants expressed how much their job requires constant

vigilance in anticipation of patient violence, even though their tasks may appear mundane. Several participants described discomfort when they witnessed others being harmed by a patient. One described witnessing a co-worker being picked up and body slammed, another described a co-worker having their teeth knocked out, and others described the destruction of windows, computers, and phone chords. A couple participants who were older reported that as they have aged, they struggle physically when required to restrain patients who are in danger of harming themselves or others. All participants mentioned how draining it is to be on alert all the time for potential harm while at work. Some examples of this were:

> I work on the special unit, the more acute unit. So, we tend to have more aggressive patients, their psychosis are a lot more severe. So, my unit can get very intense. I feel like it is easier for burnout to happen if you don't have that support on the unit. With that, you kind of have to always know where the patients are, always know how their behaviors are, know where they're at. You have to know how they're feeling. So, I feel like just that environment and always having to beware of what's going on that you're constantly kind of on edge almost, even though you don't have to be at all times. (P6)
>
> Um, I actually left for a period. One day I just like put my two-week notice in. It was just very unsafe one day, and I just, it was very unsafe and I just, I can't. It isn't worth it to me anymore. The money's not worth it, my safety. That particular day there was only me and one nurse with 13 patients. And one of them had been in the quiet room all day, pretty violent. And both of

> us… I put my notice the next day. I found out. He put it in his notice the next day. Neither one of us knew about it. Like we didn't talk about it. So anyways it was just a very unsafe. (P5)

MHT Support and Teamwork. Another sub theme related to safety was that many participants expressed the importance of having supportive co-workers in the MHT position. They emphasized that milieu safety depended on this fact and on whether the MHT knew how to work with the patients, leaving the safety of the unit not only up to themselves, but also coworkers who may or may not have what they deemed an adequate dedication to teamwork. They expressed the importance of having a teamwork mentality and not leaving a co-worker at risk for harm. One participant added that different MHTs have certain abilities to help unique patient needs, which is why teamwork is important to creating a safe environment. Examples of this sub theme were:

> You know [the aggression] was never really much of a problem for me before. I'm prior military, so I guess I'm just like not fazed by that as much. I think what would contribute most is when I used to work with another CNA, but she took the role as an MHT. And a lot of the times she would leave me to the wolves, you know. She would sit in the enclosed nurse's station and send me out to do grounds every 10 min, and then to manage the unit, even though that was her core unit. So, I think the part that would contribute most is like having staff members who don't really seem to care about your safety. They would rather hang back where it is safe and send another person out. So, kind of not

> having support or maybe not being very in tune with like other people like, 'Well? Does she feel safe?' I guess that would contribute. (P9)
>
> Well, a lot of times it could be not being supported, you know. Sometimes you have coworkers, and they're not on the same level as you, and they don't respond the same way that you respond. Their approach is totally different, and it doesn't line up. And I am a person that I go hard, and what I mean by that I put my all into it. I tried my best to resolve [issues], deescalate, and all of that. That's just who I am, and so I'm gonna go the extra step, the extra mile. I'm going to put in what I can, regardless of if it seems like it's not effective. I'm still gonna at least try. (P7)

Theme 4: Workload

The fourth theme that emerged from the data collection was spending too much time on the job and not having enough time off to recuperate. When job demands are beyond an employee's capacity to perform, burnout is inevitable (Maslach & Leiter, 2016). Struggle with workload was reported by more than half of the participants in this study, making it a strong theme related to factors that influenced burnout in this sample.

Most participants described experiencing burnout or disenchantment from work due to working too much; specifically, that they overworked themselves and took on job duties when other MHTs did not exert as much effort. Some described the pressure of circumstances that resulted in being at work more than their scheduled hours, such as being contacted by work to come in when coverage was needed. They noticed they made more errors when they worked long hours, shared that they were so tired that they fell

asleep and received discipline for their work performance, and that being underpaid and not getting the required breaks was discouraging. A common impression was that part of mitigating burnout involved saying “no” when asked to work extra hours and learning to ask for what they need from supervisors. Many needed to experience burnout symptoms in order to enforce that limit. For example:

> At that time, it was just the final straw that broke the camel’s back. But the real culprit, when I look back on it, I was just there too much. I was always there, like always. I just picked up too many extra shifts. (P5)
>
> I picked up a lot of shifts. If somebody said, ‘Hey, we need help,’ or ‘Can you come to the floor?’ I would not say no, and I learned that not saying no actually is harder for me, because it puts more pressure on me. So, I feel like I could never step away from work because either somebody was like calling or texting me to come in, so I really didn't have that time away! I work night and days, so I transfer back and forth. I work days this week, and then usually every other week I work days. And then next week, nights, and then days. So, my schedule is very hectic as it is, and then, even if I would agree to come in for a little bit, then there would be no one to even relieve me. So, then I was there, I was just stuck there because I just didn't want to leave the nurses without the right kind of staffing. So, then I’d feel like I was pressured to stay. (P6)

Theme 5: Workplace Culture

The fifth theme that emerged from the data collected concerned the connection between workplace culture and burnout. According to most of the participants, a lack of teamwork among MHT and RNs and a lack of support from supervisors in managerial roles played a major part in creating a workplace culture that increased stress. Sub themes of the theme of Culture as contributors to burnout included Nursing (RN) Teamwork/Support and Co-worker Attitudes and Corporate Perception and Managerial Support.

