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Process, Factors, Resources, and Health Consequences of Burnout in Psychiatrists

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Walden University
2020

Abstract

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Brittany Plaven

MA, University of Alabama, 2016

BS, Metropolitan State University, 2011

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Burnout among psychiatrists in the United States is prevalent; however, scholarly literature lacks studies exploring why psychiatrists are burnt out, what resources mitigate burnout, and the health implications of burnout, which is needed to improve health education programs for psychiatrists. Understanding the reasons for psychiatrist burnout, the resources that can mitigate burnout, and the health implications of burnout provided the purpose for this dissertation and foundation for the four research questions. The multidimensional theory of burnout, job demands-resource model, and the conservation of resources theory grounded the study. A qualitative, exploratory, multiple case study was conducted using data gathered from 14 participants. Surveys and semistructured interviews were thematically analyzed. Results indicated that the burnout process for psychiatrists occurred gradually over time, was precipitated by work stress, and was a multidimensional experience. Factors that contributed to burnout included feelings of ineffectiveness, challenging patients, lack of appreciation, secondary trauma, excessive work demands, insufficient organizational support, and burnout culture. Resources that were found to be protective included relational support, self-care, enhancing self-awareness, collaborative communication, notice and appreciation, manageable case load, and increased flexibility. Finally, results indicated that psychiatrists perceived both physical and mental health consequences as an outcome of their burnout; however, mental health consequences were prominent. This research could inform health promotion programs aimed at reducing burnout in psychiatrists, which could ultimately contribute to a reduction in psychiatrists leaving their job due to burnout.

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Chapter 1: Introduction to the Study

Introduction

According to the American Psychiatric Association (APA, 2018a), in 2018, two out of five psychiatrists reported experiencing professional burnout. The prevalence of burnout among psychiatrists has also been addressed by empirical researchers (Grisham, 2018; Shanafelt, Hasan, et al., 2015). Grisham (2018) found that 38% of psychiatrists reported symptoms of burnout. Shanafelt, Hasan, et al. (2015) found that 40% of psychiatrists reported burnout in 2011 and that this percentage increased to 48% in 2014. Although empirical literature has demonstrated the prevalence of burnout among psychiatrists (Garcia et al., 2015; Grisham, 2018; Shanafelt, Hasan, et al., 2015; Volpe et al., 2014), few studies have explored why psychiatrists are burnt out, what resources mitigate burnout, and the perceived health consequences of burnout (Heinemann & Heinemann, 2017; Maslach & Leiter, 2016; Schwenk & Gold, 2018). This qualitative, multiple-case study aimed to explore these gaps in the literature. Specifically, this study investigated how psychiatrists define and explain burnout, what factors impact the process of burnout, what resources protect against the effects of burnout, and how burnout affects perceived health consequences from the perspectives and self-reports of a sample of psychiatrists who self-identified as having experienced burnout.

This study is socially significant because its results could be used to advance the professional health education development tools needed to improve the health outcomes of psychiatrists who work in jobs characterized by high levels of burnout. As is described further in this chapter, the number of practicing psychiatrists in the United States is

decreasing (Satiani, Niedermier, Satiani, & Svendsen, 2018) while the need for mental health services is dramatically increasing (National Council for Behavioral Health [NCBH], 2017; United States Department of Health and Human Services [USHHS], 2016). It has been shown that burnout contributes to psychiatrists' intent to leave their jobs (Garcia et al., 2015). Thus, the current study's results could be used to mitigate burnout among psychiatrists, which could reduce the number of psychiatrists who leave the field due to burnout.

In Chapter 1, I describe the topic of the study, discuss why the study is necessary, and identify the relevant gaps in current knowledge. The chapter then presents the study's conceptual framework and research questions and delineates the nature of the study. The chapter concludes with a discussion of the study's assumptions, limitations, and delimitations as well as its potential social significance.

Background of the Study

According to Maslach, Schaufeli, and Leiter's (2001) seminal definition, professional burnout is a psychological syndrome that develops as a response to chronic occupational stress (Maslach, 2017). It is characterized by symptoms including overwhelming fatigue and emotional exhaustion, loss of motivation, a cynical view of one's job, and a reduced sense of personal accomplishment (Maslach, 2017; Maslach et al., 2001). In physicians, the consequences of burnout are profound and can include negative patient outcomes such as medication mistakes, organizational consequences such as financial loss due to absenteeism, and negative personal health consequences (Patel, Bachu, Adikey, Malik, & Shah, 2018; West, Dyrbye, & Shanafelt, 2018).

Burnout specifically among psychiatrists has recently attracted the attention of professional organizations, such as the APA. The APA reported that in 2018, two out of five practicing psychiatrists in the United States experienced professional burnout (APA, 2018a). Additionally, in a Medscape survey, Grisham (2018) found that 38% of psychiatrists reported symptoms of burnout. Several empirical studies have also demonstrated the prevalence of burnout among psychiatrists practicing in the United States (Garcia et al., 2015; Shanafelt, Hasan, et al., 2015; Volpe et al., 2014). Garcia et al. (2015) found that 86% of psychiatrists working at the Veterans Administration (VA) reported high levels of emotional exhaustion and that 90% reported high levels of cynicism, both of which are factors of burnout as defined by the multidimensional theory of burnout (MTB; Maslach, 2017). Volpe et al. (2014) found that 52% of early career psychiatrists practicing in the United States had "moderate□to□high" scores on all three burnout dimensions: emotional exhaustion, depersonalization, and reduced personal accomplishment. Alarmingly, Shanafelt, Hasan, et al. (2015) found that burnout among psychiatrists increased from 40% in 2011 to 48% in 2014.

The results of these studies demonstrate that burnout among psychiatrists is prevalent and therefore an important topic for study. Although it is known that psychiatrists practicing in the United States exhibit high rates of burnout (Garcia et al., 2015; Shanafelt, Hasan, et al., 2015; Volpe et al., 2014), few researchers have investigated the underlying reasons for this burnout (APA, 2018b). Moreover, researchers have neither identified resources that could mitigate burnout among psychiatrists nor investigated how burnout affects their physical and mental health (Heinemann &

Heinemann, 2017; Maslach & Leiter, 2016; Schwenk & Gold, 2018). Health education programs targeting workplace stress and wellness are clearly effective for improving health and wellness (Hendriksen, Snoijer, De Kok, Van Vilsteren, & Hofstetter, 2016; Ledikwe et al., 2018; Ryu, Jung, Cho, & Chin, 2017). However, despite the alarming rates of burnout among psychiatrists, few studies have addressed critical questions related to the improvement of health education programs and services, such as why burnout occurs, what helps to alleviate burnout, and the consequences of burnout (APA, 2018b; Heinemann & Heinemann, 2017; Maslach & Leiter, 2016; Schwenk & Gold, 2018). Exploring these issues is necessary for the development and justification of health education programs aimed at reducing burnout in this population.

Problem Statement

As described in the Background section, burnout among psychiatrists practicing in the United States is prevalent and exposes a current social problem (Garcia et al., 2015; Shanafelt, Hasan, et al., 2015; Volpe et al., 2014). Although ample research has quantified the high rates of burnout (Garcia et al., 2015; Grisham, 2018; Shanafelt, Hasan, et al., 2015; Volpe et al., 2014), little research has demonstrated why psychiatrists are burnt out (APA, 2018b), and no studies have explored what resources might mitigate burnout or whether and how burnout affects perceived physical and mental health (Heinemann & Heinemann, 2017; Maslach & Leiter, 2016; Schwenk & Gold, 2018). These gaps in the literature must be addressed to establish a comprehensive understanding of burnout among psychiatrists, which could be used to inform health promotion programs.

A few studies have identified factors that psychiatrists practicing in the United States have recognized as contributing to their burnout (Garcia et al., 2015; Grisham, 2018). According to Garcia et al. (2015), psychiatrists working for the VA reported that not being part of a coherent team, not having protected time outside of patient care, unfair treatment, having insufficient resources, number of times on short call, and caseloads with a high percentage of severely mentally ill patients contributed to burnout. Grisham (2018) found that 60% of burnt-out psychiatrists reported that excessive bureaucratic and administrative tasks contributed to burnout, 34% reported that excessive hours spent at work led to burnout, and 30% reported that lack of respect from administrators and staff resulted in burnout (Grisham, 2018). Although these two studies have offered insight into self-reported factors of burnout among psychiatrists, both were quantitative in nature, which did not allow for richly detailed exploration or elaboration of these factors. Similar studies have been conducted with psychiatrists working outside the United States (Evans & Young, 2017; Rotstein & Jenkins, 2017), but it is inadvisable to generalize their results to psychiatrists practicing in the United States because work conditions and the health-care environment can differ from country to country (Jovanović et al., 2016). It is important to understand why psychiatrists are burnt out because this information could support health promotion specialists' design and implementation of health education programs aimed at reducing burnout among psychiatrists.

In addition to the limited research on factors psychiatrists identify as contributing to burnout, no empirical research has addressed what resources are needed to mitigate or prevent burnout among psychiatrists. Hobfoll's (1989) conservation of resources (COR)

theory identifies four categories of resources that, when gained or lost, can either mitigate or lead to perceptions of burnout: objects, conditions, personal characteristics, and energy. Objects are physical in nature and may include food or shelter (Hobfoll, Halbesleben, Neveu, & Westman, 2018). Condition resources are structures or states that allow access to other resources and may include health status or social support (Gregory, 2015; Hobfoll et al., 2018). Coping skills and mindfulness are examples of personal characteristics, which are skills or traits that aid in dealing with stress (Hobfoll et al., 2018). Energy resources are exemplified by time or money, which aid in acquiring other resources (Hobfoll et al., 2018; Prapanjaroensin, Patrician, & Vance, 2017).

Ample literature has demonstrated how these types of resources can mitigate burnout in a broader population of physicians (Busis et al., 2017; Hyman et al., 2017; Penberthy et al., 2018). For example, condition resources, such as health status, marital status, and social support, have been shown to reduce burnout perceptions in populations of physicians (Hyman et al., 2017; Shanafelt et al., 2014; Starmer, Frintner, & Freed, 2016). Although many studies have demonstrated what resources help a broad population of physicians (Busis et al., 2017; Hyman et al., 2017; Penberthy et al., 2018), it is noteworthy that there is no current research on psychiatrists. Different medical specialties have different rates of burnout (Lee, Seo, Hladkyj, Lovell, & Schwartzmann, 2013) and significantly different work environments and tasks (Jovanović et al., 2016), and they may, therefore, have different factors that affect burnout. Thus, it is reasonable to assume that the resources that mitigate burnout may differ across medical specialties. Additionally, current research may have overlooked some of the resources that

psychiatrists report as helping to mitigate burnout. This information could be used to inform health education intervention programs aimed at reducing burnout among psychiatrists.

Finally, there is a gap in the literature that addresses the health consequences of burnout among psychiatrists (Heinemann & Heinemann, 2017; Maslach & Leiter, 2016; Schwenk & Gold, 2018). Heinemann and Heinemann (2017) noted that few studies have examined the psychological and somatic symptoms of physician burnout. Maslach (2017) discussed the need to further understand the relationship between burnout among psychiatrists and mental health indicators, such as depression. Schwenk and Gold (2018) discussed the need for more research on the importance of well-being for physicians who experience burnout. Limited research has demonstrated the burnout–health relationship in physicians and other medical professionals, such as nurses (Khamisa, Peltzer, Ilic, & Oldenburg, 2016; Lazarescu et al., 2018). For example, moderate to severe burnout was associated with increased suicidal ideation in Danish physicians (*OR*: 0.46; $p = 0.01$) (Lazarescu et al., 2018). Emotional exhaustion was associated with a higher likelihood of lower self-rated general health status in nurses (*OR*: 1.93; 95% CI: 1.81–2.06; Khamisa et al., 2016). Although it is known that burnout involves a health-impairment process (Khamisa et al., 2016; Lazarescu et al., 2018; Schneider, Hornung, Weigl, Glaser, & Angerer, 2017), it is important to note that no research on the health-impairment process of burnout has been conducted with a population of psychiatrists. Clarifying the experience of burnout for this population is imperative to further understand the consequences of burnout among psychiatrists.

Purpose of the Study

The purpose of this qualitative study, which utilized an exploratory multiple-case study design, was in part to understand how psychiatrists who have experienced burnout describe and explain the process of burnout. Moreover, based on the perspectives and self-reports of a sample of psychiatrists who self-identified as having experienced burnout, this study investigated what factors impact the process of burnout, what resources protect against or mitigate burnout, and how burnout affects perceived health consequences. Research has quantified high rates of burnout among psychiatrists (APA, 2018a; Garcia et al., 2015; Grisham, 2018; Shanafelt, Hasan, et al., 2015; Volpe et al., 2014). However, there is a dearth of research documenting the process of burnout, factors that impact burnout, resources that mitigate burnout, and effects of burnout on physical and mental health in a population of psychiatrists (Heinemann & Heinemann, 2017; Maslach & Leiter, 2016; Schwenk & Gold, 2018).

Research Questions

RQ 1: From the perspective of a sample of psychiatrists working in the public or private sector in Arizona, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming, or Colorado and self-identifying as having experienced burnout, how do these individuals describe and explain the process of burnout?

RQ 2: From the perspective of a sample of psychiatrists working in the public or private sector in Arizona, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming, or Colorado and self-identifying as having experienced burnout, what factors do these individuals identify as contributing to their burnout?

RQ 3: From the perspective of a sample of psychiatrists working in the public or private sector in Arizona, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming, or Colorado and self-identifying as having experienced burnout, what resources protect against the effects of burnout?

RQ 4: From the perspective of a sample of psychiatrists working in the public or private sector in Arizona, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming, or Colorado and self-identifying as having experienced burnout, how does burnout affect perceived health consequences?

Framework

This dissertation's conceptual framework was based on the MTB (Maslach & Jackson, 1981), the job demands-resource (JD-R) model, and the COR theory (Hobfoll, 1989). These theories aligned with the purpose of the study, supported the operational definition of the phenomenon under investigation, and informed the research questions. Proposed by Maslach and Jackson in 1981, the MTB posits that burnout is a multidimensional outcome characterized by emotional exhaustion, depersonalization, and a lack of personal accomplishment (Maslach & Jackson, 1981). Emotional exhaustion is defined as general emotional fatigue resulting from the perception that excessive time and effort devoted to a job or task is not beneficial (Maslach, 2017; Maslach et al., 2001). Emotional exhaustion leads to the second construct, depersonalization, which is represented by feelings of cynicism, indifference, and detachment from others or the work environment (Maslach, 2017; Maslach et al., 2001). Finally, reduced personal

accomplishment consists of the perception of ineffectiveness (Maslach, 2017; Maslach et al., 2001).

Qualitative studies have used the MTB to conceptualize and define burnout (Hammond, Crowther, & Drummond, 2018; Oser, Biebel, Pullen, & Harp, 2014; Rozo, Olson, Thu, & Stutzman, 2017). Doulougeri, Georganta, and Montgomery (2016) noted that burnout is not a clinical diagnosis in the United States, which prevents researchers from establishing a consensus definition. Because the MTB offers an operational definition with an ample research base (Doulougeri et al., 2016; West et al., 2018), using the MTB was the most appropriate way to operationally define and conceptualize burnout in this dissertation.

Further, the JD-R model informed and grounded the current study. Demerouti, Bakker, Nachreiner, and Schaufeli's (2001) study was the first to suggest that burnout and work engagement are outcomes of the interaction between job demands and job resources. Unmanageable job demands can lead to burnout, whereas job resources can mitigate it (Schaufeli & Bakker, 2004). Additionally, Schaufeli and Bakker (2004) identified the health-impairment process of burnout. They suggested that unmanageable job demands can lead to burnout, which in turn can lead to physical and mental health impairment (Schaufeli & Bakker, 2004). The qualitative literature has frequently used the JD-R model to frame research questions and interview questions with the goal of examining job demands and job resources (Davidson, 2018; Gauche, De Beer, & Brink, 2017). The framing of such questions is described in Chapter 2. Similarly, this dissertation used the JD-R model to explore job demands and resources in relation to

burnout. This model informed the second, third, and fourth research questions as well as the interview questions.

Finally, the COR theory informed and grounded this dissertation's conceptual framework. The COR theory was developed by Hobfoll (1989), who proposed that individuals accumulate resources that they can apply to accommodate, endure, or overcome stress. Hobfoll proposed four categories of resources: objects, conditions, personal characteristics, and energy. These resources are described in Chapter 2. The more resources an individual has accumulated, the more resistant the individual is to stress (Hobfoll, 1989). Conversely, individuals experience stress or burnout when resources become depleted or threatened (Hall, Rattigan, Walter, & Hobfoll, 2006; Hobfoll, 1989). Various studies have used the COR theory as a predictive theory of burnout (Dubois, Bentein, Mansour, Gilbert, & Bédard, 2014; Gregory, 2015; Prapanjaroensin et al., 2017). In this dissertation, the COR theory was used as a guide to empirically identify different types of resources that may reduce symptoms of burnout. This was particularly important for the third research question. In summary, the theories outlined above provided the conceptual framework for this dissertation, because they helped to conceptualize the phenomenon of burnout and aided in the development of research questions and interview questions. They are discussed in greater detail in Chapter 2.

Nature of the Study

In choosing an appropriate research method and design, alignment with research questions and the potential to yield data were driving factors (Flick, 2018). Because the

research questions were exploratory, open-ended, and designed to examine a process, it was concluded that a qualitative method had the potential to yield the most appropriate data for this study. A quantitative design would have been unsuitable because this study did not take a deductive approach. Specifically, an exploratory multiple-case study was selected as the most appropriate design, because such studies enable an in-depth investigation of a contemporary phenomenon within a real-life or natural context (Burkholder, Cox, & Crawford, 2016; Yin, 2014). Moreover, as described by Yin (2014), a multiple-case study is a type of qualitative design that allows the researcher to collect in-depth data pertaining to contemporary experiences in a natural context from multiple individuals or groups.

In this study, the unit of analysis was individual psychiatrists, and the phenomenon was burnout. A multiple-case design is suitable when research question(s) are descriptive (i.e., What happened?) or exploratory (i.e., How did it happen?; Yin, 2014). In this study, both descriptive and exploratory questions were addressed. An inclusion survey was used to bind the cases and keep the study's scope reasonable (Patino & Ferreira, 2018). Purposeful snowball sampling was used to gather participants, and semistructured interviews were conducted to triangulate the data and expand on the information collected in the burnout survey (Yin, 2014). Data were analyzed using thematic analysis based on Yin's (2014) five-step framework.

Operational Definitions

Burnout: Prolonged exposure to chronic interpersonal stressors on the job, which results in a combination of emotional exhaustion, depersonalization, and reduced

personal accomplishment (Maslach, 2017; Maslach & Jackson, 1981; Maslach et al., 2001).

Emotional exhaustion: General emotional fatigue resulting from the perception that excessive time and effort devoted to a job or task is not beneficial (Maslach, 2017; Maslach et al., 2001).

Depersonalization: An impaired perception of oneself, others, or the work environment (Maslach, 2017; Maslach et al., 2001), often characterized in medical personnel by inattentive and impersonal responses to patient concerns (Vidal Batista et al., 2017).

Reduced personal accomplishment: The perception of ineffectiveness in one's professional duties and an uncaring attitude toward those duties (Maslach, 2017; Maslach et al., 2001).

Self-perceived health: An individual's or group's perception of their physical and/or mental health status (Centers for Disease Control and Prevention [CDC], 2018; Karimi & Brazier, 2016).

Psychiatrist: A mental health physician with a medical doctorate degree (MD) and licensure who practices a combination of psychopharmacology, psychotherapy, and/or psychoanalysis (APA, 2018c).

Assumptions, Scope, and Delimitations

Assumptions

This study contained a variety of assumptions that were justified. The first assumption was that the participants would answer interview questions with truthfulness

and transparency (Merriam & Tisdell, 2015). This assumption was addressed by assuring participants of the confidentiality of their responses, obtaining the informed consent of all participants, and reminding participants that they could withdraw from the study at any time without negative consequences (Patton, 2015). It was assumed that upholding participant trust and comfort would ensure that participants answered questions honestly (Austin & Sutton, 2014; Patton, 2015). Second, it was assumed that all the participants were practicing psychiatrists who had experienced burnout at some point within the previous 5 years. To verify this assumption, I distributed an inclusion survey that contained the definition of burnout and a self-reported burnout question to potential participants. Individuals were excluded from the study if they had not experienced burnout within the previous 5 years. An additional assumption was that researcher bias would be well controlled during the process of data collection and analysis (Bradshaw, Atkinson, & Doody, 2017). To ensure this, I collected data in a manner that supported impartiality, including the use of open-ended interview questions (Bradshaw et al., 2017) and member checks (Frey, 2018). Moreover, I engaged in memo writing throughout the data collection and analysis process in order to practice reflexivity and identify personal assumptions or biases (Allen, 2017). To avoid bias in data analysis, I followed a prearranged and stringent set of rules as outlined by Yin (2014). As the focus of this study was on burnout experienced at the professional level, a final assumption was that professional burnout can be viewed and experienced separately from burnout at the personal level.

Scope and Delimitations

There is little information about why psychiatrists are experiencing burnout, what resources mitigate burnout in this population, and how burnout can affect perceived health consequences, both physical and mental, among psychiatrists. To address this gap in the literature, I investigated these issues through a qualitative approach using a multiple-case design, with individual psychiatrists as the unit of analysis. The study's delimitations included the participants selected and the geographic region covered (Simon & Goes, 2017).

The population investigated in this study was licensed, practicing psychiatrists working in the public or private sector. In order to discuss how burnout impacts perceived health consequences, only psychiatrists who had experienced burnout at some point within the previous 5 years were included. Geographic location was restricted to the Western region of the United States, which included the states of Arizona, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming, and Colorado. Because the population selected for this study had specific characteristics, the study's results may not be transferable to other types of physicians or to psychiatrists who did not meet the study's demographic criteria. Although qualitative studies are limited in transferability, if they delineate their methodology in detail and offer rich descriptions, transferability can be determined by other researchers (Anney, 2014; Coghlan & Brydon-Miller, 2014; Korstjens & Moser, 2018).

Limitations

Limitations are constraints of study methodology and design (Simon & Goes, 2017). A significant limitation of qualitative research involves transferability to other populations (Merriam & Tisdell, 2015). This study used a limited number of participants due to the nature of a qualitative multiple-case methodology and constraints on time (Yin, 2014). To improve transferability, I employed rich descriptions in order to allow readers to determine whether the findings were transferable to their setting or population (Korstjens & Moser, 2018). Another limitation was the potential for researcher bias. Because I was the sole researcher and had limited experience, bias may have been a limitation. I employed several strategies to mitigate bias, including an audit trail, transcripts of digital recordings, member checking, and using an independent reviewer (see Flick, 2018; Yin, 2014). A final limitation of this study was the reliance on self-reported data, which can be subject to response bias (Althubaiti, 2016). Although these potential limitations should be acknowledged, I implemented strategies in the current study to minimize their impact on the findings.

Significance

The current study is socially important because there is a shortage of psychiatrists practicing in the United States and such practitioners are needed to serve the population's mental health needs. The NCBH noted that between 2003 and 2013, there was a 10.2% decline in the number of psychiatrists for every 100,000 people (NCBH, 2017). In terms of future trends, Satiani et al. (2018) predicted that due to steady population growth, the growing demand for mental health practitioners, and the retirement of half of practicing

psychiatrists, there will be a shortage of between 14,280 and 31,091 psychiatrists in the United States in 2024. This shortage will be particularly apparent in rural areas (Satiani et al., 2018). Other reports have indicated similar trends in the shortage of psychiatrists. According to a report by the USHHS, in 2013, there were 45,580 practicing psychiatrists; the report predicted that by 2025, this number will fall to 45,210, a 1% decrease (USHHS, 2016). Assuming current demand, the USHHS (2016) calculated that by 2025, 51,290 full-time equivalent (FTE) psychiatrists will be needed in the United States. This is a 6% increase in psychiatric demand. Coupled with the predicted 1% decrease in the number of practicing psychiatrists, this increase in demand will result in a shortage of approximately 6,080 FTE practicing psychiatrists in the United States (USHHS, 2016).