RN Teamwork/Support and Co-worker Attitudes. A tense relationship between nursing and MHTs was a clear sub theme in the contributions to burnout in the sample. Many participants described experiencing a lack of support from nurses on the hospital units that ultimately contributed to their burnout. A few described experiences with nurses being "hostile," not being willing to settle their differences, and eventually seeking assistance from HR or supervising managers. Some described being "belittled" by nurses that they work with, being made to feel that their observation of patients was not important, being kept from team shift reports about the patients, and being reprimanded by nurses when they are not their supervisors. The MHTs often had more years of education than the nurses and were resentful of being treated as inferior by the nursing staff. Many participants also shared examples of how nurses did not support them in duties that they were expected to, thus leaving tasks such as activities of daily living and certain groups to "fall on" MHTs. A couple participants stated that it depended on

which nurses you were working with and that not all experiences with nurses were negative.

Regarding co-worker attitudes, a few participants discussed how gossiping, negative attitudes, and politics in the workplace can affect burnout. One described pressure to engage in workplace gossip and that not doing so was reflected in her performance evaluation. Another participant was overwhelmed with the lack of professionalism and complaining from co-workers. These participants discussed how they focused on patient care as way to make work worthwhile. Examples of RN teamwork and Co-worker attitudes are included here:

> Well, a lot of the nurses pit themselves against mental health techs, making them kind of seem like they're above us. I've been kicked out of report by a nurse who… so there's a night nurse who, I'm not sure where she came from. I think she's a traveling nurse, but she's kicked me out of report multiple times, because, in her words "we don't need to know about patients," which is crazy to me because we're doing, we're spending all day with them. Recently, they kicked me out of report. This happened a couple of weeks ago, and I was running a group. I did not know that one of my patients was highly aggressive and psychotic. He was sitting next to me in group, and suddenly stood up, charged me and looked like he wanted to kill me. He's standing right over me, so that was a pretty terrifying experience. I knew nothing about any of the kids, and I rarely have time to sit down and read the notes. I try to, but I can't get all of that in, you know, trying to plan groups, every hour. So, it's hard

> when you're not included as a member of the staff. When you are probably one of the more valuable members of the staff. Just because you are, well for us in the kids unit anyway, we are running everything all day. And you know, when walking into a patient's room when it's pitch black as 7:30 in the morning alone, you'd wanna know if they're aggressive or not, if there's a trigger or something. I think that's probably one of the biggest things, is just feeling like a lot of the nurses think that you're not as valuable. I don't even know what the reason is. I mean maybe some of them don't have degrees, but I mean I'm about to graduate with a 4-year degree, too. (P9)
>
> I never felt like I was a favorite. Not at all. Not at all. I guess it's because I'm not forthcoming with telling my business, for one. It's like a gossip fest. I don't like it so that's mainly why I stayed at the main hospital, because I can stay to myself there. And I got told during one of my evaluations that my co-worker says I'm too anti-social. Yeah, I just like to stay to myself, I don't like to do all the… I mean I get it we are there the majority of our time during the week and we supposed to be like a family, and I get that part. But it becomes too much. You know I just learned to just do my job and go home. I just want to do my job and go home and just mind my business. (P1)

Corporate Perception and Managerial Support. Participants also commented on how they perceived lack of managerial support as contributing to burnout**.** There were two main sources of this lack of managerial support, one related to communication and the other to preferential treatment. Participants expressed frustration with little to no

transparency and inconsistency from administrators. Half of the participants discussed how decisions made by management caused stress at work. They describe a disconnect between what they experienced working on the psychiatric units and the communication or lack of communication from managers and administrators. Examples of this included:

> Okay, when the health network proposes one set of values and one set of expectations, and then you find out in reality there is a completely different set of expectations and reality. I actually left for a year and came back due to burnout. And it was not the patient care it was the discontinuity between stated corporate values and practiced corporate values. How specific do you want me to be in this setting? Okay, so we talked about our sacred work, and we're in nonprofit. But when it comes down to practice, if it's not making money, it's not gonna happen. Specifically, the closing of the adolescent unit was traumatic because all of us that worked that unit were very connected to it. And we knew that as far as the network went, mental health was not a priority, and the adolescent unit was the lowest priority of the metal health, which was also not a priority. (P4)

> ’So, we want you to be safe but we're not gonna increase staff,’ you know. ‘If you're injured, we’ll stand behind you,’ and then you watch people get injured. And no, nothing. They don't get the support that they need. So, the same corporation that states the values also puts obstacles to achieving those values. That's where the burnout comes in where you’re just, yeah. I feel like anecdotally people have gotten injured, and then filed for you know the

> getting payment for it, and it's like, 'No, no, that's really not a real injury.' But I would expect corporate denial like, 'Oh, no, we fully support,' but it's like, no, no you don't. (P3)

Participants shared specific examples of poor decision making by professionals in management positions. Four participants related these experiences directly to burnout. In one example, management did not support a poorly staffed unit during a period of high patient acuity. This led to the participant as well as a nurse on duty resigning the next day without the other knowing. Another participant gave the example of how the decision to admit a patient is based more on if there is a free bed on the unit instead of safety. Another concern was the staff-to-patient ratio that did not consider issues related to medication management, creating the chance for more frequent emergency medication events and "take-downs." One participant described hearing untrue statements from a manager and wondering if they knew the facts better than an administrator, saying there was a disconnect the "further you go up the chain of command." Another participant had reported to their manager that they had been kicked out of shift report for being an MHT and that rounding was not being taken seriously and reported that they had come to terms with the fact that no changes were going to be made as a result. The same participant expressed frustration about being called on what they thought was their day off by administrators saying that they were on the schedule to work that day. They were then required to take a sick day or call off work, which caused discipline. Another participant struggled with being generalized with other MHT's who did not have children and had

more freedom to work more shifts. This MHT wished their life routine was considered more and that they were not contacted so frequently.

A few participants attributed burnout to unfair and preferential treatment to some staff on an organizational level. This was described as an issue with cliques that originated from the top down, resulting in some MHTs being assigned preferred job tasks over others. Some participants also stated that MHTs that had seniority could be given opportunity to decide on schedule and work locations before more newly employed MHTs. One of these participants stated that their health issues were exacerbated by being made to work weekends, while others were not. Some examples or corporate perception and managerial decision-making are included:

> Oh, I know we weren't supported by [unit management]. I mean the hospital knew that someone had been in the quiet room all day that was violent, that no one was staffed… One nurse and one tech. As far as I know. Nobody was trying to call, come in early, or… Security knew about it. They could've stood up there or something just… I can't tell them how to do their job. I don't know. Maybe they can't. I don't know. (P5)

> I'll drop one last thing, the decisions on how to use emergency medication to intervene with behavior, 'Well other hospitals only use this amount of staff,' and I'm like, but what is the medication level? Because if they're not medicated, that's a whole other world. Then, if they were actually sleeping, staying down mellow. So all the pieces of the organization, not just the staffing grids. Yes, and there's the trend that well, 'we don't wanna over

> medicate,' and you know, they gotta be just slamming walls and screaming and tackling people, 'Oh, maybe we'll medicate now cause we're doing trauma-informed care,' which I love. But if you get doctors or you get people, 'oh, well, we don't want the state to get upset,' You know you're in quite a pressure cooker. (P10)
>
> They give preference to staff who have been there longer. I even experienced that after I'd been there a year. I started to get more of a say where I could be assigned. It's preferential treatment. I know I feel like it exists almost everywhere, you know. But there's like little cliques, and like those cliques are more obvious, and it starts from the top. It's from leadership like all the way from the director to the clinical nurse manager to the supervisor, down to the nurse. Like everybody has their favorites, which is fine, but you know, you have to understand everybody's human. Everybody's equal, like. So how about we, you know, if A has done the sitting today, maybe B can do it. Like why do we have to give that preferential treatment, like, it just doesn't make sense to me. (P8)

Theme 6: Unpredictability

The sixth and final theme that emerged from the data involved how unpredictability contributed to burnout. Participants shared how burnout was in part caused by not knowing how to anticipate aspects of their job. Such ambiguity was attributed to schedule and unit assignments, changes on the unit, COVID related changes, and job expectations and duties. A few participants attributed their stress to not

anticipating which unit they would be assigned to work. Their hospital had different units with patients of different levels of risk; they did not practice informing MHTs where they could prepare to work until they arrived at work. Disruption by COVID to their work experience in general was mentioned to contribute to burnout as well as major changes made to their facility operations. These facility changes were described as major transfers of hospital units to different locations.

> It was at the start of the pandemic. and then we were also changing our kids unit and our adolescent unit into our co-occurring unit. So, we were no longer seeing our pediatric patients, and we were getting people who were higher acuity. And then I was also being switched from being primarily on our adult unit to working on our BICU with some of the co-occurring patients. I was never sure where I was gonna be when I came in. If I was gonna have patients who were there for anxiety, depression, suicide, or if it was going to be psychotic patients, violent patients, if they were going to be pleasantly psychotic. Just a lot, of unknown about what I was walking into. And also, not knowing who I was going to be working with anymore. (P2)

> I think probably just the fact that I had a lot of expectations when I was coming into this job. During the interview I was told there was room for me to advance. There was, I would be getting a raise in 6 months. Kind of just like all these tales, and none of them ended up being true, which is very disappointing. I felt like I'm just kind of like a number versus get annual

bonuses. The doctors get bonuses, and I get 'hey, you're scheduled on Christmas.' (P9)

Summary

The purpose of this study was to explore the manner to which psychiatric hospital staff reported their experience with burnout while working in an acute psychiatric hospital setting. Ten participants met the criteria and met with me to tell me about their experiences with burnout. There were two foundational research questions to address this phenomenon: (a) How do mental health staff working at inpatient psychiatric units describe experiences of burnout? and (b) What factors do mental health staff working at inpatient psychiatric hospitals identify as contributing to burnout?