Notably, burnout has been shown to contribute to psychiatrists' intent to leave their jobs (Garcia et al., 2015). Garcia et al. (2015) found that high levels of cynicism, a component of burnout, predicted the likelihood of psychiatrists leaving their position at the VA within 2 years (B = .067; p = .004). Although this is the only recent study to address a population of psychiatrists, studies of other physician populations have established the correlation between burnout and quitting the job, intent to leave, or retiring early (Dewa, Jacobs, Thanh, & Loong, 2015; Huber et al., 2018; Miyasaki et al., 2017; Schwarzkopf et al., 2017). Therefore, it is critical to understand the process of burnout, what factors contribute to burnout, what resources protect against burnout, and perceived health consequences of burnout so health educators can implement programs based on empirical evidence. Further, this information could contribute to positive social change because it could be used to inform and develop health education programs needed

to improve the health outcomes of psychiatrists who work in jobs with high levels of burnout and to decrease the number of psychiatrists who leave the field due to burnout.

Summary

In Chapter 1, the social problem and research problem were delineated. The research questions, nature of the study, and conceptual framework were presented. Finally, the study's assumptions, scope and delimitations, and limitations, as well as its significance, were discussed. These elements served to introduce and frame the current research study. In the next chapter, the relevance of the research problem and questions is framed through a synthesis and analysis of the current literature. In addition to a thorough investigation and synthesis of this literature, the study's conceptual framework is examined. Finally, in Chapter 2, relevant gaps in the literature are identified and discussed.

Chapter 2: Literature Review

Introduction

Burnout is prevalent among psychiatrists practicing in the United States (Garcia et al., 2015; Shanafelt, Hasan, et al., 2015; Volpe et al., 2014). Although ample research has quantified the high rates of burnout among psychiatrists (Garcia et al., 2015; Grisham, 2018; Shanafelt, Hasan, et al., 2015; Volpe et al., 2014), few studies have demonstrated why psychiatrists are burnt out (APA, 2018b), and no extant research has addressed what resources might mitigate burnout or whether and how burnout affects perceived physical and mental health (Heinemann & Heinemann, 2017; Maslach & Leiter, 2016; Schwenk & Gold, 2018). The purpose of this literature review was to (a) conceptualize the phenomenon of burnout; (b) understand the prevalence of burnout among psychiatrists, the reasons why this population is burnt out, and the consequences of burnout; and (c) identify gaps in the literature related to these topics. These issues have received scant attention in the burnout literature. The literature review begins with a delineation of the study's conceptual framework and then discusses the origins and evolution of the concept of burnout. The problem of psychiatrist burnout is then investigated through the lenses of burnout prevalence and the factors and resources that influence or mitigate burnout in this population. Finally, the consequences of burnout are discussed, highlighting the gap in the literature regarding the impacts of burnout on mental and physical health.

Literature Search Strategy

To locate relevant literature, I used the Walden University Library, Metropolitan State University of Denver Library, and Google Scholar search engines. The databases

accessed were ProQuest, SAGE, JSTOR, Medline, EBSCO, CINAHL Plus, and Science Direct. Literature published between 2014 and 2019 was prioritized unless earlier studies were seminal or there was no recent literature on a given topic. Because there is scant literature on the topics explored in this dissertation, research up to 10 years old was used when no current or updated sources were available. Searches were conducted using the following phrases and keywords: *burnout and physician; burnout and mental health professional*; *psychiatrist burnout*; *burnout and psychiatrist*; *medical resident burnout*; *consequences of physician burnout*; and *psychiatrists or resident and burnout professional*. To begin the literature review, the search term *burnout and physician* was entered and limited to articles published since 2014. In this initial search, 5,780 articles were found. To narrow these search parameters, the terms became increasingly specific, as follows: *burnout and mental health professional* (413 articles); *psychiatrists or resident and burnout professional* (475); *burnout and psychiatrist* (226); *psychiatrist burnout* (17); *medical resident burnout* (148); *consequences of physician burnout* (57); *burnout and physical health and physician* (265); *burnout and mental health and physician* (1,801); *burnout and physical health and psychiatrist* (5); *burnout and mental health and psychiatrist* (106); and *burnout and self-reported health and psychiatrist* (3). To organize these search results, I used a literature review matrix. The literature review was an iterative process of narrowing the research to identify germane scholarship for each section of the review.

The literature review used various criteria of inclusion and exclusion. First, the articles had to be related to burnout among health professionals. Articles were excluded if

the population studied did not consist of health professionals because health professionals are particularly at risk of burnout due to the helping nature of their careers (Shanafelt, Hasan, et al., 2015). Articles were also excluded if they did not use burnout-related terminology as defined by Maslach and Jackson (1981). Articles using terminology such as *work stress*, *job dissatisfaction*, and *compassion fatigue* were excluded because these topics fell outside the scope of this study's operational definition of burnout. Although these topics are related to burnout, this study conceptualized burnout as a specific set of three dimensions that are unique to other types of work stress (Maslach & Schaufeli, 2017; Montero-Marin, Prado-Abril, Piva Demarzo, Gascon, & García-Campayo, 2014). Finally, articles were excluded if they were written in a language other than English and if they were not peer reviewed. To begin the review of relevant literature, I explore this study's conceptual framework. The MTB, the JD-R model, and the COR theory provided the foundation for this study.

Conceptual Framework

The MTB (Maslach & Jackson, 1981), the JD-R model, and the COR theory (Hobfoll, 1989) were the theories used to establish this dissertation's conceptual framework. These theories aligned with the purpose of the study, supported the study's operational definition of the phenomenon under investigation, and informed the research questions. The MTB was established by Maslach and Jackson in 1981 as a response to exploratory interviews with doctors and nurses, on the basis of which the researchers discussed how these professionals coped with strong emotional reactions from negative work-related events (Maslach & Jackson, 1981). According to their theory, burnout is a

multidimensional outcome that comprises emotional exhaustion, depersonalization, and lack of personal accomplishment (Maslach & Jackson, 1981).

Emotional exhaustion is general emotional fatigue resulting from the perception that excessive time and effort devoted to a job or task is not beneficial (Maslach, 2017; Maslach et al., 2001). Prolonged exposure to stress is usually the main cause of the emotional exhaustion component of burnout (Maslach et al., 2001). Loss of enthusiasm for work and feeling defeated are characteristics of emotional exhaustion (Maslach et al., 2001). This MTB construct has been applied to physician populations. Among physicians, the perception of excessive work, the fear of having committed a medical error, and the perception of being alone have been associated with high levels of emotional exhaustion (Torppa, Kuikka, Nevalainen, & Pitkälä, 2015; West et al., 2018).

Emotional exhaustion leads to the second MTB construct, depersonalization, which is characterized by feelings of cynicism, indifference, and detachment from others or the work environment (Maslach, 2017; Maslach et al., 2001). Depersonalization has also been described as self-protecting emotional withdrawal (Ó Laoide, Egan, & Osborn, 2017). Physicians who score high on the depersonalization scale have been shown to treat patients indifferently and develop hostile attitudes toward their patients, colleagues, and profession (Patel et al., 2018; Romani & Ashkar, 2014).

Finally, reduced personal accomplishment involves the perception of ineffectiveness (Maslach, 2017; Maslach et al., 2001). Negatively evaluating work, feelings of insufficiency, and poor professional self-esteem are characteristics of this construct (Maslach et al., 2001). Reduced personal accomplishment is characterized by

negative self-evaluation of one's success in the workplace (Maslach et al., 2001). Physicians who reported low personal accomplishment displayed negative self-appraisal and inefficiency at work (Patel et al., 2018). The MTB's use of three distinct constructs reflects the complexity of the phenomenon of burnout (Maslach, 2017), and the multidimensional nature of the theory best captures the phenomenon as a whole (Maslach & Leiter, 2015). Both quantitative and qualitative burnout research have used the MTB as a framework.

The MTB has been widely used as a basis for the quantitative assessment of the prevalence of burnout in physician populations (Jung Tak, Curlin, & Yoon, 2017; Shah, Wyatt, Gourneau, Shih, & De Ruyter, 2018; Shanafelt, Hasan, et al., 2015; Shenoi, Kalyanaraman, Pillai, Raghava, & Day, 2018). For quantitative approaches to the assessment of burnout, the MTB can inform data collection and tool decision because the MTB aligns with the Maslach Burnout Inventory (MBI; Doulougeri et al., 2016; Poghosyan, Aiken, & Sloane, 2009). The MBI is a 22-item quantitative survey instrument developed by Maslach and Jackson (1981) to measure the three constructs of burnout: emotional exhaustion, depersonalization, and reduced personal accomplishment. A systematic literature review of burnout in physician populations found that 85.7% of studies used the MBI to assess burnout prevalence (Rotenstein et al., 2018). To a lesser extent, the MTB has been used as a framework for qualitative studies, in particular, to conceptualize and define burnout (Hammond et al., 2018; Oser et al., 2014; Rozo et al., 2017).

For this dissertation, I used a qualitative methodology. Hence, I used the MTB to operationally define and conceptualize burnout. Burnout is not a clinical diagnosis in the United States, which prevents researchers from establishing a consensus definition (Doulougeri et al., 2016). Because the MTB offers an operational definition with an ample research base (Doulougeri et al., 2016; West et al., 2018), it was the most appropriate way to operationally define burnout in this dissertation.

In addition to the MTB, the JD-R model was used to establish this study's conceptual framework. This model informed the study's research questions. The JD-R model is heuristic in nature and suggests that burnout and work engagement are outcomes of the interaction between job demands and job resources (Demerouti et al., 2001). The model contains a few key assumptions. First, any work environment will impose job demands, which are challenging conditions that require sustained physical, emotional, or cognitive effort (Chirico, 2016). Job demands in health-care settings include high patient volumes, role conflict, stressful events or intense patient interactions, emotional labor, and work pressure (Demerouti et al., 2001; Montgomery, Spânu, Băban, & Panagopoulou, 2015; Tomo & De Simone, 2018). Moreover, the JD-R model proposes that any work environment will offer job resources, that is, physical, psychological, social, or organizational aspects of the job that help to either complete workloads, reduce job demands, or stimulate personal growth (Chirico, 2016). Job resources in health-care environments include social support, performance feedback, autonomy, and opportunities for development (Demerouti et al., 2001; Kawamura et al., 2018). Job resources can

mitigate the impact of job demands; for example, work support can ease work pressure (Demerouti et al., 2001).

The motivational process and the health-impairment process, depicted in Figure 1 and used with permission (see Appendix E), represent the second key assumption of the JD-R model. The motivational process indicates that a high perception of resources leads to increased productivity and motivation (Croon, Van Veldhoven, Peccei, & Wood, 2015; Schaufeli & Bakker, 2004). The health-impairment process assumes that when job demands exceed job resources, burnout and negative health outcomes can ensue (Bakker, Demerouti, & Euwema, 2005; Schaufeli & Bakker, 2004). Prolonged exposure to excessive job demands results in chronic exhaustion, fatigue, and other manifestations of psychological strain (Bakker, Demerouti, & Sanz-Vergel, 2014).

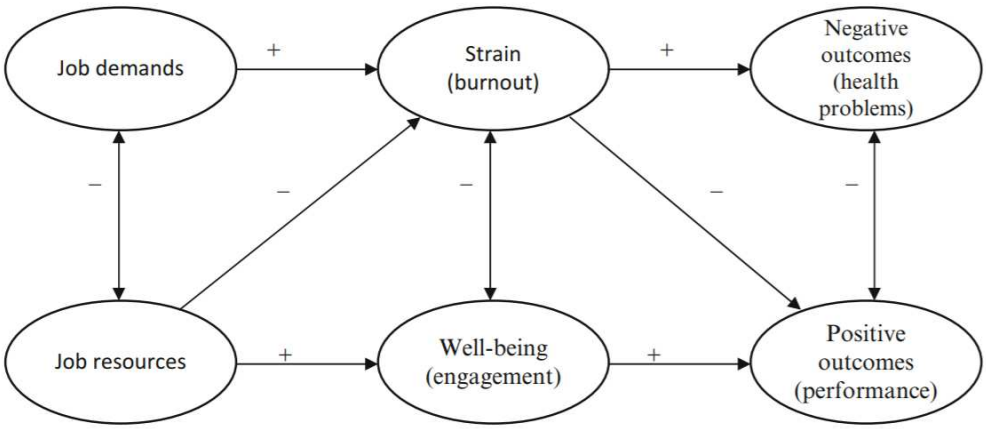

Figure 1. The job-demands resources model. From "Job demands, job resources, and their relationship with burnout and engagement: A multi-sample study," by Schaufeli, W. B., & Bakker, A. B., 2004, *Journal of Organizational Behavior*, 1, p. 297. Copyright 2004 by Wiley InterScience. Adapted with permission.

The JD-R model has been used to understand how environmental factors (demands and resources) in work settings can contribute to burnout and negative health outcomes among physicians. Using the JD-R model as a theoretical framework to define variables, Schneider et al. (2017) found that more job resources were associated with reduced depersonalization at a statistically significant level in a sample of 400 German physicians. Depersonalization was assessed using the MBI (Schneider et al., 2017). In a study of 310 Canadian physicians, Lee, Lovell, and Brotheridge (2011) investigated how job resources and demands were associated with burnout. The researchers found that workload and work-life conflict were positively associated with the burnout construct of emotional exhaustion and that autonomy was positively associated with the burnout construct of personal accomplishment (Lee et al., 2011). In both of these studies, adequate job resources were predictive of lower perception of burnout constructs. Excessive demands were related to higher levels of perceived burnout, which supports the health-impairment process of the JD-R model. No recent research in a physician population has supported the final component of the health-impairment process (negative health outcomes); thus, studies of other populations were explored to address this component of the model. Adil and Baig (2018) utilized the entire JD-R health-impairment-process component through the addition of the construct of health outcomes. The researchers assessed the health outcome component with a population of pharmacists using an employee well-being assessment. Adil and Baig (2018) found that job demands, including workload, autonomy, and work-life imbalance, had a significant impact on

perceived burnout and that burnout, in turn, was related to negative outcomes of perceived well-being.

Qualitative research using the JD-R to investigate burnout in physician populations is scant; thus, I explored the use of the JD-R model in studies of other populations. The qualitative literature has often used the JD-R model to frame research questions and interview questions with the intent to examine job demands and job resources (Davidson, 2018; Gauche et al., 2017). For example, Gauche et al. (2017) used the JD-R model as a guide to creating interview questions, such as "Are there things happening in your work life that are contributing to the stress and/or exhaustion you are experiencing?" (Gauche et al., 2017). This question was guided by the demands aspect of the JD-R model. A qualitative approach enables the researcher to provide a rich description of the participants' perceptions of job demands and job resources, which cannot be provided on the basis of a survey alone. In this qualitative dissertation, I explored job demands and resources in relation to burnout. The JD-R model informed the second, third, and fourth research questions and the interview questions.

Finally, the COR theory informed and grounded this dissertation's conceptual framework. Developed by Hobfoll (1989), the COR theory proposes that individuals accumulate resources that they can apply to accommodate, endure, or overcome threats. Stress results from circumstances involving threatened or actual loss of valued resources (Hobfoll, 1989). The COR posits four distinct categories of resources: objects, conditions, personal characteristics, and energy (Hobfoll, 1989). Objects are physical in nature and may include food, shelter, or material items (Hobfoll et al., 2018;

Prapanjaroensin et al., 2017). Condition resources are structures or states that allow access to other resources and may include health status, employment or marital status, or social support from a friend (Hobfoll et al., 2018; Prapanjaroensin et al., 2017). Coping skills, resilience, and self-efficacy are examples of personal characteristics, which are skills or traits that aid in dealing with stress (Hobfoll et al., 2018; Prapanjaroensin et al., 2017). Energy resources, such as time, money, or knowledge, are those that aid in acquiring other resources (Hobfoll et al., 2018; Prapanjaroensin et al., 2017).

Hobfoll et al. (2018) suggested that when an individual faces a perceived threat, this individual will use one or more of the four resources. The more resources an individual has, the better equipped the individual is to deal with threats productively (Hobfoll, 1989). Conversely, if an individual faced with a threat has fewer resources, the threat is perceived as more stressful (Hobfoll, 1989). Individuals experience stress when resources become depleted or threatened (Hall et al., 2006; Hobfoll, 1989). Hobfoll (2001) demonstrated that persistent inadequacy of resources can lead to symptoms of burnout as defined by Maslach and Jackson (1981). In this respect, the COR theory mirrors the relationship between resources and burnout in the JD-R model. However, the COR theory is unique in its division of resources into four distinct categories. The COR theory frames burnout in terms of the perception of loss or gain of resources, and it has been used to explain burnout in populations of health-care professionals.

Empirical studies have used the COR theory to predict burnout in a variety of populations of health-care professionals (Dubois et al., 2014; Gregory, 2015; Prapanjaroensin et al., 2017). The literature review broadened this application to include

other types of medical professionals because only one study used the COR theory to investigate burnout in a physician population. Dubois et al. (2014) examined a population of 386 nurses in order to quantitatively understand the relationship between the loss of resources over time and changes in perceived burnout. The authors found that the perceived loss of resources as defined by the COR theory, such as autonomy, opportunities for stimulating work, and group cohesion, was associated with higher scores for emotional exhaustion, as defined by the MBI (Dubois et al., 2014). In a study of 244 primary care physicians, Gregory (2015) found that resources, including community and fairness, reduced feelings of emotional exhaustion, a construct of the MTB. Additionally, Prapanjaroensin et al. (2017) found that in a population of nurses, burnout was experienced as a result of actual or perceived loss of any of the four resources identified by Hobfoll (1989). The authors noted that the maintenance of these resources is important to preventing burnout in this population (Prapanjaroensin et al., 2017). All the studies described above used the COR theory to frame resources or the lack thereof as an important component of burnout and burnout mitigation. In other words, perceptions of adequate resources can reduce perceptions of burnout.

This dissertation used the COR theory as a guide for empirically identifying different types of resources that may reduce symptoms of burnout. This was particularly relevant for the third research question, which concerned the identification of resources psychiatrists report as being important to mitigating burnout. Previous studies, specifically of populations of health-care providers, can offer guidelines for identifying what resources clinicians find important, a task this dissertation took up using a

population of psychiatrists. Moreover, the studies reviewed here are quantitative in nature, which facilitates the identification of correlational relationships between resources and burnout. This dissertation, however, filled a gap in the literature by allowing the priority population to explore and elaborate on the impact of lost or gained resources in an in-depth and personal manner, an approach that would not have been afforded by a quantitative methodology. To date, although all of these theories and models have been used in studies of physician populations, they have not been combined to inform empirical research. By contrast, the MTB, the JD-R model, and the COR theory were combined to form this dissertation's conceptual framework, because they helped to conceptualize the phenomenon of burnout and to develop the research questions and interview questions.

Evolution of the Term Burnout

This section will present the historical evolution behind the term burnout. It is important to demonstrate how the term burnout originated and how it has evolved to operationally define burnout for this study. The concept of burnout was first introduced by Herbert Freudenberger (1974) to describe the emotional exhaustion experienced by workers in public services. He proposed that burnout was experienced by individuals differently, but was characterized by a gradual emotional depletion, fatigue, and physical maladies, such as headaches and gastrointestinal issues (Freudenberger, 1974; Heinemann & Heinemann, 2017). Freudenberger (1974) also suggested that those who were most prone to burnout were individuals who were drawn to the helping fields due to their idealistic nature and high level of achievement. He observed that when these

individuals experienced failures in their careers, they put in more time and energy and had subsequent feelings of exhaustion (Freudenberger, 1974; Schaufeli, 2017). Freudenberger's definition of burnout focused heavily on the aspect of exhaustion and aimed to qualitatively explore and define the nature of burnout as opposed to doing empirical studies (Heinemann & Heinemann, 2017; Maslach & Leiter, 2016). Since the work of Freudenberger, the term burnout has evolved to include a more holistic and multidimensional view of the phenomenon and empirical research on the topic has grown immensely (Maslach, 2017).

In 1981, Maslach and Jackson refined and expanded the concept of burnout, which is presently the most widely accepted definition (Heinemann & Heinemann, 2017). Maslach and Jackson (1981) proposed that prolonged exposure to chronic interpersonal stressors on the job contributed to burnout. As described in the previous section, the MTB includes three dimensions; emotional exhaustion, depersonalization, and reduced personal accomplishment (Maslach, 2017; Maslach et al., 2001). Based on the multidimensional burnout theory, the MBI was developed, which was a standardized instrument designed to assess the three core constructs of burnout. Although the MBI has been expanded to be used for many different types of professionals, the MBI has been utilized predominantly with professionals in health and service-related fields (Maslach & Schaufeli, 2017). Additionally, in a systematic review of burnout in physician populations, 85.7% of studies utilized the MBI to assess burnout prevalence (Rotenstein et al., 2018). Thus, the definition of burnout as proposed by Maslach and Jackson (1981) was used in this dissertation to operationally define the phenomenon of burnout because

it is currently the most widely used definition and assessment measure in empirical burnout research for health professionals (Heinemann & Heinemann, 2017; Maslach et al., 2001; Rotenstein et al., 2018). In the following section, the MBI will be discussed in greater detail.

Assessment of Burnout

Burnout prevalence has been widely assessed in physician populations, including psychiatrists (Dyrbye et al., 2017; Garcia et al., 2015; Shanafelt, Hasan, et al., 2015; Volpe et al., 2014). An overview of burnout prevalence in psychiatrists will be presented later in this literature review. As previously mentioned, the MBI is a 22-item instrument to measure the three constructs of burnout that dominates the field of burnout literature (Doulougeri et al., 2016; Hemmeter, 2013), with up to 85.7% of studies utilizing the assessment tool (Rotenstein et al., 2018). The instrument is also recognized as one of the leading measures of burnout based on reliability and validity within diverse populations (Bria, Spânu, Băban, & Dumitraşcu, 2014; Riley, Mohr, & Waddimba, 2017; West, Dyrbye, Satele, Sloan, & Shanafelt, 2012). Maslach and Jackson (1981) define burnout as high scores in both the emotional exhaustion subscales (≥27) and depersonalization subscales (≥13) and low scores in personal accomplishment subscale (≤21). In using the MBI, researchers are able to classify participants into low, medium, and high-level burnout categories, which is effective in the assessment of burnout degree and burnout prevalence. Although understanding prevalence is important to quantify the extent of the situation, there remains a need to understand the greater complexities and experience of

burnout on practitioners that can only be addressed through a qualitative inquiry, such as this dissertation.

Prevalence of Burnout in Psychiatrists

To become a psychiatrist, an individual must first complete 4 years of medical school. Following medical school, psychiatrists then complete a 4- or 5-year residency training program. After this residency program, they have the option to work within adult populations or they can choose to specialize further in sub-populations, such as addiction psychiatry, child psychiatry, or geriatric psychiatry (United States Department of Labor, 2014). In the United States, practicing psychiatrists must be licensed (APA, 2018c). These requirements vary by state, but generally, physicians must graduate from an accredited medical school, complete residency training, and pass written and physical exams (APA, 2018c). To become board-certified, physicians must pass the examination from the American Board of Psychiatry and Neurology (ABPN, 2015). On average, including undergraduate school, medical school, and residency training, psychiatrists train for approximately 11 to 12 years before they begin to practice (ABPN, 2015). Researchers have found that burnout occurs as early as medical school and continues into residency and post-education clinical practice (Dyrbye & Shanafelt, 2015; Dyrbye et al., 2014). The following sections will discuss the prevalence of burnout in medical students, psychiatry residents, and practicing psychiatrists. This research comprehensively demonstrates that burnout is a documented and severe problem in this population of medical practitioners. Demonstrating that burnout is a quantified and significant problem

in psychiatrists is relevant to this dissertation as it offers justification of the identified problem.

Burnout in Medical Students and Psychiatry Residents

As with all medical doctors trained in the United States, psychiatrists begin their careers with 4 years of medical school followed by a 4- or 5-year residency program. Researchers have confirmed that burnout in U.S physicians begins as early as medical school (Dyrbye & Shanafelt, 2015; Dyrbye et al., 2014) and increases as students transition from premedical undergraduate students to medical students (May, Seibert, Sanchez-Gonzalez, & Fincham, 2016). Medical school has been characterized by long hours, stressful examinations, overwhelming academic pressures to learn within a limited time span, overnight calls, and lower autonomy (Dyrbye & Shanafelt, 2015; Fares, Al Tabosh, Saadeddin, El Mouhayyar, & Aridi, 2016).

In a study of medical students in the United States, Jackson, Shanafelt, Hasan, Satele, and Dyrbye (2016) found that of the 3,389 students who participated, 56.6% reported being burnt out as identified by results of the MBI survey. Hojat, Vergare, Isenberg, Cohen, and Spandorfer (2015) found that of 265 third-year medical students at Sidney Kimmel Medical College in the United States, the mean scores for exhaustion, depersonalization, and accomplishment as assessed by the MBI were in the moderate category for burnout. In a study of 546 medical students from six different schools in the United States, Brazeau et al. (2014) found that 27.3% reported moderate to severe symptoms of burnout as assessed by the MBI. Finally, Wolf and Rosenstock (2016) found that of 624 medical students at the University of Pittsburgh School of Medicine

who completed the survey, burnout prevalence was 22.4%. All of these studies assessed burnout in medical students in the United States using the MBI and found prevalence rates between 22.4% and 56.5%. Researchers have shown that although the burnout prevalence rate varies among U.S medical students, the phenomenon is significant and is higher in medical students than similarly aged students pursuing other graduate degrees (Dyrbye et al., 2014). Burnout does not end after the rigorous medical school experience but continues into residency (Dyrbye et al., 2018; Holmes et al., 2016).

Symptoms of burnout continue throughout residency programs, where medical doctors select a specialty to train in. As this dissertation focused on psychiatrists in the United States, only studies that used psychiatry residents will be presented in this section. While it is known that medical residents suffer from high rates of burnout (Dyrbye et al., 2018; Holmes et al., 2016; Rodrigues et al., 2018) it is important to note that the literature becomes increasingly scant when limited to specific types of residents and specialties of physicians, such as psychiatrists. However, this also demonstrates the gaps in the literature that must be addressed.

As with medical school, residency is a challenging time for training psychiatrists. Long work hours, adverse experiences with patient care, and lack of mentoring and guidance are a few of the factors that influence burnout in psychiatry residents (Dennis & Swartz, 2015; Holmes et al., 2016). There are only a handful of recent studies in the United States that address burnout, specifically in psychiatry residents. In a study of 148 psychiatry residents in the United States, Dyrbye et al. (2018) found that among the residents, burnout prevalence was an alarming 43.9%. Even more alarming were the

burnout rates found by Holmes et al. (2016) in their multidisciplinary study of medical residents in a tertiary academic hospital in the United States. Using the MBI, Holmes et al. (2016) found that an alarming 70% of psychiatry residents were burnt out. As this study was multidisciplinary, many resident specialties were tested and out of the 14 medical specialties represented, psychiatrists were ranked 6th out of the 14 specialties in terms of burnout prevalence (Holmes et al., 2016). This study was unique in that it ranked the medical specialties by burnout prevalence and showed that psychiatrists were more burnt out than eight other medical specialties (Holmes et al., 2016).

Although there are only a handful of recent studies describing the burnout prevalence in United States psychiatry residents, the high rates exposed are alarming and quantitatively demonstrate the extent of the issue. Researchers have demonstrated that burnout does not subside after the psychiatrists are fully educated and practicing medicine in the field. Burnout prevalence in both medical students and psychiatry residents was explored to understand that burnout is an issue that starts early in a practicing psychiatrists' career. The final section on prevalence addresses burnout rates in practicing psychiatrists in the United States.

Prevalence of Burnout in Practicing Psychiatrists in the United States

This section will delineate and analyze the literature on burnout in practicing psychiatrists, which is particularly relevant for this dissertation as practicing psychiatrists were the population addressed in my study. Research was limited to studies conducted in the United States, as burnout prevalence can vary drastically from country to country as training requirements and job responsibilities can differ (Jovanović et al., 2016; Kumar,

2016). Furthermore, to maintain focus on the population under study in this dissertation, this section will only address burnout prevalence in psychiatrists, as opposed to other types of physician specialties. As noted previously, as inclusion criteria became more stringent in this literature review, there were fewer studies. This was beneficial for identifying and addressing the gaps in the literature, but also made this section significantly shorter than it would have been if it were broadened to physician burnout. However, as my study only addressed psychiatrists in the United States, the review on burnout prevalence in practitioners was limited to only include psychiatrists practicing in the United States.

In 2018, the APA reported that two out of five practicing psychiatrists in the United States experienced professional burnout (APA, 2018a). Additionally, in a Medscape survey of 900 psychiatrists practicing in the United States found that 38% of psychiatrists reported symptoms of burnout (Grisham, 2018). This phenomenon has also been confirmed by empirical researchers (Garcia et al., 2015; Shanafelt, Hasan, et al., 2015; Volpe et al., 2014).

In a national sample of practicing psychiatrists in the United States, Shanafelt, Hasan, et al. (2015) found that 40% of psychiatrists reported burnout in 2011. In 2014, 48% of these psychiatrists reported burnout; an 8% increase. To identify this prevalence rate over time, the MBI was used as the instrument. Garcia et al. (2015) found high levels of occupational burnout in psychiatrists who worked at the VA. Of this national sample, 86% of psychiatrists reported high exhaustion and 90% reported high cynicism, which are both factors of burnout as defined by the MBI (Garcia et al., 2015). Volpe et al.

(2014) found that 52% of early career psychiatrists practicing in the United States had ‘moderate to high’ scores on all three burnout dimensions as defined by the Maslach MTB. Although the specific rates of burnout in these studies vary, it is clear that burnout in psychiatrists is an extensive problem, which seems to be increasing over time (Shanafelt, Hasan, et al., 2015). In these three studies, burnout was quantitatively addressed to understand prevalence rates using the MBI as the assessment instrument. Although the quantification of a problem allows for an understanding of the extent of the phenomenon, it is also important to explore how these psychiatrists describe and explain their experience of burnout, which has not been addressed in the literature to date. As such, this inquiry led to the development of the first research question for the current dissertation, which aimed to understand how psychiatrists describe and explain their experiences related to burnout. In addition to understanding how psychiatrists perceive burnout, it was important to explore what factors may mitigate or influence this burnout process. These issues, and gaps in the literature, will be discussed in the following sections.

Factors Contributing to Practicing Psychiatrists’ Burnout

Burnout prevalence in practicing psychiatrists has been identified as prevalent and increasing (Garcia et al., 2015; Shanafelt, Hasan, et al., 2015; Volpe et al., 2014). A logical continuation of inquiry would then be to understand why psychiatrists are burnt out. In other words, the next step for researchers would be to identify factors and reasons for psychiatrist burnout. Although there is research on the topic and population, it is scant. At the time of this literature review, there were only two studies on the topic that

utilized a population of practicing psychiatrists in the United States. Garcia et al. (2015) reported that high rates of burnout in psychiatrists working for the VA may be due to not being part of a coherent team, not having protected time outside of patient care, unfair treatment, having insufficient resources, number of times on short call, and percent of caseload comprised of severely mentally ill patients. These outcomes came from survey questions assessing patient care, patient characteristics, and workplace/organizational factors gathered through the use of a questionnaire (Garcia et al., 2015). A limitation of this study was that the tool did not allow for the psychiatrists to elaborate on the factors or offer additional factors that may not have been included in the survey.

The other study, which aimed to understand the factors of burnout in a population of United States psychiatrists, was completed by Grisham (2018). This study was for a survey conducted through Medscape, in which the researcher found that 60% of burnt-out psychiatrists reported that too many bureaucratic and administrative tasks contributed to their burnout (Grisham, 2018). This was followed by 34% reporting too many hours spent at work and 30% reporting a lack of respect from administrators and staff (Grisham, 2018). Again, this information was deduced through a quantitative analysis, which limited the extent to which factors could be elaborated on by the psychiatrists. A major limitation of these two aforementioned studies was the quantitative nature of data collection did not allow for a rich understanding of the factors or demands the psychiatrist's perceived as contributing to burnout.

As the research in the United States is so sparse, it is worthwhile to understand what studies have been done abroad to gain insight. In a population of Swiss

psychiatrists, a lower perception of job satisfaction was a predictor for burnout (Baumgardt, Moock, Rössler, & Kawohl, 2015). Too much work, long working hours, an aggressive administrative environment, and lack of support from management were factors that were positively associated with burnout in New Zealand psychiatrists (Kumar, 2016). Too much work to do in too little time, an aggressive administrative environment, and lack of management support emerged as key predictors of burnout in studies done by Evans and Young (2017) and Rotstein and Jenkins (2017) in populations of psychiatrists in Australia and New Zealand.

Although it is helpful to understand what factors and demands psychiatrists in other countries identify as influencing their burnout, it would not be advisable to generalize these factors to psychiatrists in the United States as work conditions and the health care environment are different from country to country (Jovanović et al., 2016). Although researchers have identified factors that psychiatrists have identified as contributing to their burnout, there is a gap in studies of psychiatrists in the United States and an opportunity to allow this population to elaborate on these factors and demands in a qualitative study. Understanding what factors psychiatrists in the United States identify as contributing to their burnout in a qualitative manner would be beneficial in gaining a rich and thorough depiction of their experiences. Understanding what factors and demands contribute to burnout would be valuable to health promotion specialists as programs could be tailored to reduce or mitigate these factors. In this dissertation, I filled this gap in knowledge through the second research question, which addressed factors psychiatrists identified as contributing to their burnout.

Resources Identified as Helping with Burnout

Although limited, the factors psychiatrists identify as contributing to their burnout have been addressed (Garcia et al., 2015; Grisham, 2018). The following section will address what resources help mitigate physician burnout. Intervention based studies in physician populations have shown that work environment interventions, such as shortened attending rotation length, modifications to clinical work processes, and built-in, protected time off during the workday can reduce physician burnout (Gregory, Menser, & Gregery, 2018; Linzer et al., 2015; Lucas et al., 2012; Shanafelt & Noseworthy, 2017; Siedsma & Emlet, 2015). However, work environment interventions are largely out of the control of an individual physician as these types of interventions are driven by organizational management and change (West, Dyrbye, Erwin, & Shanafelt, 2017); thus, it was important to consider how other resources, such as personal resources, could aid physicians in burnout mitigation.

As defined by the COR theory (Hobfoll, 1989), resources can help mitigate burnout. There are four categories of resources: objects, conditions, personal characteristics, and energy (Hobfoll, 1989). Objects are physical in nature and may include food, shelter, or material items (Hobfoll et al., 2018; Prapanjaroensin et al., 2017). Conditions resources are structures or states that allow access to other resources and may include health status, marital status, or social support (Hobfoll et al., 2018; Prapanjaroensin et al., 2017). Coping skills, communication skills, and mindfulness are examples of personal characteristics, which are skills or traits that aid in dealing with stress (Hobfoll et al., 2018; Prapanjaroensin et al., 2017). Energy resources are those such

as time or money, which aid in acquiring other resources (Hobfoll et al., 2018; Prapanjaroensin et al., 2017). To date, there are no scholarly studies aimed at documenting what resources may help to mitigate burnout in psychiatrists. It is important to understand as the prevalence rates of burnout in this population are severe and resources can help mitigate burnout (Hobfoll, 1989). In this section, the literature review has been broadened to understanding what resources all specialties of physicians in the United States identify as helping to mitigate burnout. Studies on physicians outside of the United States and medical residents were excluded as these populations may have drastically different working conditions and health care environments (Jovanović et al., 2016).

While it is known that resources gained or lost, as defined by the COR theory, influences burnout (Hobfoll et al., 2018; Prapanjaroensin et al., 2017; Starmer et al., 2016), there is a paucity of empirical research in physicians concerning how object resources, such as food, shelter, clothing, or material items, affect burnout. However, as a fundamental concept of well-being, having basics needs met, such as food and clothing, would be implied as a loss of those resources would cause distress (Hobfoll & Freedy, 1993; Prapanjaroensin et al., 2017). Object resources could be described as the psychological needs and safety needs of Maslow's hierarchy of needs, which are considered the basics requirements that must be attained before fulfilling higher needs, such as belonging and esteem (Maslow, 1943). Additionally, it could be assumed that one of the reasons physicians work (or any individual works) is because these individuals need to procure object resources to maintain their most basics needs (Hobfoll & Freedy,

1993; Prapanjaroensin et al., 2017). Thus, object resources are seldom mentioned in relation to burnout, yet serve as an important buffer to mitigate burnout. Interestingly, money is considered an energy resource in the COR theory as it allows for the purchase of object resources, such as food (Hobfoll, 1989). The relationship between income and burnout has been studied in empirical research but will be addressed in the section related to energy resources.

Condition resources are structures or states that allow access to other resources and include health status, marital status, or social support (Hobfoll et al., 2018; Prapanjaroensin et al., 2017). This category of resources has received much attention in empirical literature. Health status is a state that could incorporate both physical and mental health and wellness. In a study of early career pediatricians, Starmer et al. (2016) found that burnout was more prevalent among physicians who rated their personal health as "good", "fair", or "poor" (burnout 41.3%) as opposed to those who rated their personal health as "very good" or "excellent" (burnout 25%). Additionally, Starmer et al. (2016) found that pediatricians who "met" or "exceeded" federal exercise recommendations had a lower burnout prevalence (27.3% burnout) than pediatricians who reported not meeting federal exercise recommendations (33.9% burnout). Moreover, in another study, both mental ($p < 0.01$) and physical ($p < 0.01$) composite scores of anesthesiologists were significantly associated with burnout perception as assessed through the MBI (Hyman et al., 2017). Shanafelt, Oreskovich, and Dyrbye (2012) also found that surgeons who reported participating in "recreation/hobbies/exercise" reported being less burnt out at statistically significant levels. These comprehensive studies established that health status,

including physical and mental health, and resources related to health status (sleep and physical activity) were important condition resources in reducing physician burnout.

Marital status is another condition resource that has been shown to influence physician burnout. Specifically, researchers have found that married physicians are less likely to report perceptions of burnout (Shanafelt et al., 2014; Starmer et al., 2016). Though, it is important to note that not all studies support this relationship (Dyrbye et al., 2013). Some researchers suggest the underlying factor in marital status is having "sufficient time" with one's spouse (Shanafelt et al., 2014) rather than simply the status of marriage. This perception and importance of "enough time" will be extrapolated on in the energy resources section, as "time" is defined as an energy resource by Hobfoll (1989).

A final condition resource with much empirical evidence on burnout mitigation is that of social support, both professional support, and personal support. In a study of 221 anesthesiologists, stronger personal and professional support scores were associated with lower scores of emotional exhaustion (as assessed through the MBI) at statistically significant levels ($p < 0.03$ and $p < 0.02$ respectively; Hyman et al., 2017). Starmer et al. (2016) found that perceived support from physician colleagues was associated with a lower prevalence of burnout at statistically significant levels. Being able to "discuss stressful aspects of work with colleges," an indicator of professional support, was significantly associated with a lower risk of burnout in surgeons ($p < 0.0001$; Shanafelt et al., 2012). Social support, although not defined by personal or professional, was also associated with reduced perceptions of burnout ($p < 0.003$) in a sample of primary care

physicians (Dossett et al., 2012). Finally, personal support from family was associated with lower perceptions of burnout (Shanafelt et al., 2012; Taku, 2014). In summary, health status, marital status or quality of a relationship, and support, either personal or professional, seem to be important condition sources that correlate with reduced burnout perceptions in physicians. This empirical evidence, which supports the presumption that condition resources can mitigate physician burnout, informed the interview questions for the third research question. In the next section, personal characteristics that mitigate burnout in physicians are addressed.

Personal characteristics, which are skills or traits that aid in dealing with stress (Hobfoll et al., 2018; Prapanjaroensin et al., 2017), are the third category of resources as defined by Hobfoll (1989). These resources are well addressed in literature with physician populations and can include coping skills, mindfulness, and communication skills. It is important to note that although these personal characteristics will be delineated as separate resources, there can be crossover between them. Numerous studies will be discussed in the following section that draw on multiple "personal characteristics," such as mindfulness and communication. This demonstrates that while personal characteristics can be delineated separately, they are a category of resources that seem to synergistically work together to mitigate burnout. Additionally, the concept of resilience, which is characterized by the ability to positively recover when exposed to the stress of adversity (Epstein & Krasner, 2013), will not be discussed as a personal characteristic in this section. Researchers have found that physicians describe resilience as having social support, coping skills, and practicing mindfulness (Epstein & Krasner,

2013; Zwack & Schweitzer, 2013). These constructs of resilience have been deconstructed and discussed as separate condition resources (social support), and personal characteristics, (coping and mindfulness).

Coping skills play an important role in physician burnout mitigation (Howlett et al., 2015; Penberthy et al., 2018; West, Dyrbye, Satele, & Shanafelt, 2015). In a sample of emergency department physicians, Howlett et al. (2015) found emotion-oriented coping was associated with increased risk of burnout and task-oriented coping was associated with decreased risk of burnout. Task-oriented coping was considered an action-based coping strategy, which the researchers suggested for implementation in interventions to target burnout in the emergency department physicians (Howlett et al., 2015). In an interventional study, 46 physicians completed a coping and communication skills program with burnout tested at baseline and follow-up (Penberthy et al., 2018). The researchers found that emotional exhaustion scores (as defined by the MBI) were significantly higher at baseline compared to the final 6-month follow-up ($p < 0.05$), demonstrating the intervention had lasting effects through 6 months (Penberthy et al., 2018). Finally, in a randomized controlled trial, coping strategies were included as part of the intervention program (along with self-reflection and mindfulness; West et al., 2015). The researchers found that the intervention group had decreased levels of depersonalization after the intervention than the control group (West et al., 2015). Although a few of these studies had additional components, such as communication and mindfulness skills, which are also considered personal characteristics as defined by Hobfoll (1989), there is a commonality of effective coping mitigating the perception of

burnout in physicians. As touched upon, mindfulness skills have also been shown to reduce burnout perceptions in physician populations.

Mindfulness has been described as bringing an enhanced quality of attention to the moment-by-moment experience (Lindsay & Creswell, 2017). Researchers have addressed how mindfulness can impact physician burnout. In a study by Fortney, Luchterhand, Zakletskaia, Zgierska, and Rakel (2013), 30 primary care physicians participated in an abbreviated version of the 8-week Mindfulness-Based Stress Reduction (MBSR) program, originally developed by Jon Kabat-Zinn. Burnout, as assessed through the MBI, was measured at baseline, and 1 day, 8 weeks, and 9 months postintervention (Fortney et al., 2013). The results indicated that participants had significantly better scores on all three subscales of the MBI at the 9-months postintervention (Fortney et al., 2013).

Furthermore, in a randomized clinical trial, West et al. (2014) examined how an intervention including mindfulness, reflection, and group discussion impacted burnout in 74 physicians. Post-intervention, the researchers found that the mean depersonalization score as assessed through the use of the MBI had decreased by 15.5% in the intervention group versus a 0.8% increase in the control group ($p < 0.004$) (West et al., 2014). The intervention was also associated with reductions in overall burnout composite score post-intervention (West et al., 2014). Mindfulness was also associated with reduced physician burnout in studies done by Dossett et al. (2012), Loiselle, (2018), and Shanafelt et al. (2012). These researchers have demonstrated that mindfulness training can be a powerful resource in reducing perceptions of physician burnout. Although the rates of success vary

between studies, they all identify mindfulness as a tool that physicians can use to help alleviate professional burnout. In addition to mindfulness, communication skills are a personal characteristic that has been shown to help mitigate physician burnout.

Communication skills have been shown to be associated with decreased burnout perceptions in physicians (Krasner et al., 2009; Penberthy et al., 2018), though research is more limited than studies on coping skills and mindfulness skills. As mentioned in the study by Penberthy et al. (2018) in the coping skills section, these researchers combined an intervention including coping strategies and communication skills, which resulted in decreased emotional exhaustion scores from baseline to 6-month follow-up. As this was the only study less than 5 years old in a population of physicians practicing in the United States, an older correlational study was included.

In a study done by Krasner et al. (2009) an educational program including communication skills, mindfulness, and self-awareness was conducted with 70 primary care physicians with burnout measured at baseline and at 2, 12, and 15 months. The researchers found that the program was associated with reductions in burnout, specifically, emotional exhaustion (Krasner et al., 2009). At baseline, the researchers found a mean emotional exhaustion score of 26.8, as assessed through the MBI (Krasner et al., 2009). At the 15-month follow up, the mean score for emotional exhaustion was 20 (Krasner et al., 2009). Although communication skills have not been extensively studied in relation to burnout in a physician population, the available literature demonstrates that communication skills (often in combination with coping or mindfulness skills) are effective in reducing the perception of physician burnout. In summary, personal

characteristics, including coping skills, mindfulness, and communication skills have been identified as resources that aid a physician in mitigating professional burnout. This empirical evidence, which supports that certain personal characteristics can mitigate physician burnout, informed the interview questions in this dissertation. The final category of resources that will be discussed is energy resources.

Energy resources are those such as time, money, or knowledge, which aid in acquiring other resources (Hobfoll et al., 2018; Prapanjaroensin et al., 2017). Empirical research in physician populations has shown that perceived or actual loss of energy resources, specifically income and time, can result in perceptions of burnout (McAbee et al., 2015; Qureshi et al., 2015; Shanafelt et al., 2014). In a study of neurological surgeons, McAbee et al. (2015) found that 75.2% of the physicians reported anxiety over future earnings due to health care reform. The physicians' anxiety over future earnings was a factor associated with burnout at a statistically significant level ($p < 0.001$) (McAbee et al., 2015). This is the only study in physicians practicing in the United States to date that targets the perceived loss of future income in relation to burnout. However, other researchers studying physician populations have found that those who earn a higher income are less likely to be burnt out (Qureshi et al., 2015), and those who have greater student loan debt are more likely to be burnt out (Shanafelt et al., 2014). What these studies have in common is demonstrating that physician burnout perceptions are affected by earnings; either perceived or actual loss or gain in income. In other words, money is an important energy resource in physician burnout perceptions. In addition to money,

time is another energy resource that has been shown to impact physician burnout (Busis et al., 2017; Dyrbye et al., 2013; McAbee et al., 2015; Shanafelt et al., 2012).

Time away from work (or lack thereof) is another energy resource that has been studied in relation to physician burnout. Not having adequate time for personal development was a factor associated with increased burnout ($p < 0.001$) in a survey of 783 neurosurgeons (McAbee et al., 2015). The perception of excessive workload, which results in longer work hours (and thus decreased perception of personal time), is another frequently cited resource associated with burnout (Busis et al., 2017; Dyrbye et al., 2013; Shanafelt et al., 2014). For example, in a multivariate analysis, Busis et al. (2017) found that neurologists who reported working more hours during the week were more likely to also report feeling burnt out. Shanafelt et al. (2014) found that each additional hour per week spent on work tasks at home increased the risk of burnout in oncologists by 3.5%. In a sample of 7,123 physicians of various specialties, including psychiatrists, hours worked per week was statistically significant in predicting burnout (Dyrbye et al., 2013). These studies identify time pressure as a commonly cited energy resource that is associated with physician burnout. Researchers have also found that physicians who perceive to have adequate personal and family time are more satisfied with their careers and experience lower rates of burnout (Shanafelt et al., 2012). Thus, time is an important energy resource that can contribute to or mitigate physician burnout. This empirical evidence, which supports the presumption that energy resources can mitigate physician burnout, informed the interview questions in this dissertation.