The first two themes resulted from participant response to the first research question. The first theme addressed how burnout affected them with subthemes of personal experiences including mental health and their experience coping with burnout. The second theme involved how participants recognized effects of burnout and ways to mitigate it.

The third, fourth, fifth, and sixth themes and corresponding subthemes resulted from responses to the second research question. The third theme that emerged regarded safety on the unit with subthemes on patient violence and support and teamwork from fellow MHTs. The fourth theme observed addressed workload which referred to picking up shifts or overworking while at work. The fifth theme was work culture with emerging subthemes of teamwork and support from nurses, co-worker attitudes, and corporate

perception and managerial support. The sixth theme was unpredictability which referred to changes on the unit and job expectations.

The final chapter of this study will refocus the purpose of this study by interpreting its outcomes in comparison to existing literature on burnout. This will include assessing the outcomes through the lens of the theoretical framework. Any limitations of this study that resulted from its protocols was addressed and recommendations for future study was described. Also, this study's impact for positive social change was shown.

Chapter 5: Discussion, Conclusion, and Recommendations

Burnout among staff working in acute psychiatric hospital settings has been widely studied due to its impact and prevalence (Sprang et al., 2019; Turgoose & Maddox, 2017). The impact of burnout in psychiatric hospital staff is evident as they are commonly the first and most frequent line of contact for acute psychiatric care patients (Jacobowitz, 2018). However, an in-depth exploration of psychiatric hospital staff perception of burnout was needed. The purpose of this qualitative study was to explore how psychiatric hospital staff working at inpatient psychiatric units describe their lived experiences of burnout and what factors they identify as contributing to burnout.

Ten psychiatric hospital staff members shared compelling information about their experience with burnout. Data were collected using a semi-structured interview to explore this phenomenon from their perspective. The semi-structured interviews allowed participants to elaborate on their unique experiences with burnout, which enriched the interpretative process. Data were analyzed using the IPA method, which allowed me to capture the essence of the lived experiences through themes and subthemes that were generated from participant responses. The data that were collected has helped to better understand how psychiatric hospital staff experience burnout and their understanding of its etiology.

The results of this study indicate a sixfold thematic explanation for burnout. The first theme referred to the effects of burnout in their lives with subthemes of personal experiences including mental health and their experience coping with burnout. The second theme involved how participants recognized effects of burnout and ways to

mitigate it. The third theme that emerged regarded safety on the unit with subthemes on patient violence and support and teamwork from fellow MHTs. The fourth theme addressed workload relating to picking up shifts or overworking while at work. The fifth theme was work culture with emerging subthemes of teamwork/support from nurses and co-worker attitudes and corporate perception and managerial support. The sixth theme was unpredictability relating to schedule, changes on the unit and job expectations.

This chapter outlines a brief overview of the findings followed by a thorough interpretation of the findings when compared to existing literature described in Chapter 2 as well as the applied theoretical framework of the transactional model of stress theory. Any limitations that may result from this study's protocols was addressed as were recommendations for future study. Finally, this study's capacity for meaningful contributions to social change was presented.

Interpretation of the Findings

The findings from this study give insight into and expand on the findings on burnout among psychiatric hospital staff in the acute psychiatric setting. Participants shared details on how they experienced burnout at work and how it impacted them at work and away from work. Their insights brought together common themes that are pre-existing in the literature. However, most literature on burnout studied physicians and nurses, excluding psychiatric hospital staff. Populations studied were specified when they involved subjects other than psychiatric hospital staff.

Theme 1: Effects of Burnout

The first theme that emerged from the data collection was the reports of the effects of burnout by psychiatric hospital staff. This included their personal experiences with burnout and its impact on their mental health and how they coped. Many participants expressed how they failed their job's purpose by not caring for the patients adequately, due to feeling burnt out.

The participants' experience with effects of burnout in the workplace is supported with the literature. Shanafelt et al. (2016) identified several personal factors that have a causal relationship with burnout, and this includes engaging in unhelpful coping strategies, being self-critical, over-commitment, sleep deprivation, idealism, perfectionism, inadequate support system outside the work environment (such as having no children, or spouse), and work-life imbalance. Similarly, Grover et al. (2019) found that burnout causes healthcare providers to complain of feeling exhausted, tired, irritable, inattentive, and fatigued. They further determined that burnout is correlated with depression, mood disorders, stress, and disruptive behavior (Grover et al., 2019).