This section focused on resources, as defined by Hobfoll (1989) that can mitigate burnout in physicians. Condition resources, such health status, marital status, and social support have been shown to reduce burnout perceptions (Dossett et al., 2012; Hyman et al., 2017; Shanafelt et al., 2014; Shanafelt et al., 2012; Starmer et al., 2016). Coping skills, communication skills, and mindfulness are personal characteristics associated with reduced burnout perceptions (Fortney et al., 2013; Howlett et al., 2015; Krasner et al., 2009; Penberthy et al., 2018; Shanafelt et al., 2012; West et al., 2014; West et al., 2015). Finally, energy resources, such as time and money, have been shown to mitigate physician perception of burnout (Busis et al., 2017; Dyrbye et al., 2013; McAbee et al., 2015; Shanafelt, et al., 2012).

As demonstrated with empirical evidence, condition resources, personal characteristics, and energy resources can reduce physicians' perception of burnout. Therefore, this information served as an empirical base and guided the conceptualization of interview questions for the third research question. Although this evidence guided interview questions to an extent, there are limitations of these studies in relation to this dissertation. Notably, none of these studies were done with populations of psychiatrists, though one study included psychiatrists within the larger sample. Different medical specialties have different rates of burnout (Lee et al., 2013) and significantly different work environments and tasks (Jovanović et al., 2016). Thus, it is reasonable to assume that resources that mitigate burnout for some specialties of physicians may not be the same resources that mitigate burnout for other specialties. Additionally, there may be other resources that have not been identified in current literature that psychiatrists

identify as helping to mitigate burnout. This dissertation addressed this gap in knowledge regarding resources that psychiatrists identify as helping to mitigate burnout through the third research question. Thus far, burnout prevalence in psychiatrists, factors related to psychiatrist burnout, and resources identified as mitigating burnout in physicians have been addressed. In other words, the "what" and "how" questions. The following line of inquiry will address the consequences of physician burnout and why psychiatric burnout is a significant issue.

Consequences of Burnout

In this literature review, the prevalence of burnout in psychiatrists, the factors contributing to their burnout, and resources identified as helping to alleviate burnout in physicians have been addressed. In other words, this review has explained "what is the problem?" and, to the best of the ability of the available literature, "why is it happening? and what helps?". The next section in this review will explore the consequences of burnout in an attempt to explain why professional burnout matters. There are myriad consequences of physician burnout. The three distinct consequences of burnout are organizational consequences, patient-related consequences, and individual consequences (Patel et al., 2018). Neither organizational consequences, such as loss of productivity, nor patient-related consequences, such as medical error, will be covered in this literature review as this dissertation focuses solely on the third consequence of burnout, consequences to individuals. Individual consequences will be conceptualized as the negative effect burnout can have on the health and well-being of an individual, both physical and psychological in nature (Patel et al., 2018).

Researchers who study physician burnout generally cite that burnout has negative health implications as a reason to justify the issue, yet if references are given, they are generally very outdated, scant, or cite studies that haven't used physician populations (Nicola, McNeeley, & Bhargava, 2015; Panagioti et al., 2017; West et al., 2017; Wiederhold, Cipresso, Pizzioli, Wiederhold, & Riva, 2018). There are very few studies that examine the psychological and somatic symptoms of physician burnout (Heinemann & Heinemann, 2017). The beginning of this section will review the literature on the consequences of burnout on physician health. Due to the limited nature of the concept, however, studies of resident physicians, studies up to 10 years old, and studies of physician populations outside of the United States were included, as this section would have been extremely limited otherwise. This, however, is a limitation and demonstrates a gap in the literature. The following section will focus on recent literature on the health-related effects of burnout in general to obtain a broader understanding of the burnout-health connection.

Health-Related Consequences of Burnout for Physician Populations

Burnout and its relationship to mental health has been one of the more comprehensively studied topics of individual consequences of physician burnout. This could be due to the severity and high incidence of physician suicide, which is disproportionately higher than in the general population, with an estimated 300 to 400 doctors committing suicide each year (Center et al., 2003; Schernhammer & Colditz, 2004). In a study of 7,905 practicing surgeons in the United States, Shanafelt, et al. (2011) found that burnout was independently associated with suicidal ideation after

controlling for personal and professional characteristics. Specifically, for each 1-point increase for each domain of burnout, as assessed through the MBI, surgeons were 5.7% to 10.9% more likely to report suicidal ideation (Shanafelt et al., 2011). In a study of Dutch medical residents, suicidal thoughts were significantly more prevalent ($p < 0.001$) in residents who reported burnout, as assessed through the MBI, in comparison to those who did not report burnout (Van der Heijden, Dillingh, Bakker, & Prins, 2009). Finally, in a study of French radiation oncology residents, moderate to severe burn-out, as assessed through the MBI, was associated with increased suicidal ideation (*OR*: 0.46; $p = 0.01$; Lazarescu et al., 2018). These studies expound results that demonstrate the association between burnout and increased risk of suicidal ideation.

The link between burnout and depression is less clear as many researchers have suggested that burnout and depression have similar symptomatology and are associated with each other at statistically significant levels (Bianchi, Boffy, Hingray, Truchot, & Laurent, 2013; Bianchi, Schonfeld, & Laurent, 2015). Other researchers, however, have identified burnout as a predictor for depression (Hakanen & Schaufeli, 2012; Shin, Noh, Jang, Park, & Lee, 2013). To date, there are no studies that suggest physician burnout predicts depression; however, there are various studies on burnout and association with poor mental health.

Vandenbroeck, Van Gerven, De Witte, Vanhaecht, and Godderis (2017) evaluated the prevalence of burnout and its association with health outcomes of physicians and nurses in Belgium. Both mental and physical health outcomes were evaluated using a scale from the Short-Form General Health Survey (Vandenbroeck et al., 2017).

Vandenbroeck et al. (2017) found that emotional exhaustion, as assessed through the MBI, was negatively related to perceived mental health ($\beta = -0.75$, $p < 0.001$). In a study of physicians from various countries, including the United States, Lee et al. (2013) found that emotional exhaustion was strongly associated with contributors to poor mental health. The researchers defined mental health as a composite score of fatigue, anxiety, and depression (Lee et al., 2013). Additional studies have supported the association between poor mental health outcomes and burnout in physician populations, but they used other instruments to measure burnout than the MBI, specifically, the Copenhagen Burnout Inventory (Ilić, Arandjelović, Jovanović, & Nešić, 2017; Voltmer, Wingenfeld, Spahn, Driessen, & Schulz, 2012). Although the assessment tool for mental health and burnout was not consistent between these studies, all results indicate that burnout is associated with poor mental health outcomes in physician populations. In addition to burnout and its relationship to poor perceived mental health, researchers have explored the relationship between burnout and physical aspects of health in physician populations.

There is a paucity of empirical research regarding the physical health consequences of burnt-out physicians. In two recent literature reviews of physician burnout by Patel et al. (2018) and West et al. (2018), physical health is cited as one of the consequences of burnout, yet in each article, only two sources (the same two sources) are offered in support of the claim. The burnout-health relationship has been explored in greater depth in non-physician populations, which will be addressed later in this section to broaden the understanding of the relationship.

The research that is presently available in populations of physicians covers only physical health constructs, such as substance abuse and motor vehicle accidents (Oreskovich et al., 2013; Stafford & Judd, 2010; West, Tan, & Shanafelt, 2012). Oreskovich et al. (2013) found that surgeons who were burnt out (*OR*, 1.25; $p = .01$) were more likely to suffer from alcohol abuse or dependence. In a population of Australian gynecologic oncologists, Stafford and Judd (2010) found that emotional exhaustion, as assessed through the MBI, was positively associated with smoking cigarettes. Although alcohol abuse and smoking cigarettes are not ostensibly health outcomes, due to the widely acknowledged negative health ramifications of each (National Institute of Alcohol Abuse and Alcoholism, 2018; USHHS, 2014), these studies were included. Physician burnout has also been associated with an increased risk of motor vehicle accidents. West, Tan, et al. (2012) found that burnout, as assessed through the MBI, was associated with statistically significant increased odds of reporting a motor vehicle incident. This is the only study of burnout and motor vehicle incidents in a physician population and does not address if injury occurred as a result of these incidences. It is important to note that burnout may not cause ill-health but is only associated with it. More likely, the burnout-health relationship has reciprocal associations with one impacting the other (Toker & Biron, 2012).

Research specific to how burnout influences health is limited in physician populations and is non-existent in a population of psychiatrists. Yet, this relationship is imperative to further understand the consequences of burnout in psychiatrists and justify why burnout is important to address. The intent of the fourth research question in this

dissertation addressed this gap by exploring how burnout affects perceived health consequences. The next section in this review will discuss the health implications of burnout in a broader population.

Health-Related Consequences of Burnout for Non-Physician Populations

While it is known that there are health consequences of burnout (Arrogante & Aparicio-Zaldivar, 2017; Balayssac et al., 2017; Mousavi, Ramezani, Salehi, & Khanzadeh, 2017) the research is limited on health outcomes and relationship with burnout in physician populations. Thus, to demonstrate a comprehensive and recent overview of the burnout-health relationship, the following section will explore this relationship in non-physician populations. In this section, the literature was limited to only studies published since 2014 to synthesize the most updated and relevant research. Burnout and relationship to mental health indicators, such as depression and anxiety, has been well researched in health professionals, particularly nurses. In three separate studies of populations of nurses, Arrogante and Aparicio-Zaldivar (2017), Balayssac et al. (2017), and Mousavi et al. (2017) found significant positive correlations between burnout dimensions, as assessed through use of the MBI, and symptoms of both anxiety and depression. Depression was positively associated with the emotional exhaustion construct of burnout in a study of 386 Korean nurses ($p < 0.001$) (Choi et al., 2018). Additionally, anxiety symptoms were positively related to burnout ($r = 0.388$, $p < 0.001$) in a study of Chinese nurses (Zhou et al., 2018). Finally, in a longitudinal study of 305 nurses, Zhang, Loerbroks, and Li (2018) found that after taking into account health-related quality of life

scores at baseline and sociodemographic factors, mental health declined by 3.02 points ($p < 0.05$) in the high job burnout group compared with the low job burnout group.

As demonstrated by these studies, there is more literature in non-physician populations that has established the association between burnout and mental health outcomes, such as depression and anxiety, in greater detail than physician populations. There is also more literature on physical health outcomes and the relationship with burnout in non-physician populations.

As previously mentioned, burnout many not cause physical ill-health but is associated with negative health outcomes such as perceived general health and specific ill-health symptoms (Kaeding et al., 2017; Moodie, Dolan, & Burke, 2014). Various studies have been done showing the correlation between burnout and perception of decreased general health (Khamisa et al., 2016; Moodie et al., 2014; Zhang et al., 2018). In a study of Spanish nurses, Moodie et al. (2014) assessed the relationship between burnout and employee general health. They found that participants who self-reported low burnout scores exhibited better health, and those who reported high burnout exhibited poorer health (Moodie et al., 2014). Khamisa et al. (2016) found that emotional exhaustion, as assessed through the MBI, was associated with higher odds of lower self-rated general health status in nurses (*OR* 1.93, 95% CI: 1.81–2.06). After taking into account health-related quality of life scores at baseline and sociodemographic factors, Zhang et al. (2018) found that physical functioning declined by 2.53 points ($p < 0.05$) in the high job burnout group compared with the low job burnout group. Other researchers have supported the association between lower perceived general health status and burnout

but do not use the MBI to measure burnout (Lee, Chen, & Xie, 2014; Solcova, Kebza, Kodl, & Kernova, 2017). In addition to perceived general health, burnout has also been explored in relation to specific health conditions.

In a study of Australian post-graduate psychology trainees, Kaeding et al. (2017) explored the relationship between burnout and participants' physical health. Using the MBI, the researchers split the group into those with moderate to high burnout and those with low burnout scores (Kaeding et al., 2017). Kaeding et al. (2017) found that mean scores of physical health symptoms including colds/viruses, headaches, muscle aches, back/neck pain, dizziness, and tiredness were all higher in the high-burnout group than the low-burnout group. Additionally, there was a statistically significant difference ($p < .05$) in total physical health scores between the two groups (Kaeding et al., 2017). In a study of Chinese civil servants, Guan et al. (2017) identified that the risk of chronic disease was higher in individuals with moderate to high burnout scores compared to individuals with lower scores. The researchers defined chronic disease as the prevalence of hypertension, coronary disease, diabetes, and stroke; however, each chronic disease was not analyzed individually with burnout scores (Guan et al., 2017). Finally, in a study of German hospital workers, higher blood pressure readings and higher cortisol levels were found in individuals with high burnout symptoms as compared to those with low burnout symptoms (Traunmüller et al., 2019). These studies demonstrate that burnout is associated with specific health conditions, such as increased colds/viruses, headaches, muscle aches, back/neck pain, dizziness, tiredness, chronic disease, high blood pressure,

and high cortisol levels (Guan et al., 2017; Kaeding et al., 2017; Traunmüller et al., 2019).

In summary, in this section I expanded upon the literature by demonstrating the relationship between burnout and symptoms of mental and physical ill-health in non-physician populations. It was important to explore this relationship to justify that burnout is significantly associated with symptoms of ill-health and offers empirical literature to support the health impairment process of the JD-R model. I also demonstrated the gap in knowledge about how burnout can affect the health status of psychiatrists. In this dissertation, the fourth research question aimed to address this gap in a qualitative manner by exploring how burnout affects perceived health consequences in a population of psychiatrists.

Social Implications of Psychiatrist Burnout

In this literature review, the prevalence of burnout in psychiatrists, the factors contributing to their burnout, resources identified as helping to alleviate burnout in physicians, and the health-related consequences of burnout have been synthesized in this literature review. This final section will explore the social implications of psychiatrist burnout. The NCBH noted that between 2003 and 2013, there was a 10.2% decline in the number of psychiatrists for every 100,000 people (NCBH, 2017). In terms of future trends, Satiani et al. (2018) discussed that due to steady population growth, the growing demand for mental health practitioners by 2024, and the retirement of half of practicing psychiatrists, there will be a shortage of between 14,280 and 31,091 psychiatrists in the

United States. This shortage will be particularly apparent in rural areas (Satiani et al., 2018). Other reports indicated a similar trend in psychiatric shortage.

According to a report by the USHHS (2016), in 2013, there were 45,580 practicing psychiatrists. By 2025, it was reported that there will only be 45,210 practicing psychiatrists; a 1% decrease (USHHS, 2016). Assuming current demand, the USHHS (2016) calculated that by 2025, 51,290 FTE psychiatrists would be needed in the United States. This is a 6% increase in psychiatric demand. Assuming a 1% decrease by 2025, coupled with a 6% demand increase, there will be a shortage of approximately 6,080 FTE practicing psychiatrists in the United States (USHHS, 2016). This shortage is severe, and research has shown that burnout can contribute (Garcia et al., 2015).

Burnout has been shown to contribute to the shortage of psychiatrists. Garcia et al. (2015) found that high cynicism, a component of burnout, predicted the likelihood of leaving the VA within 2 years (B = .067; p = .004). Although this is the only recent study specifically addressing a population of psychiatrists, in other populations of physicians the trend between burnout and quitting the job, intent to leave, or retiring early has been established (Dewa et al., 2015; Huber et al., 2018; Miyasaki et al., 2017; Schwarzkopf et al., 2017). Therefore, it is critical to understand how to best mitigate burnout in this population, which may help to keep psychiatrists in the field working to meet societal demands.

Although burnout is so widely prevalent in practicing psychiatrists (Garcia et al., 2015; Grisham, 2018; Shanafelt, Hasan, et al., 2015; Volpe et al., 2014), there are very few studies that describe intervention strategies specifically aimed at reducing burnout in

practicing psychiatrists (Mache, Bernburg, Baresi, & Groneberg, 2016; Maslach & Leiter, 2016). In a study that utilized practicing psychiatrists in Germany, Mache et al. (2016) found that a self-care skills training program coupled with solution-focused counseling was associated with significant improvements in perceived stress. There are a few additional intervention related studies, however, they use populations of psychiatry residents or interns (Hoenders, Booij, Knegtering, & Vanden Brink, 2016; Szabo et al., 2019). Although these interventions could be informative to health educators, there is a need for more research on intervention studies in practicing psychiatrists. This resonating theme for more research is also recognized by Maslach and Leiter (2016). The authors noted that due to the limited research on burnout interventions in psychiatrists, there is no consensus on whether there are currently viable approaches in reducing the risk of burnout in this population. Understanding why psychiatrists are burnt out, what resources can mitigate burnout, and potential health implications of burnout could be valuable to health promotion specialists when designing and implementing health education programs that are tailored to a population of psychiatrists. Programs that are specifically tailored the audience's needs is a common best practice in health education (Cottrell, Girvan, McKenzie, & Seabert, 2014; Shirazi et al., 2015). The intention of this study was to offer additional research that could be used to tailor health education programs aimed at reducing burnout in psychiatrists.

Summary and Conclusions

Burnout prevalence in practicing psychiatrists has been identified as prevalent and increasing (Garcia et al., 2015; Shanafelt, Hasan, et al., 2015; Volpe et al., 2014), though

there is limited research on factors that contribute to burnout in this population (Garcia et al., 2015; Grisham, 2018). Research is also non-existent in this population in regards to what resources might help to mitigate burnout, though there is ample evidence in other populations of physicians (Busis et al., 2017; Howlett et al., 2015; Hyman et al., 2017; McAbee et al., 2015; Penberthy et al., 2018; Shanafelt et al., 2014; Starmer et al., 2016; West et al., 2015). Finally, although the relationship between burnout and decreased perception of mental and physical health has been identified (Oreskovich et al., 2013; Shanafelt, et al., 2011; Vandenbroeck et al., 2017), the literature in physicians is scant and the relationship has not been explored at all in a population of psychiatrists. Furthermore, these gaps in literature are well suited to a qualitative approach due to the explorative nature of inquiry requiring thick and rich description.

Burnout is a complex problem with multifaceted consequences (West et al., 2018), all of which need to be understood to be addressed and mitigated. With a diminishing professional psychiatric population and an increasing need for psychiatry, it is imperative to have a holistic understanding of the consequences of psychiatric burnout and what might help mitigate burnout in this population. This information could contribute to social change as it could be used to inform and develop health education programs needed to improve the health outcomes of psychiatrists who work in jobs with high levels of burn-out, as well as potentially decreasing the shortage of psychiatrists who leave the field due to burnout. In the following chapter, the research methodology will be identified and defended.

Chapter 3: Research Method

Introduction

The purpose of this qualitative study, which used an exploratory multiple-case design, was in part to explore how psychiatrists working in the public or private sector explain their experiences related to burnout. Specifically, this study investigated what factors impact the process of burnout, what resources protect against the effects of burnout, and how burnout affects perceived health consequences from the perspectives and self-reports of a sample of psychiatrists who self-identified as having experienced burnout. Chapter 3 presents detailed information about the study's research method and the rationale for conducting a multiple-case study instead of using other qualitative and quantitative study designs. I then explain the role of the researcher and the study's methodological strategies, including participant selection and recruitment, instrumentation, data collection, and the data analysis plan. Finally, issues of trustworthiness, including credibility, transferability, dependability, and confirmability, as well as ethical considerations are delineated.

Research Design and Rationale

Consistent with the study's purpose and based on empirical literature, four research questions were developed that provided a focus for the study and guided the data collection and analysis:

RQ 1: From the perspective of a sample of psychiatrists working in the public or private sector in Arizona, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming, or

Colorado and self-identifying as having experienced burnout, how do these individuals describe and explain the process of burnout?

RQ 2: From the perspective of a sample of psychiatrists working in the public or private sector in Arizona, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming, or Colorado and self-identifying as having experienced burnout, what factors do these individuals identify as contributing to their burnout?

RQ 3: From the perspective of a sample of psychiatrists working in the public or private sector in Arizona, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming, or Colorado and self-identifying as having experienced burnout, what resources protect against the effects of burnout?

RQ 4: From the perspective of a sample of psychiatrists working in the public or private sector in Arizona, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming, or Colorado and self-identifying as having experienced burnout, how does burnout affect perceived health consequences?

In this dissertation, burnout among psychiatrists was the central phenomenon addressed, with a focus on factors that influence burnout, resources that mitigate burnout, and the question of whether burnout affects perceived health consequences. Maslach and Jackson (1981) conceptualized burnout as increased emotional exhaustion and depersonalization and decreased feelings of personal accomplishment. Burnout prevalence in physicians has been widely studied, but as the literature review demonstrates, there are gaps in the current knowledge that the research questions presented above were designed to address. Due to the limited literature on the

relationships addressed by the research questions, a qualitative, exploratory multiple-case study represented the best approach to addressing these questions. In the following sections, the rationale for this selection is delineated.

In determining an appropriate research method and design, the alignment with research questions and the potential to yield data relevant to those questions were driving factors (Flick, 2018). Because this dissertation's research questions were exploratory, open-ended, and focused on a process as opposed to an outcome, it was determined that a qualitative method would yield the most appropriate data. Qualitative research is essential to gaining a deep understanding of a complex phenomenon such as physician burnout (Restauri, Flug, & Mcarthur, 2017). Because the research questions and purpose aligned with an exploratory, process-driven approach, I selected a qualitative methodology. Moreover, the qualitative design selected was an exploratory multiple-case study, which is described in detail in the following section.

For this dissertation, an exploratory multiple-case study was determined to be the most appropriate research design. An exploratory design is appropriate when there is a lack of detailed preliminary research about the phenomenon under investigation (Ridder, 2016). Thus, an exploratory study is well suited to advancing the field of inquiry and developing needed research on the topic of burnout among psychiatrists. A multiple-case study is a type of qualitative research that allows the researcher to collect in-depth data pertaining to contemporary experiences in a natural context from multiple individuals or groups (Yin, 2014). Yin (2014) defined a unit of analysis as an individual or organization

from which the researcher collects data. This dissertation's unit of analysis was individual psychiatrists working in the public sector.

A multiple-case study was selected over a single-case study for a few reasons. First, a multiple-case design allowed me to examine similarities and differences between and among cases, which improved data triangulation (Ridder, 2016; Yin, 2014). Moreover, I chose a multiple-case design because it is a more rigorous means of achieving data saturation and increasing convergent validity compared to a single-case study (Cronin, 2014; Ridder, 2016; Yin, 2014). A multiple-case design is suitable when research questions(s) are descriptive (i.e., what happened) or exploratory (i.e., how it happened; Yin, 2014). The research questions included both "what" and "how" questions.

Another characteristic of a case study design is the focus on understanding a complex phenomenon within its natural setting (Heale & Twycross, 2017; Ridder, 2016; Yin, 2014). This dissertation focused on the complex process of burnout, and this phenomenon was explored in the natural setting of the psychiatrists' professional lives. Moreover, a multiple-case design was appropriate because this study aimed to capture the complexity of multiple participants' experiences with a complex phenomenon (Cronin, 2014; Marshall & Rossman, 2016; Yin, 2014). Finally, a multiple-case design was selected for its hallmark characteristic of using multiple sources of data (Houghton, Casey, & Smyth, 2017; Ridder, 2016; Yin, 2014). For this dissertation, I used a case study survey as well as in-depth interviews to enhance the reliability of the results and data saturation (see Yin, 2014).

In selecting the study design, several qualitative approaches, including phenomenology, ethnography, and grounded theory, were considered. Phenomenology was briefly considered as a research design for this dissertation, because a characteristic of this design is to construct a rich narrative of the participants' experiences (Chesnay, 2014; Neubauer, Witkop, & Varpio, 2019). Because one of the purposes of this dissertation was to understand psychiatrists' perceptions of how burnout symptoms influence health consequences, phenomenology could have been suitable. However, rather than understanding the rich, lived experience of the individual (Eberle, 2014), the dissertation's goal was to improve the understanding of a complex process regarding the phenomenon of burnout based on the perspectives and experiences of the population. Therefore, although a phenomenological design could have provided some appropriate data, it would not have provided a suitable approach to the dissertation's core research questions.

Ethnography, another qualitative design, allows the researcher to both observe and participate in the lives of participants, communities, or organizations, with a focus on culture-specific exploration (Grossoehme, 2014). Marshall and Rossman (2016) noted that the purpose of ethnography is to explore the behaviors and interactions of cultural groups. Often, the researcher devotes an extended period of time to living with, interacting with, and observing the study participants (Shagrir, 2016). Ethnographic research would not have been appropriate for this dissertation because it neither focused on culture-specific exploration nor involved direct participation in the lives of the participants.

Grounded theory is another qualitative design that was ultimately not selected for this study. Grounded theory focuses on theory generation as the approach to inquiry (Chun Tie, Birks, & Francis, 2019; Patton, 2015). In grounded theory methodology, the researcher does not approach the study with an existing theoretical lens but rather begins the study with what is relevant and allows a theory to emerge (Chun Tie et al., 2019). Instead of grounded theory methodology, the MTB (Maslach & Jackson, 1981), the JD-R model, and the COR theory provided a conceptual framework for developing the research questions and guiding the data collection. Because my goal was not to generate a theory but rather to explore and generate themes using an existing theory as a framework, a grounded theory design was not appropriate.

Finally, a quantitative design would not have been suitable for this study, because it did not take a deductive approach. Quantitative researchers collect data with the goal of testing hypotheses and using statistical tests to confirm relationships between variables (Burkholder et al., 2016). Typically, large numbers of participants are needed to allow for generalizability to a larger population (Burkholder et al., 2016). This dissertation's research goal was neither to assess hypotheses using statistical tests, identify relationships between variables, nor demonstrate generalizability to a greater population. Furthermore, because a quantitative design is not inductive, it does not enable the in-depth exploration of different perspectives (Patton, 2015). An exploratory, inductive, qualitative approach was best aligned with this dissertation's purpose and research questions. Due to the qualitative, exploratory characteristics of the study, its collection of data from multiple

individuals, and its use of multiple data sources, a multiple-case design was the most appropriate research design.

Role of the Researcher

As outlined in Chapter 1, the purpose of this dissertation was to explore how psychiatrists who self-identified as having experienced burnout explained and described their experiences related to this phenomenon. Specifically, this study investigated what factors impact the process of burnout, what resources protect against the effects of burnout, and how burnout affects perceived health consequences. To achieve this purpose, a qualitative, exploratory multiple-case study was identified as the most appropriate design to answer the four research questions. Therefore, it becomes important to identify, clarify, and operationalize the role of the researcher.

In qualitative studies, the researcher is considered the instrument, because the researcher interacts with participants to collect data, for example, through interviews (Austin & Sutton, 2014). My role in this dissertation was as a research tool or instrument. Specifically, as the researcher in this exploratory multiple-case study, my role included collecting, analyzing, and interpreting the data in a manner that reduced researcher bias, maintained trust with participants, and minimized ethical issues (Austin & Sutton, 2014; Flick, 2018). It was imperative to consider ethical implications involving the relationship of the participants. Potential ethical issues were limited by adhering to a rigorous and systematic methodology (Yin, 2014). In qualitative research, three concerns must be addressed when the researcher is the data collection instrument: potential research bias, conflict of interest, and ethical concerns (Mecca et al., 2014; Sanjari, Bahramnezhad,

Fomani, Shoghi, & Cheraghi, 2014). In the following paragraphs, I discuss my personal worldview to identify any potential for bias. Moreover, potential conflicts of interest and a plan to mitigate them are discussed. Finally, ethical concerns, including the use of incentives, are explored.

Potential Research Bias

This study adopted a postpositivist approach. Postpositivists argue that an individual's perspectives are influenced by how they view the world (Creswell & Creswell, 2017). In other words, they argue that reality is subjective. Although research may offer an understanding of a phenomenon, postpositivists claim that research cannot verify any phenomenon because individuals create their own meanings about and perspectives on reality (Frey, 2018). The postpositivist worldview aligns well with a qualitative, exploratory research design; however, this paradigm can also lead to potential researcher bias. Because postpositivists believe reality is subjective and based on personal perspective, this could bias how I created meaning from participant data.

The first step in addressing this potential bias was to acknowledge and be consciously aware of my assumptions. This awareness was facilitated through journaling. Writing a reflective journal, also known as memo writing, can facilitate researcher reflexivity and help a researcher examine personal assumptions or biases (Allen, 2017; Rogers, 2018). Various guidelines exist for memo writing; however, there are no explicit rules (Charmaz, 2014). Rogers (2018) maintained that memos should be analytic rather than descriptive. In other words, memos should not be filled with raw data but should explore emergent concepts. Moreover, my personal values and beliefs and/or

preconceptions regarding the phenomenon of burnout were potential biases that could have influenced this study (Smith & Noble, 2014). To mitigate this potential bias, I prepared and followed an interview guide, which was used to reduce possible instances of asking leading or biased questions due to personal beliefs or preconceptions (see Bradshaw et al., 2017). To further reduce the potential for bias, the interview questions were reviewed by experts. Expert validation is the process of obtaining feedback to improve the research process and inform decision-making (Tsang, Royse, & Terkawi, 2017). For the current study, two members of the doctoral review committee and one board-certified, practicing psychiatrist served as sources of expert review.

Potential Conflict of Interest

To uphold ethical research requirements, I did not have professional, supervisory, or instructor relationships with any of the participants. Although I did not engage in such relationships, it is important to note that my husband is a psychiatrist. I did not draw participants from my husband's place of work; however, it was conceivable that a prospective participant might have known my husband. Ethical measures to protect participants, such as not using individuals from my husband's place of work, were taken to ensure that participants did not feel coerced or pressured to participate in the study. Moreover, steps taken to mitigate any personal biases included (a) following the interview protocol to ensure objectivity of interview questions between participants (Yin, 2014), (b) utilizing memo writing to facilitate reflexivity and examine personal assumptions (Rogers, 2018), and (c) conducting member checks to ensure that data were interpreted correctly from the perspective of the participants (Frey, 2018).

Ethical Concerns

First, strict adherence to IRB protocol played a valuable role in maintaining an appropriate and ethical participant–researcher relationship. IRB approval was obtained before I began any phase of recruitment or data collection to ensure that the study met ethical standards. Moreover, I upheld the standards set by the Belmont Report, which include (a) respect for persons, (b) beneficence, and (c) justice (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research [NCPHS], 1978). These ethical considerations are addressed in detail at the end of Chapter 3. Because I used incentives, this was another ethical consideration that needed to be addressed.

Case study research is typically more time-consuming for participants than other types of research (Ridder, 2016). In light of this fact, I concluded that monetary incentives should be used, because incentives can facilitate recruitment and motivate individuals to participate (Zutlevics, 2016). Incentives can help to increase participation rates, but they should be used in a noncoercive manner (Zutlevics, 2016). In other words, for an incentive to be considered ethical, it must not exert an undue influence on the participant. The amount of payment, the timing and form of payment, and compensation of minors and other vulnerable populations should be taken into consideration when addressing undue influence (University of California Berkeley [UCB], 2017). To maintain ethical guidelines, compensation should be appropriate for the time and effort participants devoted to the research study (UCB, 2017). Ethical issues can arise when the

compensation is too high, which may encourage participants to accept risks they would not otherwise take (Zutlevics, 2016).

In this dissertation, the participants completed a burnout survey, participated in an interview, and member checked their interview transcript. I anticipated that these tasks would take 2 to 5 hours for participants to complete. Researchers generally base the amount of a monetary incentive on the average wage in the location where the study is conducted (UCB, 2017). This study will be conducted in Colorado, where the minimum wage is $11.10 per hour as of March 10, 2019 (Colorado Department of Labor and Employment, 2019). Therefore, it was suggested that the incentives have a monetary value of $55 (rounded from $55.50) to account for up to 5 hours of participation. Because participation did not require travel, the incentive value did not account for parking costs, miscellaneous travel costs, or food (UCB, 2017). The form of payment was an emailed Visa gift card, which is similar to cash and allowed for quick delivery to participants after study completion. The incentive was emailed to participants after they completed the member check of their interview transcript. Finally, because the participants in this study were not children, prisoners, mentally disabled persons, or economically or educationally disadvantaged persons, ethical concerns related to using incentives in these populations did not apply to this dissertation (UCB, 2017). In summary, my role in this dissertation was that of an observer responsible for collecting, analyzing, and interpreting the data. Following IRB protocol ensured that the ethical considerations of this study conformed to the highest standards. The next section outlines the dissertation's methodology.

Methodology

The purpose of the methodology section is to delineate how the study was completed, in such detail that it could be replicated by other researchers (Patton, 2015). Additionally, the methodology section describes how data were collected and analyzed in a way that best supported the research questions (Burkholder et al., 2016). Sub-sections will include participant selection logic, instrumentation, procedures for recruitment, participation, and data collection and, finally, data analysis plan.

Participant Selection Logic

Population and selection criteria. Yin (2014) defines a unit of analysis for a multiple case study design as an individual or organization in which the researcher will collect data from. In alignment with a multiple case study design, the unit of analysis, or population for this study, was individual psychiatrists. In identifying population participants, it was important to address parameters of the population according to specific inclusion and exclusion criteria. For this dissertation, psychiatrist participants were limited to those practicing in the Western geographical region, which included Arizona, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming, and Colorado (United States Census Bureau, 2015). The geographical area was limited to Western states, as opposed to the nation, because regional culture can influence health and health care (Srinivasan, 2016).

Additionally, participants identified themselves as being board-certified psychiatrists through the ABPN. This ensured that they were all medical doctors and completed a medical residency training in the field of psychiatry (ABPN, 2015). All

participants were required to have active licenses to practice in their respective state. To establish that this was known, participants were asked in the initial survey if they were licensed in their respective state. In the selection of participants, there were not any specific vulnerable populations identified for inclusion in this study. However, pregnant women were not excluded from the study as the study did not address or incite any areas for concern related to pregnancy. Specifically, the study did not require any information indicating whether a female participant might be pregnant as it did not pertain to the study questions.

Additional inclusion criteria were necessary to ensure the participants were qualified to best answer the research questions. First, to be eligible to participate in the study, psychiatrists needed to self-identify as currently experiencing burnout or having experienced burnout anytime during the previous 5 years. Five years was the maximum timespan selected for inclusion as burnout experiences older than 5 years may not be relevant to the culture of burnout presently. To best answer the research questions and gather data that could be used to inform programs to prevent burnout, it was important to gather current or recent accounts of burnout in this population. To establish current or recent burnout, a survey that used open and close-ended questions was distributed via SurveyMonkey (www.surveymonkey.com). Burnout was not addressed with a previously established quantitative measure, such as the MBI, but was rather addressed through the question, “Have you experienced burnout at any point in time within the previous 5 years or currently?”.

Furthermore, psychiatrists need to be working in the private or public sector, such as hospitals, clinics, universities, or government institutions, not in private practice. This criterion was important to include as research on psychiatrists' burnout prevalence, although scant, has only been verified with psychiatrists working in the private or public sector, not in private practice (Garcia et al., 2015; Shanafelt, Hasan, et al., 2015; Volpe et al., 2014). In other words, there is no research to date that psychiatrists in private practice are burnt out, so there was no empirical basis to study the process of burnout in this population in greater detail. Additionally, psychiatrists in the public and private sectors are decreasing as societal demand is increasing (NCBH, 2017) and burnout has been attributed to psychiatrist's intent to leave practice (Garcia et al., 2015). This is significant in terms of the social change application as the results of this study could be used to help understand and mitigate burnout of psychiatrists in the private and public sectors.

Finally, it is important to note the rationale behind the lack of inclusion criterion around how many years a psychiatrist has been practicing. In this study, psychiatrists will be eligible to participate with any amount of time in professional practice. This was concluded due to the lack of research about when burnout occurs in populations of psychiatrists. There are anecdotal, non-scholarly accounts of burnout happening later into an individuals' career due to being on the job for a longer period of time. However, there is no empirical evidence of this for physician populations or psychiatrists. This could be due to the fact that physician burnout starts as early as medical school and continues through residency and into professional practice (Dyrbye et al., 2014). In other words, newly practicing physicians may already be burnt out when entering their new

professional role, thus it was determined that inclusion criterion for how long a psychiatrist has been practicing was not supported by empirical evidence. Therefore, there was no minimum or maximum number of years a psychiatrist had to be practicing to be eligible for the study.

In summary, the population for this study was board-certified, licensed psychiatrists practicing in the Western United States. Inclusion criteria included: licensure to practice in a Western state and perception of burnout currently or within the previous 5 years. Exclusion criteria included: psychiatrists who have never perceived themselves as being burnt out, and psychiatrists who may have experienced burnout, but the occurrence was more than 5 years in the past. In the following sections, sampling strategy, sample size, as well as procedures for participant identification, contact, and recruitment will be discussed.

Sampling. In this study, purposive, snowball sampling was utilized and was identified as the most appropriate sampling strategy. Purposive sampling is warranted when a researcher needs to deliberately gather data from participants who have a particular set of characteristics (Burkholder et al., 2016). In this study, participants were not only psychiatrists, but they also self-identified as having experienced burnout, which is a particular characteristic. Snowball sampling was also utilized as I could not gather enough participants from purposive sampling alone. Using a snowball sampling technique, I identified additional potential participants by asking participants who had completed the interview for references (Merriam & Tisdell, 2015). I asked the participant to pass along the information from the study or asked the participant if they were

comfortable sharing any contact information for other potential participants. Snowball sampling was an effective method as participants with these particular characteristics were more difficult to locate (Frey, 2018).

In qualitative studies, researchers gather small sample sizes to explore a phenomenon in detail to gather rich data (Fusch & Ness, 2015). Adequacy of sample size in qualitative, case study research can range from a little as one or more and is dependent on the type of research questions being asked (Ridder, 2016). For example, if a researcher is aiming for deep contextualization of a complex phenomenon, a single case might be appropriate (Ridder, 2016). In other instances, a researcher may want to compare between cases, which would require a larger sample size and a multiple case study design (Ridder, 2016; Yin, 2014). As this dissertation was a multiple case study design, the sample size needed to be greater than one (Yin, 2014) and ended with 14 participants. Yin (2014) noted that there are no precise rules for sample size in multiple case study research and the judgment as to when data collection should cease should be discretionary, not formulaic. Yin (2014) noted that data collection should cease upon replication of data findings, also referred to as saturation. In other words, when the same themes were seen repeating with no new themes exposed, I knew that data saturation had been achieved and concluded data collection efforts. This occurred after 14 interviews had been collected and analyzed.

The target population in this dissertation was licensed, board-certified, practicing psychiatrists within the Western states including Arizona, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming, or Colorado. Participants were identified and recruited through

publicly available contact information found from a google search and websites, such as LinkedIn (www.linkedin.com). The Invitation to Participate is provided in Appendix A. Potential participants were sent the Invitation to Participate and the burnout survey link, via email. This sampling measure had open and close-ended questions. The SurveyMonkey tool was used to identify potential participants who met inclusion and exclusion criteria. After the survey, if the individual was qualified to participate, he/she was asked to provide an email address for follow up to schedule a telephone interview. In summary, individual psychiatrists were identified through publicly available data and sent an invitation to participate and the burnout survey. Individuals who met participation criteria were contacted via email and recruited to participate in the semistructured interviews. The sample size of the final study was 14 participants.

Instrumentation

As there were no published data collection instruments that would have adequately answered the research questions in this exploratory multiple case study. Thus, I created and collected a survey, as well as conducted semistructured interviews. These sources of data were deemed the most appropriate to answer the four research questions as understanding the complex process of burnout was more deeply understood through discussion as opposed to a quantitative measure. The burnout survey was used to identify participants, gather data that described aspects or characteristics of the population, and served to triangulate the semistructured interviews (Harrison, Birks, Franklin, & Mills, 2017). Survey Monkey was used as the platform to collect initial data.

The questions in the survey were also produced by me. The survey included self-report questions regarding demographic and professional data, and perception of burnout, which provided basic information. The burnout survey is presented in Appendix B. As this instrument was researcher produced, it was important to establish content validity, which was done through an expert review, also known as expert validation. Expert validation is the process of obtaining feedback to improve the research process and inform decision making (Tsang et al., 2017). For the current study, two members of the doctoral review committee and one board-certified, practicing psychiatrist served as sources of expert review. These individuals were asked to review interview questions and provide feedback, which was then used to amend the interview questions. Expert review was used in this study to help to establish content validity, which is the extent to which the interview questions represent what the researcher is seeking to measure (Zamanzadeh et al., 2015).

After completion of the burnout survey, a semistructured, individual interview was scheduled with each participant. The interviews served as an opportunity to collect verbal accounts of the participants' perspectives and experiences of burnout (Yin, 2014). Interviews are an established way to collect rich data through open-ended and probing questions (Flick, 2018) that supported gathering the data needed to answer the research questions. In this dissertation, the interview was conducted over the phone as participants were from a variety of states including Arizona, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming, or Colorado, which would have made face-to-face interviews challenging. Semistructured interviews allowed me to guide the conversation for further

clarification and elaboration on answers from the burnout survey. Clarifying questions were asked in the interview to better understand data collected from the survey.

The interview questions were also researcher produced; however, interview questions were guided by empirical research, specifically related to the MTB, the JD-R model, and the COR theory. The interview included questions inquiring about how the individual described and explained the process of burnout, what factors the individuals identified as contributing to their burnout, what resources appeared to protect against the impact of burnout, and how burnout affected perceived health consequences. An interview protocol was utilized as the data collection instrument to ensure consistent inquiry between all participants (Flick, 2018). To establish content validity, expert reviewers were used to gather feedback on the interview questions (Zamanzadeh et al., 2015). Additionally, member checking was utilized before data analysis as an effective way to establish credibility (Harvey, 2015; Yin, 2014).

Procedures for Recruitment, Participation, and Data Collection

Procedures for Recruitment and Participation

Prior to all recruitment, participation, and data collection, it was essential that approval was granted from the Walden University IRB to ensure ethical research standards. Participants were identified and recruited through publicly available contact information found from a google search and websites, such as LinkedIn. These individuals were contacted either via email or phone call and data subsequently collected. The Invitation to Participate, which served as the initial contact, is provided in Appendix A. Prior to participation in the burnout survey via SurveyMonkey, individuals were

provided with an informed consent form, which required an electronic agreement. The informed consent provided individuals with a description and purpose of the study, projected time investment, the risks and benefits of participation, the right to withdraw from the study at any time, as well as issues of confidentiality and anonymity. The anticipated sample size was between 4 and 15 individuals. Saturation was reached after 14 interviews. In addition to purposeful sampling, snowball sampling was utilized to recruit additional participants. Participants were asked to either pass on the study invitation to peers or to provide me with contact information for these individuals.

Procedures for Data Collection

As the sole researcher for this dissertation, it was my responsibility to collect, store, and secure participant data (Yin, 2014). Secure data storage was particularly important to maintaining the confidentiality of participant responses (Tufts Medical Center, 2017). The data from the burnout survey was downloaded from SurveyMonkey and these electronic files were stored in password-protected Microsoft Word file. A backup set of data were saved to a USB drive and secured in a safe in my home. The semistructured interviews were audio-recorded (with permission from the participant) using a secure recording app on my second cell phone. This cell phone was used solely for audio recording the interviews and as such, this phone was stored in a safe at my home until the transcripts were typed 48 hours after the interview was completed. After the transcripts were typed and in electronic form, the audio recording was deleted.

First, psychiatrists completed an inclusion criterion survey through SurveyMonkey, which is an online survey tool that was structured to evaluate if an

individual met participation criterion. If an individual did meet participation criteria and agreed to provide an email address for follow up, the Invitation to Participate (see Appendix A) was provided. If an individual did not meet participation criteria, they were thanked for their time and the burnout survey ended. I collected the survey data through the platform, SurveyMonkey. After a participant completed a survey, I download the data into a protected Microsoft Word file for secure storage. As SurveyMonkey is an online tool, individuals provided data from their location. The survey took between 10 and 20 minutes to complete.

Individuals who completed the burnout survey and provided an email address were then contacted to set up a 45-minute telephone interview. A semistructured interview, including open-ended questions to elicit rich answers about burnout, was scheduled with each participant. Interview questions were presented to capture participants' explanations of the burnout process, factors that contributed to burnout, resources that helped mitigate burnout, and how or if burnout contributed to health consequences. Although there are limitations to phone interviews, such as not being present to observe facial expressions or body language, phone interviews were selected for convenience, as participants were from Arizona, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming, or Colorado (Patton, 2015).

Semistructured interviews were the second source of data to triangulate information collected in the burnout survey (Yin, 2014) and to collect data on the remaining research questions. An interview guide (see Appendix D) was utilized to maintain the focus of the interview and promote thoroughness and consistency between

interviews (Flick, 2018; Yin, 2014). Interviews ended by thanking the participant and reminding the participant that the transcribed interview would be sent via email within 48 hours. Interviews were audio-recorded using an app on a cell phone and then transcribed to a word document within 48 hours. After transcription of the interview, I emailed the participant the document to verify the responses were accurate (Flick, 2018). One week was allowed for modification, clarifications, additional information, or changes that were necessary. This process of member checking enhanced the trustworthiness through augmenting credibility of the data (Fusch, & Ness, 2015; Harvey, 2015). After completion of the interview, I thanked the participant, restated confidentiality, and reminded the participant to reach out at any time via email for follow up questions. Within the same day as the interview, I made time to document an individual reflection including initial reaction, perceptions, and feelings. Writing a reflective journal enhanced insight during data analysis, as well as allowed for the identification and examination of personal bias or assumptions (Miles, Huberman, & Saldana, 2014; Rogers, 2018). Finally, after the participant completed the member check of the interview transcript, I sent the $55 Visa gift card electronically.

Data Analysis Plan

Thematic analysis was the analytic approach used in this multiple case study to explore how psychiatrists who self-identify as having experienced burnout explained and described the process of burnout, the factors that influenced burnout, the resources that mitigated burnout, and how burnout affected their health. The interview questions (see Appendix D) were designed to generate data specifically targeting the four research

questions. In this multiple case study, the four research questions that guided data collection were:

RQ 1: From the perspective of a sample of psychiatrists working in the public or private sector in Arizona, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming, or Colorado and self-identifying as having experienced burnout, how do these individuals describe and explain the process of burnout?

RQ 2: From the perspective of a sample of psychiatrists working in the public or private sector in Arizona, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming, or Colorado and self-identifying as having experienced burnout, what factors do these individuals identify as contributing to their burnout?

RQ 3: From the perspective of a sample of psychiatrists working in the public or private sector in Arizona, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming, or Colorado and self-identifying as having experienced burnout, what resources protect against the effects of burnout?

RQ 4: From the perspective of a sample of psychiatrists working in the public or private sector in Arizona, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming, or Colorado and self-identifying as having experienced burnout, how does burnout affect perceived health consequences?

Thematic analysis is a strategic tool that assists in the identification of patterns across data sets (Ridder, 2016). Utilizing thematic analysis helped to answer the specific research questions in this dissertation. As this study was a qualitative, exploratory multiple case study, it was appropriate to select a non-statistical, analytic approach that

focused on the exploration of patterns or themes that emerged as an explanation of a central phenomenon (Willig & Rogers, 2017). Thematic analysis is a systematic approach that was used to identify, analyze, organize, describe, and report themes found within data (Nowell, Norris, White, & Moules, 2017). Additionally, thematic analysis was a useful strategy for examining the perspectives of different participants, which was highlighted in this multiple case study (Nowell et al., 2017).