Studies found that brain structure among burnout subject were similar among those with depression and chronic fatigue, specifically with frontal alpha asymmetry in the medial prefrontal cortex (Golonka et al., 2019; Luijtelaar, et al., 2010). Kerr et al. (2021) also found that stress among psychiatric hospital workers was not experienced differently among gender roles in the workplace. A cross-sectional survey of healthcare workers in a large U.S. healthcare system looked at associations between patient safety, depression, and burnout (Rehder et al., 2020). The findings showed that disruptive

behavior climate was significantly correlated with increased burnout levels, low work-life balance, and poor job satisfaction (Rehder et al., 2020). Further, the researchers confirmed that burnout among healthcare providers was associated with behaviors that may be harmful to patients, including verbal abuse, physical aggression, unnecessary discontinuation of communication such as turning one's back before a conversation is over or hanging up a phone, and humiliating others publicly (Rehder et al., 2020). These disruptive behaviors, according to the authors, undermines the ability to provide holistic care to patients in a manner that they could heal physically, emotionally, and spiritually (Rehder et al., 2020).

Theme 2: Learning Burnout

The second theme that emerged from this study highlights what participants have learned from experiencing burnout. More than just recognizing how burnout affected them, many described how their experiences helped them recognize burnout within themselves and the work factors that lead to burnout. Some recognized marked understanding of organizational factors and what is outside of their personal control taught them about burnout.

Understanding factors that contribute to burnout among psychiatric hospital staff is supported by the literature. Matziari et al. (2017) studied how organizational culture impacted burnout and engagement among nurses in a general hospital and psychiatric clinic. They found that organizational values and practices were good predictors for burnout as well as an employees' investment in their work. This was especially so if a corporation was innovative with empowering nurses to take ownership of their work and

whether there were resources present to execute their job (Matziari et al., 2017). The job performance of psychiatric nurses was also studied in hospitals affected by the spread of COVID-19 (Lim et al., 2022). Burnout in these settings could be moderated by improving self-efficacy towards job performance (Lim et al., 2022). That is, hospitals that allowed nurses to make decisions based on personal judgement decreased the chances of experiencing burnout. Lim et al. (2022) suggested that a person's perceived success in their job performance can be greatly enhanced by a stable organizational system.

Theme 3: Safety

The third theme that emerged from this study was safety concerns by psychiatric hospital staff on the psychiatric unit. This included their concern for safety that originated from the potential for harm to occur towards themselves or someone else from patient aggression. Many described being harmed themselves but experienced marked discomfort when observing incidents of harm towards others. All the participants expressed how anticipating aggression from patients caused them to experience mental exhaustion. Participants also shared how difficult it was to work in an environment with potential for aggression particularly while working with others who did not show care for the safety of their co-workers.

The participants experience with violence in the workplace has been widely mentioned in academic publications (Aguglia, 2020; Hunsaker et al., 2015; Ridenour et al., 2015). According to the Bureau of Labor Statistics. (2015), violence by patients is the number one cause for injury and illness and psychiatric hospital staff are 38 times more likely to be harmed in this way than the national average.

A meta-analysis found that 1 in 5 patients in the acute hospital setting may engage in violence (Iozzino et al., 2015). A qualitative study found that these experiences with patient assault caused increased anxiety and fear, helplessness and hopelessness, and doubting personal competency in staff (Ezeobele et al. 2020). Aguglia et al. (2020) found that in this setting, female psychiatric hospital staff were likely to experience burnout from workplace violence as opposed to male staff. Psychiatric hospitals were found to be settings most likely to experience aggression from patients (Golonka et al., 2019; Spector et al., 2014). Experiencing patient violence was found to activate psychophysiological mechanisms in response to stressors. Some of these mechanisms include high heart rate, high blood pressure, and increases in salivary cortisol and plasma catecholamine, all of which increases tiredness and burnout (Golonka et al., 2019). Given the risk for work burnout due to patient violence, a healthy team mentality and positive social support from peers in the workplace was found to be a protective factor for physicians and nurses (Giménez Lozano et al., 2021).

Theme 4: Workload

The fourth theme that emerged from this study was the reports of overworking. Participants described spending too much time on the job due to picking up work hours that were beyond their regular working schedule. Others reported overextending themselves while at work compared to others. Participants noticed making more errors when they worked longer hours and feeling deprived of sleep.

The participants' experience with workload at work is supported with the literature. Velimirović et al. (2017) studied burnout factors among professionals in the

psychiatric hospital setting, 24.8% of which were psychiatric hospital staff. They found that workload influenced burnout when staff tried to increase their job satisfaction by taking on more work, with a pace that becomes excessive. West et al. (2018) similarly found that that long working hours, excessive workloads, and frequent call duties (weekend or night calls), among other factors, contribute to burnout. Long-working days and a heavy workload together with low morale contributed to burnout (Giménez Lozano et al., 2021; Matziari et al., 2017), although only several participants surveyed were support staff compared to the hundreds total. O'Conner et al. (2018) also found for mental health professionals in general, high workload or caseloads were found to be associated with higher levels of burnout.

Theme 5: Culture

The fifth theme that emerged from the data collection concerned workplace culture. Participants reported a lack of teamwork and support from nurses created hostile working environments, especially when treated as inferior staff by them. The effects of burnout were also enhanced when working with staff with negative attitudes, which usually involved gossiping, complaining, and workplace politics. These poor psychosocial dynamics were evidence of a lack of professionalism. Participants also described frustration with corporate perception and managerial support, particularly relating to poor transparency and incongruity from administration as well as poor decision-making and unit management from higher ups. Participants also described preferential treatment for certain employees over others.