Data were collected using a survey and a semistructured interview and was analyzed using Yin's (2014) five-step framework, which included (a) compilation of data, (b) disassembly of data, (c) reassembly of data, (d) interpretation of data, and (e) conclusion. First, to compile data, I used NVivo 12 qualitative data analysis software as a database and became familiar with data by reading the transcripts (Nowell et al., 2017). The semistructured interviews were audio-recorded and after, transcribed to a Microsoft Word document and member checked. The complete data sets from the burnout survey were also uploaded to NVivo 12 for organizational purposes. After compilation of data into the database, I read the data through one time, without starting the coding process, to understand the depth and breadth (Yin, 2014).

After familiarization of data, I began to disassemble the data to generate initial codes for each data set, including the surveys and semistructured interviews, in a systematic fashion using NVivo 12 as a tool. Coding is a process that transforms unstructured data into initial ideas that can then be used to identify like patterns for additional analysis (Nowell et al., 2017; Yin, 2014). In the coding process, I identified specific and important sections of data and attached labels (see Nowell et al., 2017). Yin

(2014) suggested researchers begin with level 1 coding, or in vivo codes, and then move systematically and incrementally to codes of higher conceptual levels, known as level 2 codes. NVivo 12 was utilized to assist with organizing complex and large amounts of data and codes. After all the individual data sets were disassembled, I started to reassemble the data.

In data reassembly, Yin (2014) suggested that the fragmented codes be grouped into common patterns, thus identifying emergent themes or theoretical concepts that can represent answers to the research questions. Themes have been characterized as bringing together pieces or fragments of ideas or codes into a broader meaningful concept (Yin, 2014). I cross-referenced themes identified in individual data sets across all data sets for an across case thematic analysis (see Yin, 2014). Additionally, hierarchical arrays were used to help facilitate the reassembly process. Yin (2014) noted that hierarchical arrays start with a concrete code as the top of the hierarchy and move down with more abstract codes that represent the top hierarchical code. Utilizing hierarchical arrays allowed me to visualize emergent patterns and themes that represent the entire data set (see Nowell et al., 2017). NVivo 12 was utilized to build and organize these hierarchical arrays. After data were reassembled, I moved onto the interpretation phase.

The interpretation phase is the pinnacle of data analysis in which I designated meaning and created a narrative from the reassembled data (Yin, 2014). When interpreting data, I started with the research questions and built around them, connecting relevant literature with the reassembled data (see Yin, 2014). Relevant literature and reassembled data were interpreted according to how they answered the various research

questions. The final phase in Yin's (2014) framework is the conclusion, which captures the broader implications of the research. The implications of this study are shared in Chapter 5.

Finally, there was a plan for discrepant cases, which are cases that may contradict the overall analysis or findings of the study. Yin (2014) described discrepant cases as those with inconsistencies in identified themes and noted that these cases should be analyzed to understand the differing perspectives in relation to the central phenomenon. In this study, discrepant cases were explored and analyzed to gain insight into contradictory or alternative perspectives.

Issues of Trustworthiness

Credibility

In qualitative research, credibility is characterized as the confidence in the research findings (Munn, Porritt, Lockwood, Aromataris, & Pearson, 2014). In other words, there should be a veritable link between information from the original data and the researcher's analysis of the data. Utilizing data triangulation and member checking are two methodological approaches to augment credibility (Flick, 2018). In this study, triangulation was established by gathering information from two sources of data; surveys and semistructured interviews. Utilizing these two sources of data was critical to identifying potentially varying perspectives and identifying similarities, in order to enrich the understanding of the research questions (Yin, 2014). In addition, member checking has been reported to improve credibility for a study by verifying the accuracy of participant's transcripts (Fusch, & Ness, 2015; Harvey, 2015). In this study, I employed

member checking after the semistructured interviews and before data analysis to ensure participant's responses were accurate. During member checking, participants were able to make any necessary clarifying comments for their responses.

Transferability

In qualitative research, transferability refers to the degree to which the results of the research can be applied to other contexts (Coghlan & Brydon-Miller, 2014). Employing thick descriptions is a strategy used to enhance transferability and assist other researchers in making a transferability judgment (Coghlan & Brydon-Miller, 2014). As transferability refers to the applicability of research to other settings, rich descriptions must be included for readers to determine if the findings are transferable to their setting or population (Korstjens & Moser, 2018). Thick description requires the researcher to elucidate the research process (Anney, 2014). Specifically, Korstjens and Moser (2018) noted that researchers should include (a) the setting in which the research was carried out, (b) sample size, (c) sampling strategy, (d) inclusion and exclusion criteria, and (e) interview protocol and questions. All these topics were extrapolated upon in detail in this dissertation, particularly in Chapter 3, and enhanced transferability of the study to aid other researchers in making sound transferability judgments.

Dependability

Dependability in qualitative research refers to research results that are consistent and repeatable (Flick, 2018). Anney (2014) described dependable research as the stability of findings over time. An audit trail is a transparent description of the research process and is a strategy a researcher can employ to augment dependability (Korstjens & Moser,

2018). In an audit trail, a researcher should be able to demonstrate how data were collected, recorded, and analyzed (Anney, 2014). In this study, all documents and procedures were delineated and stored so as to enable the tracing of steps in the research process.

Confirmability

In qualitative research, confirmability is characterized by the degree to which the study findings could be confirmed by other researchers (Flick, 2018). Additionally, confirmability requires that study findings are data-driven and should not be influenced by researcher bias (Korstjens & Moser, 2018). In other words, confirmability ensures the research results are neutral, based on data, and free of bias. Establishing the proper documentation for an audit trail is a strategy that can also enhance confirmability as a reader would be able to clearly see how the researcher deduced findings from data (Korstjens & Moser, 2018). Additionally, writing a reflexive journal, often referred to as memo writing, can be used to augment confirmability (Anney, 2014; Rogers, 2018). Memo writing can facilitate researcher reflexivity and help a researcher examine personal assumptions or biases that could interfere with study results (Allen, 2017). To establish confirmability in this study, I used an audit trail and engaged in reflexive journaling.

Ethical Procedures

To protect human participants, IRB approval was obtained before I began any phase of recruitment or data collection. The IRB approval number was 08-05-19-0669670. In this study, psychiatrists were identified as meeting inclusion criteria through a survey. The survey included an introduction to the study, as well as, self-report

questions regarding demographic and professional data, professional licensure, and perception of burnout. Prior to participation in the burnout survey via SurveyMonkey, individuals were provided with a consent form, which required an electronic agreement. The consent form included a clause that informed potential participants that they could withdraw from the study at any time. This document also addressed the time commitment for the semistructured interview, nature of the study, risks and benefits, and provided my contact information.

In this study, participants were identified and recruited through publicly available contact information found from a google search and websites, such as LinkedIn. As mentioned in the previous ethical concerns section, although I did not have any professional, supervisory, or instructor relationships with any of the psychiatrist participants, there was a possibility that a prospective participant may have known my husband, as he is a psychiatrist. To ensure that participants did not feel coerced or pressured to participate in this study, all participants were informed at the beginning of the survey and at the start of the interview that participation was voluntary. Additionally, participants were not recruited from my husband's workplace.

Participant confidentiality is an ethical concern that must be addressed before collecting data (Sanjari et al., 2014). To ensure confidentiality of the psychiatrist's names, alphanumeric pseudonyms were used to represent each participant (Allen & Wiles, 2015). Records of survey data and interview transcripts were secured in password-protected Microsoft Word files. A backup set of data were saved to a USB drive and

secured in a safe. Participants were made aware of the efforts to ensure confidentiality within the study, and for 5 years, after which, the data will be destroyed.

Summary

In summary, in Chapter 3, I described the research design rationale and methodological approach to completing this multiple case study. Included was a rationale for conducting a multiple case study as opposed to other qualitative and quantitative study designs, as well as the role of the researcher for this type of research design. Chapter 3 also included a comprehensive review of the methodology, including participant selection and recruitment, instrumentation, data collection, and data analysis plan. Finally, issues of trustworthiness including credibility, transferability, dependability, and confirmability, as well as ethical considerations, are discussed. In the following chapter, the results of the study will be delineated.

Chapter 4: Results

Introduction

The purpose of this qualitative study utilizing an exploratory, multiple case study design, in part, was to understand how psychiatrists who have experienced burnout describe and explain the process of burnout. According to the APA, in 2018, two out of five psychiatrists reported experiencing professional burnout (APA, 2018a). However, little is known about the process, factors, resources, and health consequences of burnout in this specific population (Heinemann & Heinemann, 2017; Schwenk & Gold, 2018). This study aimed to bridge the gap in research. In this chapter, study settings, participant demographic information, and an overview of data collection are presented. Additionally, Chapter 4 includes a comprehensive account of the data analysis process and research findings. Finally, evidence of trustworthiness of this study is explored.

Setting

The setting of the study was a recorded telephonic interview with participants from a variety of states and from a defined range of practicing physicians as determined in the inclusion criteria. Participants needed to be working in Arizona, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming, or Colorado. Interview recording and transcription was completed from a home office to ensure privacy and quality recording. Participants self-selected a location to complete their interview but were requested to complete the interview from a home office or private conference room for security and privacy.

Demographics

Defining the Unit of Analysis

The participants in this study, known in case study research as units of analysis (Yin, 2018), were required to meet inclusion criteria. This included being board-certified, licensed psychiatrists practicing in either the public or private sector in the Western United States. The Western states included Arizona, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming, or Colorado. Also, all participants needed to be currently experiencing professional burnout or needed to acknowledge having had professional burnout within the previous 5 years. These characteristics were identified through the burnout survey.

Participants' demographic characteristics are depicted in Table 1. There was diversity in the gender of participants, age range, and years of experience. In regard to gender most participants identified as male (n = 8), while six participants identified as female. A majority of participants were between 25-34 years of age (n = 7). Three participants were between the ages of 35-44. Another three participants were between the ages of 45-54, while only one participant was between the ages of 55-64. Additionally, in this sample, there was a diversity in years of experience. Most participants (n = 7) were in their early career, with 1 to 5 years of experience. Three participants were mid-career, with 6 to 10 years of experience. Four participants were late into their career, with 11 to 20 years of experience.

Table 2 shows the participants' burnout severity, which was gathered from the burnout survey. A Likert scale was used to assess how participants self-rated their

burnout at different periods of time over the previous 5 years. Participants rated their burnout levels from 1, being minimal, to 5, being severe. This survey item was used as an inclusion measure, as participants had to be experiencing some level of burnout at any point in time in the previous 5 years. This information also served to inform data analysis and augmented triangulation. Most participants' burnout ranged between a 1 and 3 out of 5 for severity. Two individuals rated their burnout at any point in time as a 4 and no participant rated their burnout severity as a 5 at any point in time. This demonstrates that for this sample, most of the participants were either mildly or moderately burnt out.

Table 1

Psychiatrists Demographic Characteristics

Participant identification number	Age range	Gender	Years of experience
P104680	25-34	Female	1-5
P104082	25-34	Male	1-5
P104059	25-34	Female	1-5
P104802	35-44	Male	1-5
P104968	25-34	Male	1-5
P104985	25-34	Male	1-5
P104397	35-44	Female	6-10
P104279	25-34	Male	1-5
P104472	35-44	Male	6-10
P104774	25-34	Female	6-10
P104703	55-64	Male	11-20
P104380	45-54	Male	11-20
P104246	45-54	Female	11-20
P104557	45-54	Female	11-20

Table 2

Psychiatrists Burnout Severity

Participant identification number	On a scale of 1 to 5, with 1 being minimal burnout and 5 being severe burnout, in the last 5 years, how would you rate your level of burnout?	On a scale of 1 to 5, with 1 being minimal burnout and 5 being severe burnout, in the last year, how would you rate your level of burnout?	On a scale of 1 to 5, with 1 being minimal burnout and 5 being severe burnout, in the last 30 days, how would you rate your level of burnout?	In the last 30 days, how many days have you experienced burnout?
P104680	3	1	1	0-5
P104082	2	1	1	0-5
P104059	3	2	1	0-5
P104802	1	1	1	0-5
P104968	2	2	1	0-5
P104985	2	2	1	0-5
P104397	3	3	2	6-10
P104279	3	3	2	6-10
P104472	3	2	2	0-5
P104774	2	2	1	0-5
P104703	4	4	3	6-10
P104380	4	3	3	6-10
P104246	2	2	2	0-5
P104557	2	1	1	0-5

Data Collection

In this exploratory multiple case study, survey data and interviews were collected from psychiatrists who had experienced burnout at some point within the past 5 years. The recruitment process and collection of data were only commenced after Walden University IRB approval. Data were collected between August 8th, 2019 and November 1st, 2019 from 14 participants. Informed consent was also gathered before any data was collected. Purposive sampling was utilized to find and collect data from participants with the particular attributes needed for this study. Snowball sampling was a secondary

sampling strategy used to support the identification and recruitment of additional participants.

All 14 participants completed an initial burnout survey and a follow-up telephone or in-person interview. Collecting data from multiple sources is a specific principle in the data collection process for case study research as it augments triangulation (Yin, 2018). The initial survey collected demographic data and data about burnout severity and was hosted through SurveyMonkey. Thus, participants could have been located anywhere to take the survey as long as they had access to internet. The survey was completed one time per participant and took about 10 minutes to complete, on average. When psychiatrists were recruited, the initial survey link was included in the invitation letter. The survey served as an inclusion criteria measure and served to triangulate data found in the subsequent interview. Survey data were initially collected and stored via the SurveyMonkey platform. After an individual completed the survey and the interview was scheduled, the individual's email address was deleted from the survey data. The data were then downloaded from SurveyMonkey to a password-protected Microsoft Word document and then imported to NVivo 12 for data organization.

After a psychiatrist completed the survey and was deemed eligible to participate, a semistructured telephone or in-person interview was scheduled. Telephone interviews were the most appropriate method of interviewing most participants as they could have been from Arizona, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming, or Colorado. In-person interviews were conducted when it was more convenient for the participant and me. Each of the 14 participants completed an interview. Participants

doing telephonic interviews were requested to complete the interview from an area they deemed suitable to have a private conversation. I conducted a telephone interview from a home office for privacy and quality audio recording. The in-person interviews were conducted in a private conference room for security and privacy.

On average, the interviews took approximately 30 minutes to conduct. The telephone interviews were audio-recorded with the consent of every participant. I recorded the interviews on a cell phone using a secure recording application. Within 48 hours after the interview, the recording was hand transcribed to a password-protected Microsoft Word document. The transcribed interview was then sent to the participant for member checking. This allowed the participant the opportunity to add, clarify, or recant any part of their interview (Fusch, & Ness, 2015; Harvey, 2015). Once the transcribed interview was member checked by the participant, the document was uploaded to NVivo 12 for data analysis and organization. Yin (2018) noted that the establishment of a study database for organization and documentation is considered a best practice for data collection and one that enhances reliability. For confidentiality, the cell phone used for audio recording was stored in a locked file cabinet. Additionally, to protect confidentiality during data collection and subsequent analysis, alphanumeric pseudonyms were used to identify participants.

Finally, in qualitative analysis using a multiple case design, sample size is dependent on when data saturation is reached (Saunders et al., 2017; Yin, 2018). Data collection was discontinued when no new patterns or themes were found, which occurred at 14 interviews. Additionally, there was a variation in the data collection plan. I had

previously planned to only use telephonic interviews but met a handful of participants at a professional conference and elected to conduct in-person interviews with those individuals.

Data Analysis

Data analysis followed the plan delineated in Chapter 3. Specifically, Yin's five-step framework was adhered to, which follows the process of data compilation, disassembly, reassembly, interpretation, and conclusions (Yin, 2014). Additionally, as this study was a multiple case design, a cross-case synthesis was used for analysis between and among cases (Yin, 2018).

Data Compilation and Disassembly

The first step in Yin's framework, data compilation, began with hand transcribing the interviews with 24 to 48 hours to ensure reliability (Saldana, 2016). Interview transcripts were then emailed to the participant for the member check process. Once the member check process was completed and the interview accuracy confirmed, the interview transcripts and burnout survey data were imported to NVivo 12 for storage and organization. Yin (2018) noted that it is a best practice in case study research to establish a study database.

Data from each individual interview were then disassembled into initial codes, known as Level 1 codes (Saldana, 2016). Yin (2018) noted that in a cross-case synthesis, each case should be evaluated separately. Each interview transcript was dissembled 24 to 48 hours after the transcript cleared the member check procedure. Breaking data from multiple sources down into smaller units allowed for the discovery of patterns within

individual interviews and analysis of these patterns across interviews (Saldana, 2016; Yin, 2014). NVivo 12 was used to support this process by utilizing the nodes feature, which allowed for dissection of the interview transcript for labeling. After disassembly of each interview and cross-case analysis, reflexive journaling was used to identify any potential for bias (Allen, 2017).

Data Reassembly

The next step in the analysis process is data reassembly, in which the fragmented Level 1 codes from each individual interview were then reassembled into common patterns. These patterns are indicative of emergent themes or theoretical concepts that can represent answers to the research questions (Yin, 2018). Cross-case analysis was used to identify themes present across data sets (Yin, 2018). Initial codes were reassembled into code hierarchies, known as node hierarchies in NVivo 12, and were utilized to visualize emergent patterns and themes that represented the entire data set (Nowell et al., 2017).

Data Interpretation and Conclusion

The fourth step in Yin's five-step framework for multiple case study data analysis was the interpretation phase, in which the reassembled data were interpreted for meaning and narrative (Yin, 2014). To interpret data, I started with the research questions and built around them, connecting relevant literature from Chapter 2 with the reassembled data (Yin, 2014). The final phase in the data analysis process was the conclusion, which captures the broader implications of the research. Data interpretation and conclusion will be extrapolated on in the Results section of Chapter 4. There were no discrepant cases.

Evidence of Trustworthiness

Credibility

As was indicated in Chapter 3, credibility is characterized by the veritable link between information from the original data and the researcher's analysis of the data, which can be augmented through data triangulation and member checking (Flick, 2018). In this study, both data triangulation and member checking were utilized. Data triangulation was established by gathering data from multiple sources, which included the burnout survey data and the semistructured interview data. Additionally, member checking was used to enhance credibility by validating the accuracy of participant's transcripts (see Fusch & Ness, 2015). Within 24 hours after each interview was completed, the interview was hand-transcribed and the transcript was emailed to the participant. The participant was instructed to read the transcript and either confirm the accuracy of responses or make any necessary clarifying comments or changes. In practice, four of the 14 interview transcripts were edited slightly to clarify responses, which increased the accuracy and ultimately, the credibility of those data sources.

Transferability

Transferability refers to the degree to which the results of the research can be applied to other contexts (Coghlan & Brydon-Miller, 2014). To augment transferability, thick descriptions were utilized in this dissertation. The following measures, as suggested by Korstjens and Moser (2018), were implemented as strategies to employ a thick description:

- the setting in which the research was carried out was described in Chapter 4;

- the determination of appropriate sample size was delineated in Chapter 3;
- the sampling strategy was discussed and outlined in Chapter 3;
- inclusion and exclusion criteria were extrapolated on in Chapter 3, and
- the interview protocol and questions were explicitly described in Chapter 3 and documented in Appendix D.

Dependability

Dependability refers to research results that are consistent and repeatable (Flick, 2018). Dependability in qualitative research can be augmented through the use of an audit trail, which is a transparent description of the research process and strategy that allows for the tracing of steps in the research process (Korstjens & Moser, 2018). In this study, there were various measures implemented to record the research process and strategy. First, all raw data, including reflexive journals, was securely stored and will be kept for 5 years (see Korstjens & Moser, 2018). Data analysis and synthesis, including the process of moving from codes and categories to themes that emerged from raw data was delineated in Chapter 4. Finally, the methodological process was explicitly described in Chapter 3. In transparently depicting the research process from conceptualization, to design, methodology, and data collection, through to data analysis and conclusions, the audit trail demonstrated that this research study was conducted in a thorough and logical manner.

Confirmability

Finally, confirmability refers to the degree to which the study findings could be confirmed by other researchers and are neutral, based on data, and free of bias (Flick,

2018; Korstjens & Moser, 2018). Confirmability can also be augmented through the use of an audit trail, which was utilized in this study and described in the paragraph regarding dependability, above. Additionally, to increase confirmability, I practiced reflexive journaling after individual interviews and during data analysis to identify and mitigate biases (see Anney, 2014; Rogers, 2018). Finally, one adjustment to the process outlined in Chapter 3 was the addition of an independent data reviewer. A feature of confirmability is the concept of consistency. In other words, data analysis and interpretation should be grounded in data and free of personal bias (Korstjens & Moser, 2018). To augment consistency, and thus confirmability, an independent reviewer assisted in reviewing data analysis (see Soilemezi & Linceviciute, 2018).

Results

The purpose of this qualitative research study was to explore how the burnout process is described and explained, what factors contribute to burnout, what resources help alleviate burnout, and how burnout affects perception of health consequences in a population of psychiatrists. In this study, data were thematically analyzed using Yin's five-step framework, which follows the process of data compilation, disassembly, reassembly, interpretation, and conclusions (Yin, 2014). A cross-case synthesis was also employed to assess the similarities and differences in the data across data sets (Yin, 2018). As there are four distinct research questions, the Results section of this chapter will be organized by research question.

Research Question 1

RQ 1- From the perspective of a sample of psychiatrists working in the public or private sector in Arizona, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming, or Colorado and self-identifying as having experienced burnout, how do these individuals describe and explain the process of burnout?

Three interview questions were used as a basis to gather data for analysis regarding research question one. The codes and themes that emerged from raw data are presented in Appendix F. Through the process of coding, described in Chapter 4, there were seven codes identified for the first research question. These codes were then grouped into three themes that described the process of burnout for this sample. The three final themes identified were labeled (a) gradually progresses over time, (b) process precipitated by work stress, and (c) burnout as a multidimensional experience.

Theme 1: Gradually progresses over time. The first theme that was identified was the concept of burnout as a process that gradually occurs over time. Out of 14 participants, 10 described the process of burnout as gradually occurring. Figure 2 depicts a visual representation of this data. Burnout was described by the 10 participants as occurring over time and not as an acute response to a single event or factor. It should be noted here that all responses from participants are identified by alphanumeric codes to maintain confidentiality. Participant P104985 recounted his experience with burnout:

> You know, burnout just doesn't happen overnight. I think people assume that burnout is like, this thing that occurs in a short time span due to a particularly stressful patient or event, and that's part of what contributes to it [burnout], but

> really, it almost starts with things you don't even notice, like staying 15 minutes late to finish up your notes, and then, over time it, it's like, wow, I have been staying late every day this week, and that really wears on you over time.

Participant P104397 described the process of burnout in this way:

> Well, I would say that the process started almost imperceptibly, with little things, like, um, you know, being asked to cover patients for a coworker who was sick, which you agree to and then, it's like, ok, you're being asked more and more. I think it just developed gradually, almost like, like a glacier retreating. I don't know, the glacier retreating represents me being asked to do more and more things, but over a longer period, so I am almost not even aware how much everything is adding up and weighting on me until it's too late.