The participants struggle with negative work cultural factors is somewhat supported by the literature. O'Conner et al. (2018) found three studies showing how in mental health personal conflicts among co-workers increased emotional exhaustion. Becket et al. (2013) acknowledged the challenge that an oppressive inpatient hospital setting can be. They also found how difficult it is to improve nursing practices in this setting, although implementing positive patient care is more likely to happen if the nurses are experiencing a positive environment themselves (Becket et al., 2013). Becket et al. found that implementing a person-centered approach with patients accompanied with a work culture that reflected these values helped to transform the negative worker experience into a positive one.

Caldwell et al. (2006) attributed negative work atmosphere in the psychiatric hospital setting to a treatment culture of simply caring for the patient's safety and other basic needs to a culture of recovery. This study focused on professions other than psychiatric hospital staff. Common psychosocial problems among healthcare providers in psychiatric units were accompanied by fatigue, absenteeism, and a decrease in quality of service deliver (De Oliveira et al., 2019). A study with all staff working at a psychiatric hospital found 69% of respondents reported generally positive experience with working with coworkers above and below them in rank (Kelly et al., 2016). Current scholarship does not address perceived negative nurse attitudes by psychiatric hospital staff.

The participants' experience with corporate perception and managerial support in the workplace is supported by the literature. Academic researchers have cited organizational factors as a major cause of burnout among healthcare providers working

across all specialties with risk factors like social supports, authoritarian leadership style, poor autonomy and poor working conditions (Giménez Lozano et al., 2021), as well as poor support from managerial staff (Hamid et al., 2017). O'Conner et al. (2018) found that being treated fairly was important protective factor against burnout. This included being rewarded fairly for the work that is done. Support from management in the way of supervision also impacted work morale. Nurses were found to attribute burnout and job disatisfaction to poor staff management among other staff issues (Velimirović et al., 2017). A meta analysis found three studies showing that inadequate supervision for psychiatric nurses contributed burnout (O'Conner et al., 2018).

Shanafelt et al. (2015) discovered the impact that organizational leadership could have on physician burnout and job satisfaction. Negative leadership behaviors, lack of opportunities for advancement and social support for physicians, and inadequate interprofessional collaboration have been cited as organizational factors that cause burnout among healthcare providers across all specialties (Shanafelt et al., 2015). Further, Shanafelt et al. noted that burnout is less common in healthcare organizations where leaders mentor, inform, and seek input from all stakeholders regardless of their rank and type of work. A longitudinal study suggested that healthcare organizations that provide physicians and their fellow providers with increased control over workplace issues experienced less burnout and had higher career satisfaction (Williams et al., 2012). This is consistent with other studies that found having a sense of ability to influence change at work contirbuted to lower levels of burnout (Giménez Lozano et al., 2021; O'Conner et al., 2018). Burnout can be mitigated by enhancing an employee's sense of control. This

percieved ability to influence decisions to make their job more effective, including having access to resources to perform their job, leads to increased job satisfaction (Maslach & Leiter, 2016).

Theme 6: Unpredictability

The sixth theme that emerged from this study referred to unpredictability about what to expect due to both short term assignments and long terms facility changes. Such ambiguity was attributed to schedule and unit assignments, changes on the unit, COVID-19 related changes, and job expectations and duties. Not knowing what to expect going into work negatively impacted participants. They reported not knowing for sure which unit they would be assigned to or which patients to expect supporting that day. Disruptions related to facility and leadership changes and adjustments for COVID were also reported to impact burnout.

The participants' experience with unpredictable factors in the workplace was similar to the findings reported in the literature. The authors of a meta-analysis found that role ambiguity was associated with emotional exhaustion in two studies and identified one study where clarity in one's role was associated with higher levels of personal accomplishment (O'Conner et al., 2018). The COVID pandemic resulted in unexpected changes for the participants in this study and this was also reflected in the literature. Li (2020) presented considerable evidence of changes made for inpatient psychiatric units, including new risk of contact among workers and patients, barriers in conducting treatment, the effects of visitor restriction, among other challenges to consider. Karcz et al. (2022) studied psychiatric staff, including support caregivers during the COVID-19

pandemic and found that loneliness, complaining, and lack of engagement by was related to burnout. Lim et al. (2022), studied levels of self-efficacy, burnout, and job performance among psychiatric nurses during the COVID-19 pandemic. Their participants scored higher in burnout than similar studies conducted prior to COVID-19. Lim et al. also reported that self-efficacy was negatively correlated with burnout, and that self-efficacy and job performance were positively correlated (Lim et al., 2022).

Theoretical Framework

The transactional model of stress theory was used as the theoretical framework for this study (Lazarus & Folkman, 1987). This model focuses on a person's interpretation of the stressor and their ability to cope with it. The stress adaptation model in this theory matches well with the responses from this study, which comprises the components associated with the experience of a stressful situation: the initial appraisal of a stressful event, appraising whether they can cope, the coping process, and then a reappraisal of the status of the stressor (Bodenmann et al., 2016, Goh et al., 2010; Gonçalves et al., 2019).