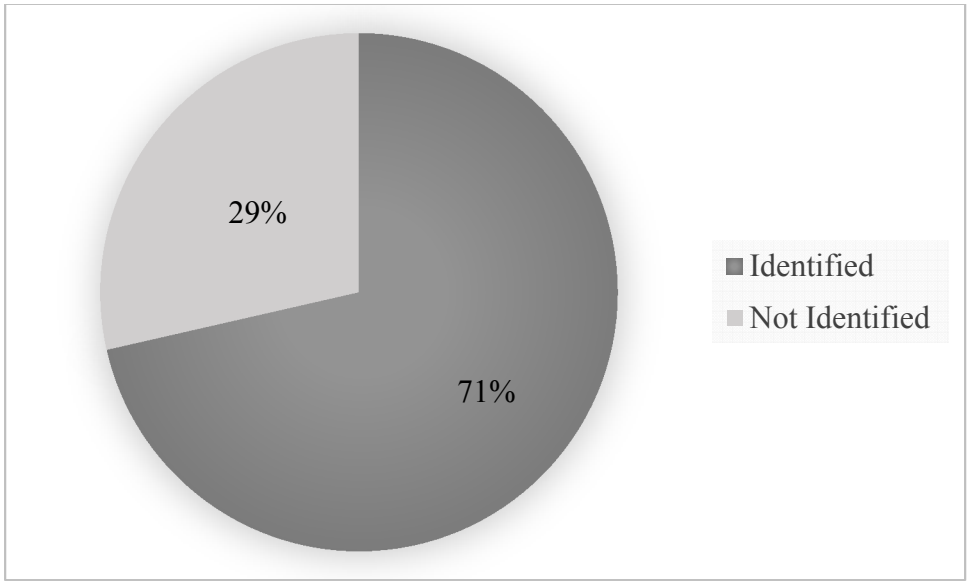

Figure 2. Percentage of participants who identified that burnout gradually progressed over time.

Theme 2: Process precipitated by work stress. The second theme that was

identified was the concept of burnout as being precipitated by work stressors. A commonality, as shown in Figure 3, was that all 14 participants noted that the onset of burnout was precipitated by various work-related stressors, in which they felt unable to meet demands. While all 14 of the participants identified work stress as an initiating factor in the burnout process, the work stressors were generally unique to their work setting. Additionally, it should be noted that work stress was distinct from any burnout related to personal or family issues, which was not noted in this population. Participant P104703 shared his experience of the burnout process:

> Definitely. I can 100% say that my burnout started from the various work pressures I was under. I can't pinpoint it to one exact thing, because there were many, but at that time I was working on the inpatient unit for a large hospital and we were short-staffed so that probably contributed, contributed most to my burnout, so I guess I could pinpoint that as a major stressor. But also, I remember there were multiple challenging patients and also challenging family members, and um, I was definitely staying late most days, so I think all those things combined contributed.

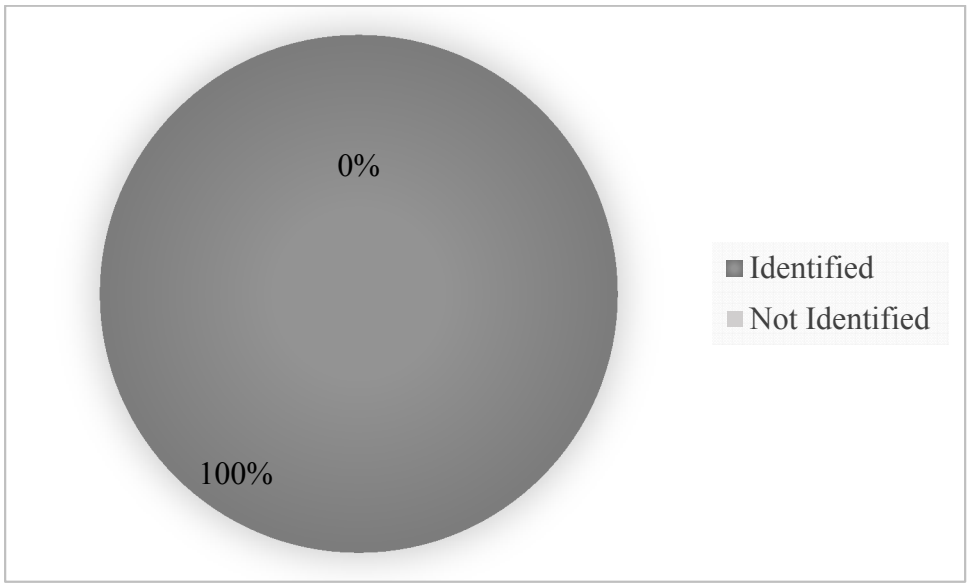

Figure 3. Percentage of participants who identified that burnout was precipitated by work stress.

Theme 3: Burnout as a multidimensional experience. The third theme that was identified was the concept that burnout is a multidimensional experience characterized by a combination of emotional exhaustion (EE), depersonalization (DE), and reduced personal accomplishment (RPA). Six out of 14 participants described their experience of burnout as having all three aspects of emotional exhaustion (EE), depersonalization (DE), and reduced personal accomplishment (RPA). This phenomenon is visually depicted by the far-left bar in Figure 4. Additionally, three participants described feelings of emotional exhaustion (EE) and depersonalization (DE) and five described feelings of emotional exhaustion (EE) and reduced personal accomplishment (RPA), as shown in Figure 3. Interestingly, all 14 participants also reported two or more characteristics of burnout, which indicates that burnout may be perceived as a multidimensional experience among psychiatric participants. Visually, note the chart indicates none of the participants

reported only one characteristic of burnout, such as EE only, DE only, or RPA only. Further, as shown in Figure 5, 100% of the sample described feeling emotionally exhausted as part of the burnout process. Figure 5 also depicts the characteristics of burnout reported by each of the 14 participants individually.

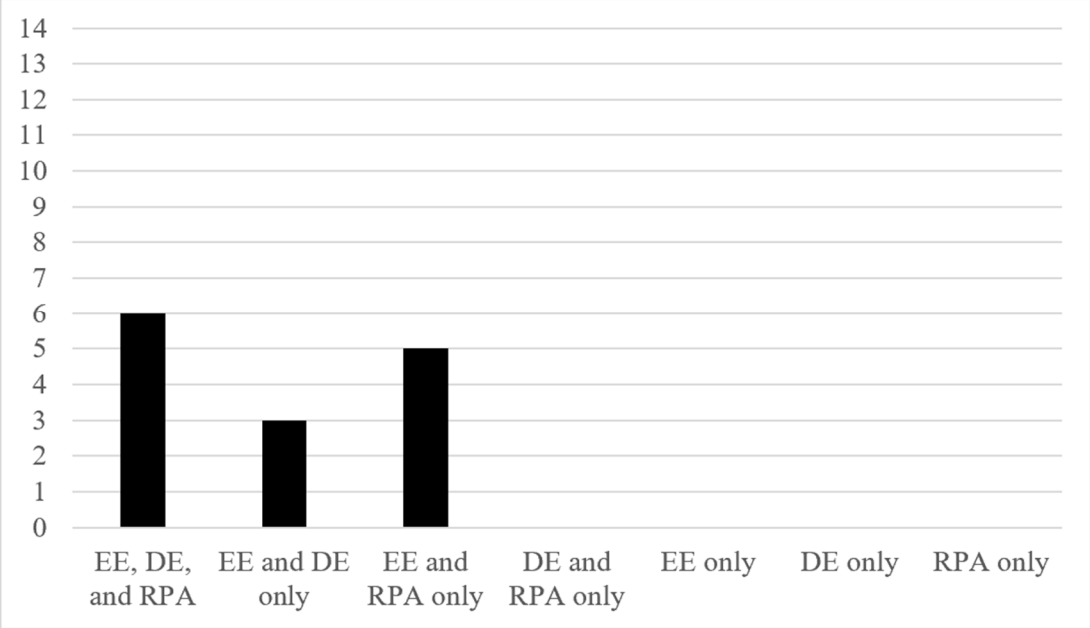

Figure 4. Number of participants identifying with different burnout characteristics.

Participant	Characteristics of Emotional Exhaustion	Characteristics of Depersonalization	Characteristics of Reduced Personal Accomplishment
P104680	X	X	X
P104082	X		X
P104059	X	X	
P104802	X	X	
P104968	X	X	X
P104985	X		X
P104397	X	X	X
P104279	X	X	X
P104472	X		X
P104774	X	X	
P104703	X	X	X
P104380	X	X	X
P104246	X		X
P104557	X		X

Figure 5. Psychiatrists burnout characteristics.

Research Question 2

RQ 2 - From the perspective of a sample of psychiatrists working in the public or private sector in Arizona, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming, or Colorado and self-identifying as having experienced burnout, what factors do these individuals identify as contributing to their burnout?

One interview question was used as a basis to gather data for analysis regarding research question two. The codes and themes that emerged from raw data are presented in Appendix F. Through the process of coding, described in Chapter 4, there were seven codes identified for the second research question. These codes were then grouped into three themes that described the factors of burnout for this sample. The three final themes identified were labeled (a) intrapersonal factors, (b) interpersonal factors, and (c) system-level factors.

Theme 1: Intrapersonal factors. The first theme that was identified was intrapersonal factors as contributing to burnout. The American College Health Association (ACHA, 2019) defines intrapersonal factors as characteristics of an individual such as knowledge, attitudes or outlook, behavior, or self-concept. The perception of ineffectiveness was an intrapersonal factor that was described as contributing to burnout. Three of the 14 psychiatrists reported feelings of ineffectiveness, as represented in Figure 6. The perception of ineffectiveness was identified as a contributing factor to burnout by participant P104968 in the following manner:

> And then you get the patients that come in and want a lot of help. They want a lot of things and they expect a lot from you. They expect that you can do a lot for them and I sometimes find myself feeling like I can't do a lot for them.

Participant P104279 also expressed internal feelings of ineffectiveness saying:

> I think one of the most difficult parts of being a psychiatrist is seeing what our limitations are and not being able to help people. Having someone come to you who is really sick and despite the medications and therapy they just don’t get

better and they are relying on you to help them change, but they don't get better and so, you feel like you aren't good at what you do.

Psychiatrists, as with most physicians, have an intrinsic drive to help their patients. When they perceive that they or the treatment might be ineffective, the feeling of failure or ineffectiveness can contribute to burnout.

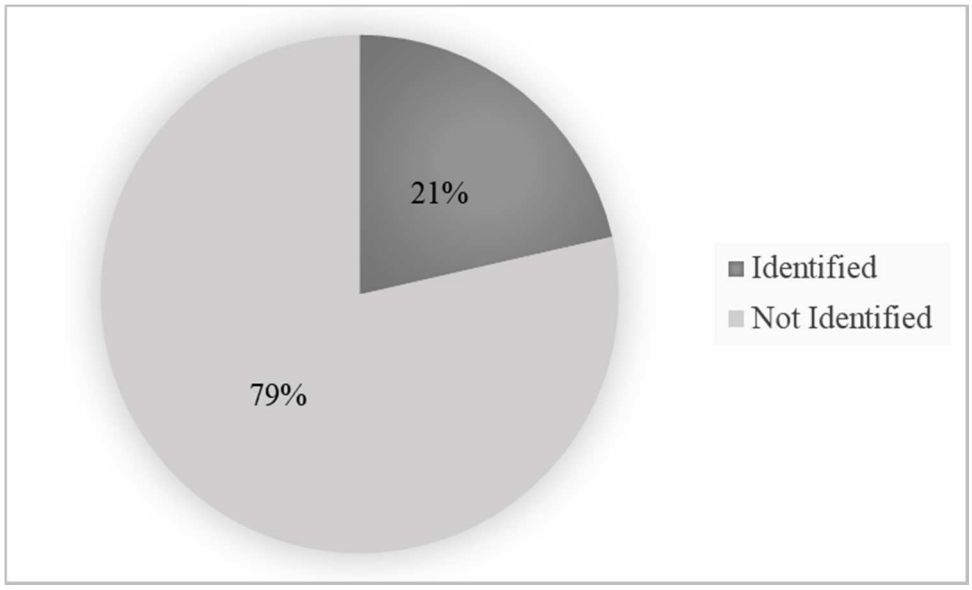

Figure 6. Percentage of participants who identified feelings of ineffectiveness.

Theme 2: Interpersonal factors. The second theme that was identified was interpersonal factors as contributors to burnout. The ACHA (2019) defines the interpersonal level as factors stemming from formal or informal social interactions, networks, or support systems. Three codes resulted in this theme: challenging interactions, lack of appreciation, and exposure to trauma. Challenging interactions with patients was the first code that was categorized as an interpersonal factor as it was the result of difficulty due to social interaction. Five of the 14 psychiatrists reported that challenging patient interactions was a factor that impacted their perception of burnout.

This is shown visually in Figure 7. The perception of challenging patient interactions as a contributing factor to burnout was recounted by participant P104059 in the following manner, “Then a month later they're back in the hospital. And then you have to go see them again, and you know it's going to be, be the same conversation over and over again. And I think that's really frustrating.” Additionally, participant P104380 expressed his frustration saying, “I would say, generally, at least 3 out of 7 weekdays, including weekends, I receive after-hours patient emails demanding an immediate response, which can be challenging when it happens so much.”

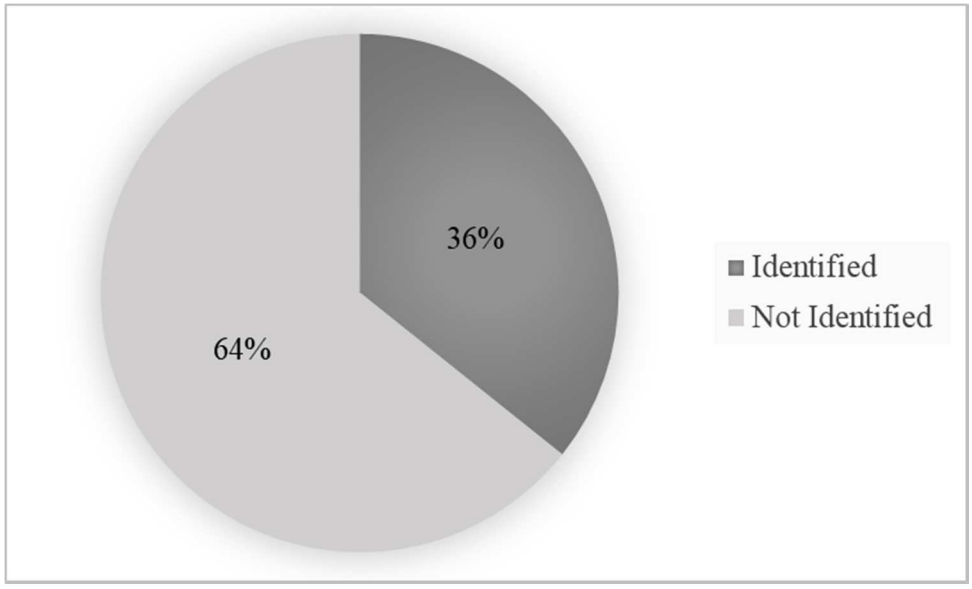

Figure 7. Percentage of participants who identified challenging patient interactions as a contributing factor to burnout.

Lack of appreciation was the second code that was categorized under the theme of interpersonal factors. Three of the 14 psychiatrists reported that lack of appreciation was a contributing factor to their burnout, as shown in Figure 8. Participant P104802 recounted his perception saying, “Most of what I have seen is more emergency room

stuff and dealing with families and patients that really did not even really want me involved let alone were appreciative of things." Participant P104246 also described not feeling appreciated. She recounted, "It's hard because I put in so much effort, I really do care about my patients, and sometimes I don't really feel like it is appreciated at all." When psychiatrists felt they were not appreciated by patients and families, this seems to be a contributing factor to burnout.

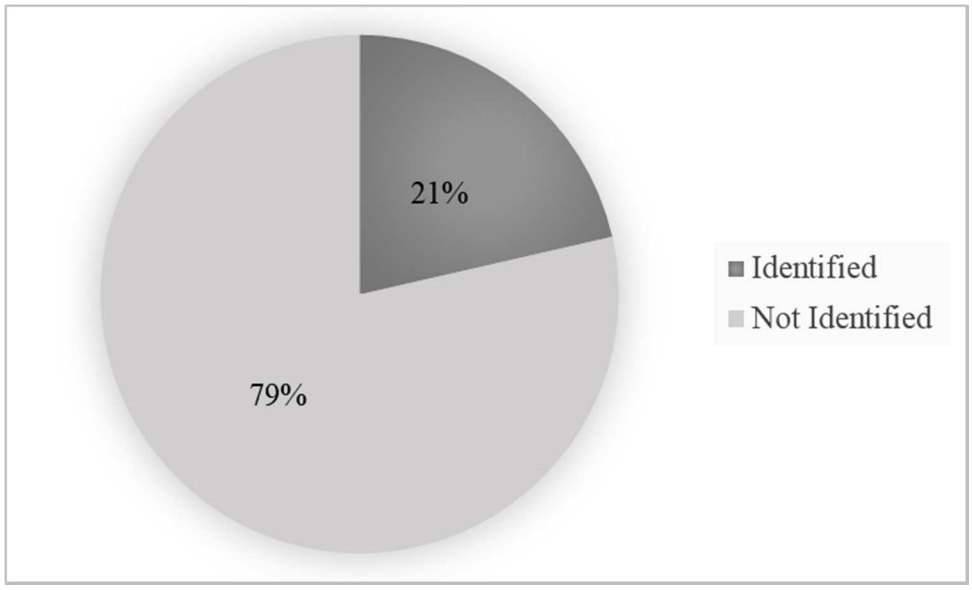

Figure 8. Percentage of participants who identified that lack of appreciation was a contributing factor to burnout.

A final interpersonal factor that was described as contributing to burnout was the exposure to secondary trauma. Secondary trauma is defined as the transfer of dysfunctional affective and cognitive states as the result of extended social contact with individuals who have experienced trauma (Shoji et al., 2015). There was only one psychiatrist who described feelings of secondary trauma, but it was an important factor in this individual's perception of burnout. Figure 9 depicts this visually.

Participant P104279 described his experience in this way:

> A majority of the patients I work with have had extremely traumatic experiences and it's my job and desire to try and help them in whatever way I can, but it's also often hard for me to let those stories go. At one point in time, I found myself thinking about a particular situation more frequently than was healthy, and so I started working with a psychotherapist to mitigate negative repercussions. It's helped working with my therapist, but in terms of your question for factors of burnout, this was a huge factor for me.

This individual was not experiencing secondary trauma at the time of the interview, but he remembered the event and associated feelings of secondary trauma as a focal point in his burnout experience.

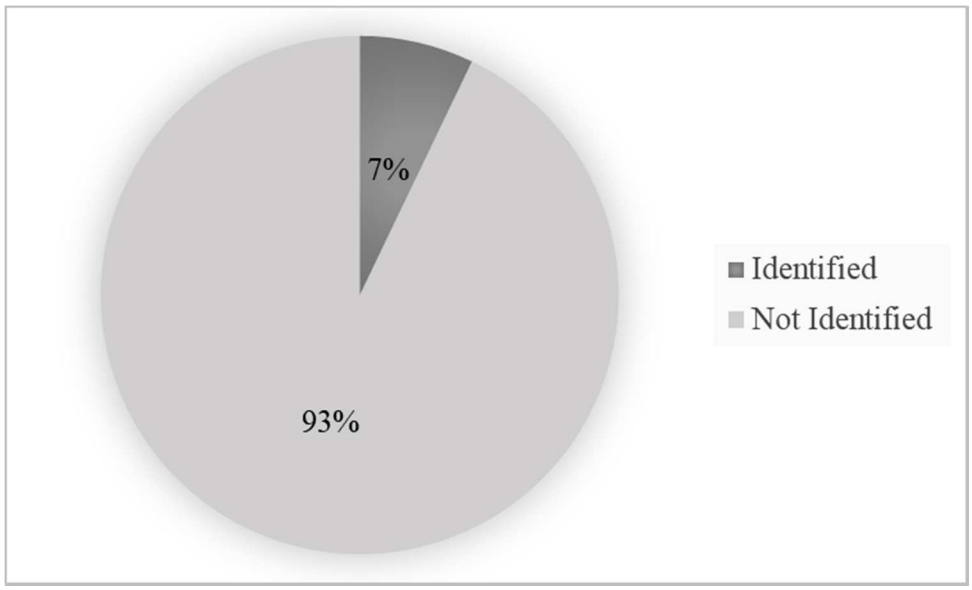

Figure 9. Percentage of participants who identified secondary trauma as a contributing factor to burnout.

Theme 3: System-level factors. The final theme identified in understanding what factors contributed to psychiatrists' burnout was system-level factors. System-level factors were defined as issues that contributed to burnout as a result of the work environment. Three codes resulted in this theme, insufficient organizational support, excessive work demands, and burnout culture. Insufficient organizational support was a frequently cited factor that contributed to psychiatrists' burnout, with seven of the 14 psychiatrists reporting it as a factor, as shown visually in Figure 10. Participant P104680 described, "Well part of it was, initially in the beginning, was that I sought support from one of my supervisors at the time and felt like my concerns were minimized." Participant P104985 discussed, "There wasn't much support from the organization at all. I think for me, that is often where burnout came from." As demonstrated by the quote from participant P104680, generally, support was referenced in terms of emotional capacity to help from those in upper management. The perception that there was a lack of emotional support was cited as a factor contributing to burnout. In a few cases, however, support was referred to in terms of more tangible help. For example, participant P104397 noted,

> There is a disconnect between the physicians and the organizations. I think that, for me at least, I felt that when there was an issue, policy change was extremely slow or didn't happen at all. That's probably just the outcome of being in a large organization, it's hard to change things quickly, but yeah, there was an issue with that. These organizations have a ton of money and power and I just find it hard to believe that they can't change a simple policy. I feel like it is mostly about them and the bottom line than the well-being of patients or staff.

Perceptions of lack of organizational support, both emotional support and tangible support, was a substantial factor that influenced psychiatrists' burnout.

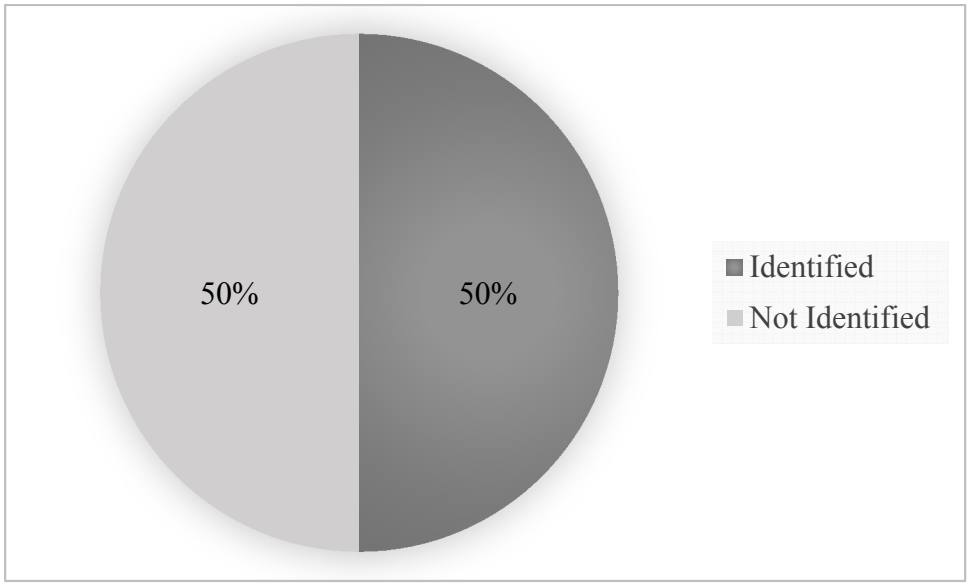

Figure 10. Percentage of participants who identified that insufficient organizational support contributed to burnout.

Excessive work demand was the most frequently cited system-level factor contributing to psychiatrists' burnout. Nine of the 14 psychiatrists, as shown in Figure 11, reported that various work demands outweighed their resources to properly manage the work, which influenced their burnout. Participant P104680 described her experience in this way,

> The institution was operating under an idea that a certain amount of patients needed to be seen and therefore we were the ones to do it regardless of anything. And they struggled to recruit and instead of reducing the census they just put more on their doctors.

Participant P104557 noted, “And there was really so little time with every patient and pressure to see more patients. Like how you do possibly understand the complexity of someone’s GAD [generalized anxiety disorder] in 15 minutes?” Although the work demands were unique to each individual and position, the experience of feeling like there was too much work and too few resources to complete the work well was a frequently cited factor that psychiatrists noted contributed to their burnout.