Appraisal

Participants in this study described stressful events when primary and secondary appraisals were required. Whenever a stressful event was described during the interview, it assumed a primary appraisal occurred. When they further described how the event was severe enough to cause stress that disrupted their work experience, they engaged in secondary appraisal. The stress was reappraised after the participants expressed their efforts to mitigate the stress through coping.

Coping

All participants described their coping experience with stress. Most described coping practices that worked to mitigate stress prior to burnout, such as engaging therapeutic support, reframing experiences, trying to stay positive, and activities for distraction. Most participants found that these emotion-focused attempts were not sufficient resource this time around. Others described attempts to engage in solution-focused coping to combat the stress at work, such as meeting with supervising managers to address sources of stress. In most cases, participants experienced emotional exhaustion, cynicism towards work, and a lack of personal accomplishment that exceeded their abilities to cope.

Limitations to the Study

Limitations of this study are given to assist future studies on burnout among psychiatric hospital staff in the inpatient hospital setting. This study was conducted with the utmost attention to accuracy and trustworthiness while evoking reliable data from participants. Through these efforts, some limitations still exist. The first notable limitation was retrieving data through an electronic medium instead of through an in-person conversation. Thunburg and Arnell (2022) found that technical difficulties can disrupt this method of data collection. Also, micro cues could be lost through this communication medium. However, the cost-effectiveness and allowance for larger data samples balances out the cons of conducting electronic interviews for qualitative research (Thunburg & Arnell, 2022). This study was conducted nearly two years after the COVID-19 pandemic; this factor stressed the usefulness of communicating via electronic

methods. Participants in this study seemed comfortable and authentic communicating through the electronic medium.

The nature of the study was phenomenological and was limited to the collection of narrative data. Although the sample size was small, it conveyed rich information with participants remarking on similar areas of concern and effects of burnout. This study was geographically limited, as all participants who were interviewed in this study were from two well established psychiatric hospitals in two specific urban areas in the United States. All participants spoke and understood English well enough to participate in the research, so no interpretation options were needed. Being geographically bounded may limit transferability of results to other geographical locations.

Another existing limitation involves full transparency from the participants. Although participants were reassured of confidentiality, their answers may have been influenced by a pre-existing or developed distrust during the interview process. I could not control for participants' life experiences that may have contributed to inclinations to withhold information. However, the participants seemed genuine in their reports.

My personal experience with burnout in the psychiatric hospital setting provided motivation for this study, but it also may have allowed for some enthusiasm when specific themes emerged from the data. I took many opportunities to recognize my emotional responses to outcomes from this study so that themes would generate as neutral as possible. My main motivation to remain aware of my reactions was the reminder that this study should serve all psychiatric hospital staff and their operational support systems. Despite many of the detailed limitations, the research findings captured

the thoughts, opinions, and subjective experience of psychiatric hospital staff. I believe that results of this study provided valuable data from thoughtful, experienced psychiatric hospital staff.

Recommendations for Future Research

This research study has contributed to the scholarly literature for burnout among psychiatric hospital staff in the acute psychiatric setting. Additional studies seeking to examine burnout among psychiatric hospital staff may find ideas that were not examined in depth during this study. For example, many participants described their personality type in terms of introversion and extroversion. They mentioned this personality factor when describing interactions with others in the hospital unit, in therapeutic groups, and in socialization factors among peers. This topic was also mentioned when describing coping needs and practices. Brown et al. (2019) found that among physicians, certain components of personality impacted burnout more than others. Further studies could explore the relationship between personality type (particularly the introversion/extroversion factor) and the likelihood of developing burnout among psychiatric hospital staff.

Participants in this study described harrowing experiences with patient violence. They also described stress when observing others being harmed. Secondary trauma may be commonly experienced among psychiatric hospital staff, which the literature also labels as *compassion fatigue* (Jacobowitz et al., 2015). Studies have used the Professional Quality of Life measure useful to find the relationship between secondary trauma and burnout (Ray et al., 2013). But these studies group psychiatric hospital staff among other

healthcare workers, depreciating the unique experience from staff who work most directly with a high stress environment. Future research may concentrate on compassion fatigue in this population. A few participants who were the most experienced in the psychiatric hospital staff position mentioned burnout factors associated with stages in life. This remark was mentioned by professionals who made this occupation a career compared to others who used it as a stepping stool for a different profession. These findings may add to existing studies that have found differences in age among psychiatric hospital staff who experience burnout (Aguglia et al., 2020; O'Conner et al., 2018).

The second theme in this study revealed that sometimes the participants were able to learn from and anticipate burnout. Research shows that it is possible to move through short bouts of stress through the appraisal process. Jamieson et al. (2013) found that cognitive reframing of the stress experience as a positive challenge instead of a negative experience can improve performance and attention. This reappraisal involves reinterpreting the meaning of stressful cues (Jamieson et al., 2013). Interventions like Inquiry Based Stress Reduction (IBSR) help to reframe the stress experience, reducing symptoms of stress across different measures of well-being (Smernoff et al., 2019). Future controlled studies could compare well-being scores for psychiatric hospital staff that undergo IBSR intervention (Zadok-Gurman et al., 2021). To add to this study's findings, further work can be done to examine issues of engagement among psychiatric hospital staff. Participants in this study presented frustration with work culture, being treated as if their contributions to the team were not important, not experiencing autonomy in their role, and conflicts with others. Meta-analyses show these issues are

associated with burnout in the acute hospital setting (Beckett et al., 2013; O'Conner et al., 2018; Yang & Hayes, 2020), but further studies could survey a larger pool of psychiatric hospital staff to explore sources of burnout and how engagement with work is impacted. In general, the themes found in this study may inform whether current research tools measure what was found important to psychiatric hospital staff.

Implications

The findings associated with this study have the potential to produce significant social change. The themes that emerged highlight factors that can inform facility operations of meaningful provisions and education. These issues, if addressed, can create protective factors against burnout among psychiatric hospital staff. Individuals in this role receive the most direct effects of patient behavior while experiencing the organizational demands, which make their burnout experience unique. This study allowed their experiences to be heard so that they can be better supported. This care for the wellbeing of psychiatric hospital staff will impact their ability to provide their highest quality work for persons vulnerable to mental health struggles. Informing psychiatric care facilities with the realities of the work setting for this unique position can then improve the quality of mental health care provided within the community.

The participants in this study shared how they experienced burnout. Rehder et al. (2020) found that burnout is associated with behaviors that were harmful to patients, including verbal and physical aggression, unnecessary discontinuation of communication, and humiliating others publicly. This aligns with the sentiments expressed by participants in this study of shame in their job performance and how they felt like they failed their

job's purpose by not taking better care of the patients. Many psychiatric facilities express a purpose to serve their communities by supporting individuals who struggle with mental illness. The most direct way that this can be shown is through the direct care for those individuals. Decreased symptoms of burnout or enhancing burnout education among psychiatric hospital staff, patients can experience the positive mindset, performance, and attention they deserve. It is my hope that psychiatric hospital staff can experience the great reward that comes with supporting patients in the acute hospital setting through the innovation of psychiatric units that desire to learn and improve their provisions. Through improved support for those who have the most front line exposure to those who are more vulnerable in a community, facilities can make direct change for the communities they profess to serve.

Conclusion

The central aim of this descriptive qualitative study was to explore the burnout experience among psychiatric hospital staff in the acute psychiatric setting. Research on how burnout effects psychiatric hospital staff apart from other medical professionals is not robust and lacking in qualitative analysis in particular. Therefore, a study is long overdue to examine burnout factors from the psychiatric hospital staff point of view. Through semi-structured interviews, ten participants were able to elaborate on their unique experiences with burnout. This enriched the IPA process of capturing the essence of the lived experience for each participant.

In obtaining their narratives, six themes and six subthemes emerged related to the two research questions: How do mental health staff working at inpatient psychiatric units

describe experiences of burnout? and What factors do mental health staff working at inpatient psychiatric hospitals identify as contributing to burnout? In addition to learning about the effects of burnout on the participants and what they have learned from experiencing burnout, the data revealed that safety concerns, workload, workplace culture, and unpredictability contributed to the burnout experience among the participants.

Participant insights brought together common themes that are pre-existing in the literature. However, most literature on burnout studied physicians and nurses, excluding psychiatric hospital staff, or when they included them, their responses were not isolated from the others for the results of the study. The results of this study can expand the understanding of the burnout experience among psychiatric hospital staff, especially within the framework of the transactional model of stress and coping. The important work from this study can increase facility preparedness to address issues at work that contribute to burnout. An increased desire to assist employees who have the most direct contact with patients will ultimately serve the facility's impact in the community and in the individual lives of the patients they serve.

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Appendix: Demographic and Interview Questions

Demographics

1. Regarding your gender, how do you identify?
2. What is your age?
3. What is your professional degree?

   Probe: If you do not have a degree, what is your education level?
4. How many years have you worked as a psychiatric hospital staff?
5. What is your racial identity?
6. What is your ethnic or cultural identity?

RQ$_1$: ***How do mental health staff working at inpatient psychiatric units describe experiences of burnout?***

Interview Questions:

7. What does burnout mean to you?
8. How did you know you were experiencing burnout?
9. How did you think about your work when you were experiencing burnout?
10. How did burnout affect you?

    Probe: Did you experience any changes in your overall mental or physical health?
11. How did you cope with the burnout?

    Probe: Were there strategies that you tried?
12. What kind of activities you currently do as a psychiatric hospital staff?
    a. Probe: Which ones led to higher levels of burnout?

RQ$_4$: ***What factors do mental health staff working at inpatient psychiatric hospitals identify as contributing to burnout?***

Interview Questions:

13. What do you think contributed to you experiencing burnout?

    Probe: What was going on at work at the time?

    Probe: What was going on in your personal life at the time?

14. Do you see yourself continuing to work in the mental health field in the future? If so, how? If not, what field do you think you would like to work in?

15. Is there anything I didn't ask about that you'd like to share with me?