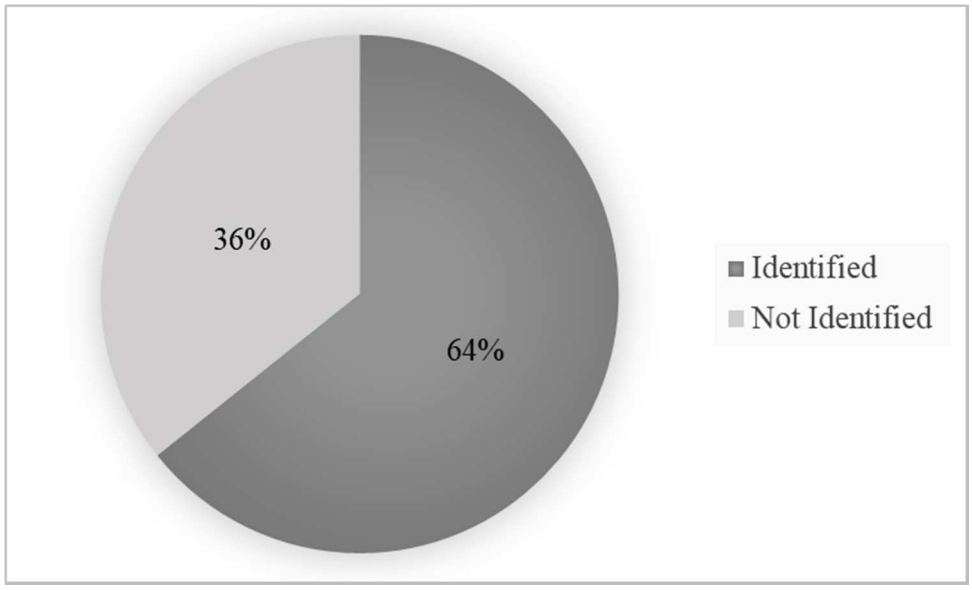

Figure 11. Percentage of participants who identified excessive work demands as contributing to burnout.

The final system-level factor that influenced burnout in psychiatrists was burnout culture. Burnout culture has been defined as unwavering and entrenched attitudes and values held and promoted within the work environment that contribute to the perception of emotional exhaustion, depersonalization, and reduced personal accomplishment of employees (Anjum, Ming, Siddiqi, & Rasool, 2018; Ledingham et al., 2019). Four of the

14 psychiatrists reported that burnout culture contributed to their burnout, as shown in Figure 12. Participant P104680 described her experience of the burnout culture by saying,

> When I think about it, I think it was such a heavy burden was because it was seen by the organization as an individual failure, that was how it was being essentially being told. And, I think the struggle was that individually everybody was doing that. And it was tough for people because they didn't feel like they personally could make a change to impact how they were feeling.

Participant P104279 discussed, “You’re sort of thrust into this situation and it’s actually seen as sink or swim. There’s a sense from people higher in the hierarchy that, oh we all did this, and we turned out fine.” The predominant culture of medicine that facilitates personal blame, limitless demands, and is built upon the entrenched attitudes and values of those higher on the hierarchy seems to contribute to burnout perception. To summarize, the factors that contributed to burnout in this population were intrapersonal factors (perception of ineffectiveness), interpersonal factors (challenging patient interactions, lack of appreciation, and secondary trauma), and system-level factors (insufficient organizational support, excessive work demands, and burnout culture).

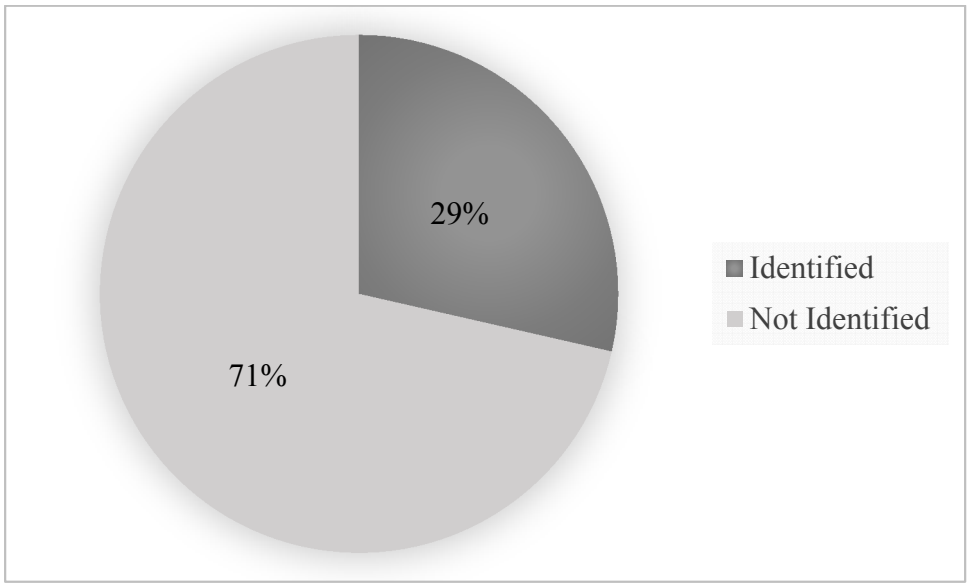

Figure 12. Percentage of participants who identified burnout culture as a contributing factor to burnout.

Research Question 3

RQ 3 - From the perspective of a sample of psychiatrists working in the public or private sector in Arizona, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming, or Colorado and self-identifying as having experienced burnout, what resources protect against the effects of burnout?

Four interview questions were used as a basis to gather data for analysis regarding research question three. The codes and themes that emerged from raw data are presented in Appendix F. As described in Chapter 4, through the process of coding, there were seven codes identified for the third research question. These codes were then grouped into three themes that described the resources that protected from burnout for this sample. The three final themes identified were labeled individual resources, system-level emotional support, and system-level tangible resources.

Theme 1: Individual resources. The first theme identified was individual resources as helping to protect against burnout. Individual resources are those characterized as being procured or utilized by the individual as opposed to organizational resources. Three codes comprised this theme: relational support, self-care, and enhancing self-awareness. The perception of relational support, or in other words, the support from friends and family, was paramount in easing the perception of burnout in psychiatrists. 10 of the 14 psychiatrists reported relational support was a resource that helped protect from or ease burnout, as shown in Figure 13. Participant 104968 described it this way: "Just talking with friends. A lot of my friends went to med school in various medical specialties and so they get some of these frustrations and we vent or joke about things." In addition to the support of friends, partners and children were also cited as relational supports. Participant P104082 noted,

> My wife is also a physician, and so being able to bounce ideas off one another and talk about work, both the good and bad, and things we are grateful for and things that are more challenging, with someone else who understands that has worked as well.

Finally, participant P104472 explained that his children were a source of support noting,

> And my kids. It's not like I mull over the hardships of my job with them, but, ok, for example, one of my kids woke up early and made me French toast for breakfast the other day. It was terrible, but a really kind gesture of appreciation and support.

Relational support was more frequently referred to in terms of emotional support, as expressed in the previous quotes, but a few psychiatrists also mentioned tangible support, such as a significant other helping around the house, or picking up children or groceries. As an individual resource, relational support, both emotional and tangible, was a source cited as protecting from burnout.

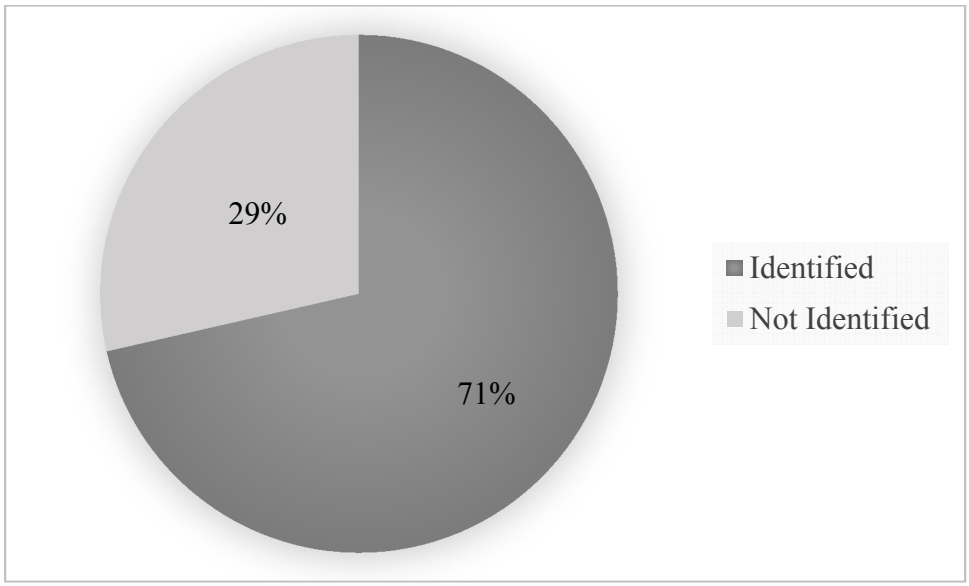

Figure 13. Percentage of participants who identified relational support as a protective resource.

Additionally, practicing self-care was a frequently mentioned individual resource that helped the psychiatrists in this sample with their burnout. In this study, the concept of self-care refers to activities and practices that an individual engages in on a regular basis to reduce stress and enhance well-being (University of Buffalo [UB], 2018). The most frequent self-care activity reported was participating in physical activity. Of the 14 psychiatrists, six reported using exercise to protect against burnout, as depicted in Figure 14. Eating healthy, participating in hobbies, playing music, getting enough sleep,

practicing mindfulness, and reading were also mentioned as activities the psychiatrists participated in that helped to mitigate their burnout. Of the 14 participants, 11 reported participating in some form of activity or practice related to self-care. This is visually depicted in Figure 15. Although the type of activities varied, most psychiatrists in this sample participated in some type of self-care activity or practice that they cited as helping to protect against burnout.

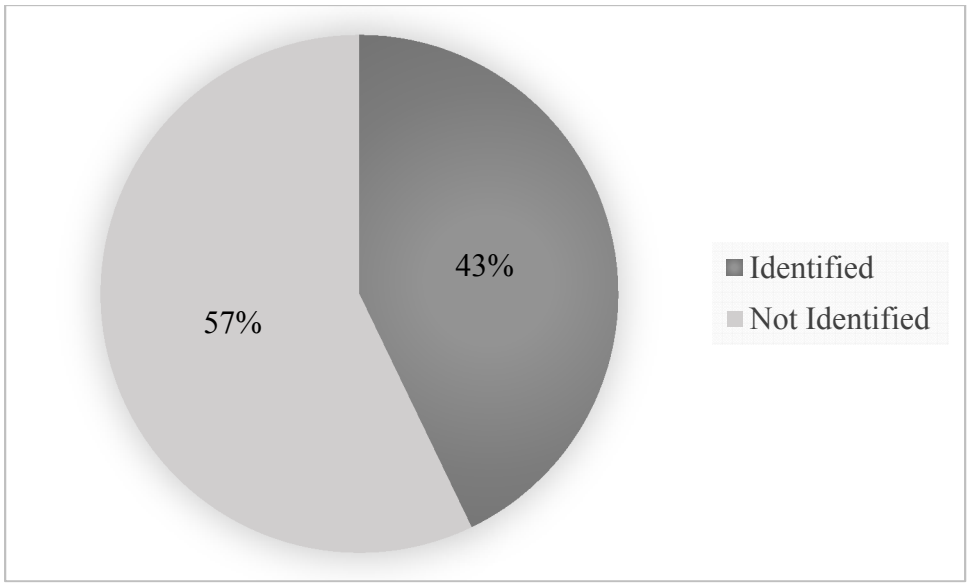

Figure 14. Percentage of participants who identified using physical activity as a protective resource.

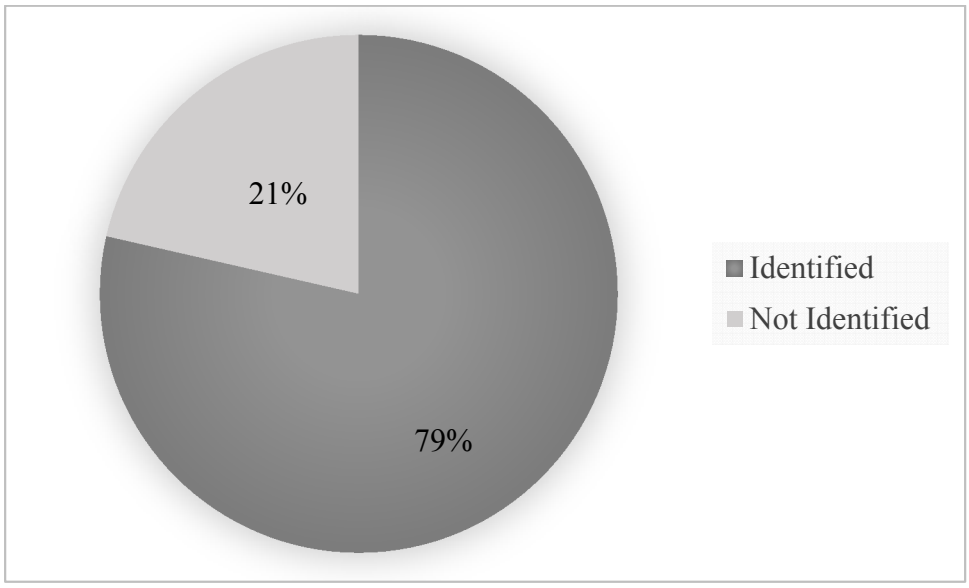

Figure 15. Percentage of participants who identified using some form of self-care as a protective resource.

Finally, enhancing self-awareness was a frequently cited individual resource psychiatrists used to mitigate burnout. In this study, self-awareness was defined as the intentional practice of self-monitoring or in other words, being aware or conscious of one's own feelings (Lou, Changeux, & Rosenstand, 2017). As shown in Figure 16, of the 14 participants, five mentioned that enhancing their self-awareness helped to protect from burnout. Participant P104680 described, "Well I think one of the things that helped me even at that time was sort of trying to personally recognize that this was not an internal flaw." Additionally, participant P104774 noted, "I started to practice mindfulness-based meditation, and then when I was in a stressful situation, to just be able to take a breath and step back from it for a moment to clear my head." Finally, participant P104246 expressed, "Individual therapy has definitely been positive in recognizing and listening to how I see and react to situations."

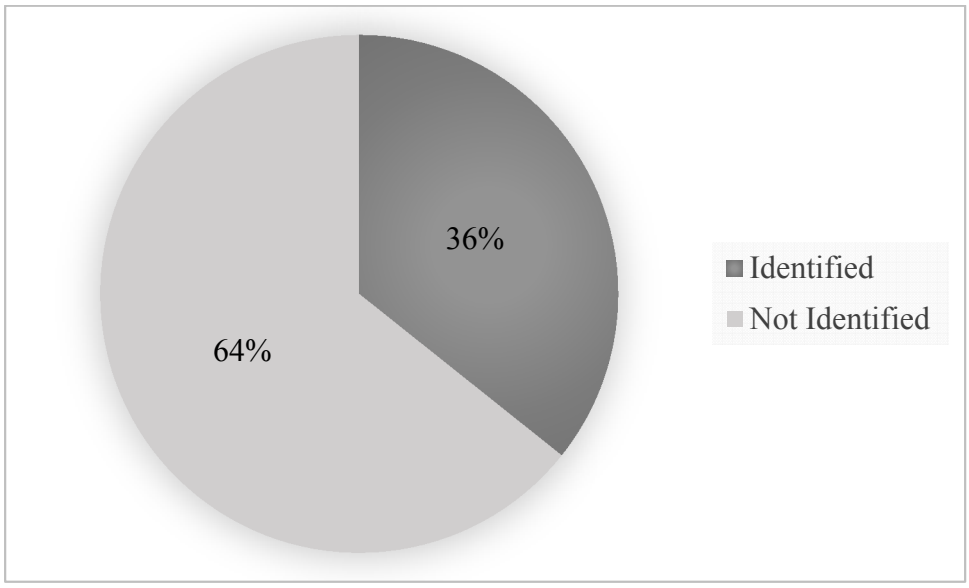

Figure 16. Percentage of participants who identified practicing self-awareness to protect from burnout.

Theme 2: System-level emotional support. The second theme identified was system-level emotional support as a resource to help to protect against burnout. System-level emotional support was characterized by the assistance or ability to provide compassion, empathy, and support in the workplace. Specifically, this theme pertained to emotional support offered by upper management and executives. Two codes comprised this theme; collaborative communication and notice and appreciation.

Collaborative communication referred to the ability of psychiatrists to feel heard and encouraged that their opinions mattered. Additionally, collaborative communication was characterized by psychiatrists expressing interest in being part of the decision-making process. As depicted in Figure 17, of the 14 psychiatrists, six cited that collaborative communication with management was a vital component to protect from burnout. A commonality for the collaborative communication code was that psychiatrists

wanted to feel heard and wanted to collaborate in decision making, specifically when discussing burnout and prevention measures with management and executives. Participant P104557 described,

> Everyone in management talks about burnout and prevention measures, it's a hot topic right now and they seem to care, but rarely are we asked our opinions and what we think could help. Like, it's so interesting, since we are the ones on the ground experiencing it. Then, we have these burnout prevention programs like every so often that generally focus on what we can do individually, like taking care of ourselves and such, but that really seems to just put the problem on us when really, there are many other things, mostly organizational related things, that need to be addressed. It's kind of a copout, like hey, we are giving you a burnout program so just go exercise and stop complaining.

Participant P104380 discussed,

> I think what would be beneficial is being part of the process in deciding how to best prevent burnout instead of just being, like something that is acted upon, if that makes sense. I talk to my organizational leaders about this, but I just don't feel like they hear my concerns.

Finally, participant P104680 noted, "One of the things that was effective was really, being open and honest with the people that I could trust and did have good mentorship with and that was really what was instrumental." Participants reported it was important that they could openly talk to their supervisors and that their "input was valuable" in

creating change. This type of support was cited as an influential resource in protecting from burnout.

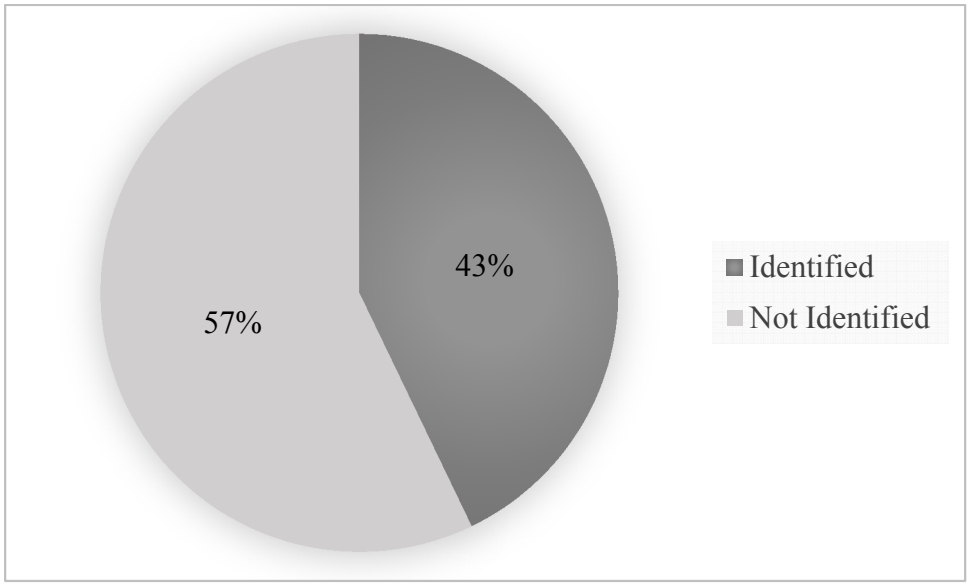

Figure 17. Percentage of participants who identified that collaborative communication helped to protect from burnout.

The second code that comprised the system-level emotional support theme was notice and appreciation. When upper management and executives acknowledged the psychiatrists' hard work, it was a valuable resource in helping to protect from burnout. Three of the 14 psychiatrists noted that appreciation and notice helped to protect from burnout, as shown in Figure 18. For example, participant P104774 noted,

> Yeah, definitely, so our manager just took my team and our significant others out to dinner recently and it was really nice, he praised all of our hard work and successes and even though there are things to work on, it was nice to be appreciated and acknowledged.

Participant P104472 described, “Another thing that helps is that my boss is really supportive and verbally tells me she is grateful to have me on staff.” In summary, psychiatrists noted that collaborative communication and appreciation and notice from management were emotionally supportive resources that helped to protect from burnout.

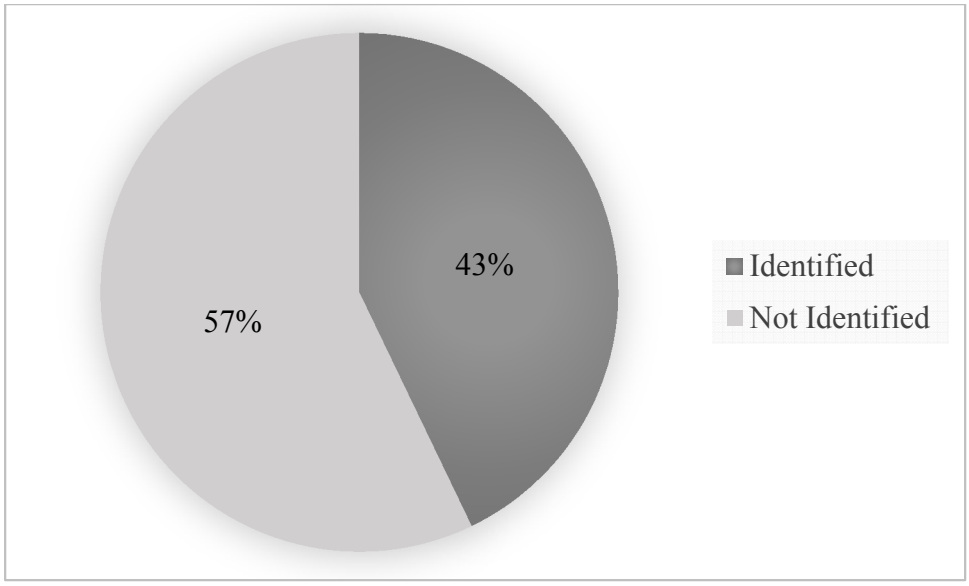

Figure 18. Percentage of participants who identified that notice and appreciation helped to protect from burnout.

Theme 3: System-level tangible resources. The third theme identified was system-level tangible resources. System-level refers to resources that are procured or utilized as an outcome of what the organization provides. Tangible resources were characterized as any systematic changes within the organization that psychiatrists noted helped to protect from burnout. Two codes comprised this theme, manageable caseload and increased flexibility.

Perceiving a manageable caseload was a resource that helped psychiatrists mitigate burnout. Caseload refers to the number of patients seen by a physician per day.

This study did not quantify the number of patient's psychiatrists felt was manageable, so the definition of manageable was subjective to each individual. A resounding idea, however, was that having a caseload that an individual felt was reasonable was noted as protective against burnout. Of the 14 psychiatrists, four specifically mentioned that a manageable caseload was something that has helped or would help protect them from burnout. Figure 19 depicts this proportion visually. All four psychiatrists noted that their current caseload was manageable, and this is something that helped them avoid burnout. For example, participant P104985 mentioned, "The position I am in now does have a pretty good patient workload, like I don't feel as overworked as I previously did which is helpful." Participant P104704 noted that he had left a previous position, in part, due to having a caseload he deemed unmanageable. He discussed,

> Yeah, the patient load I had was unsustainable for me as we were short-staffed and they were having issues hiring and this was a big reason I left that position. My current position is much more sustainable in this way.

Perceiving a manageable caseload was a resource that psychiatrists noted was important in protecting against burnout.

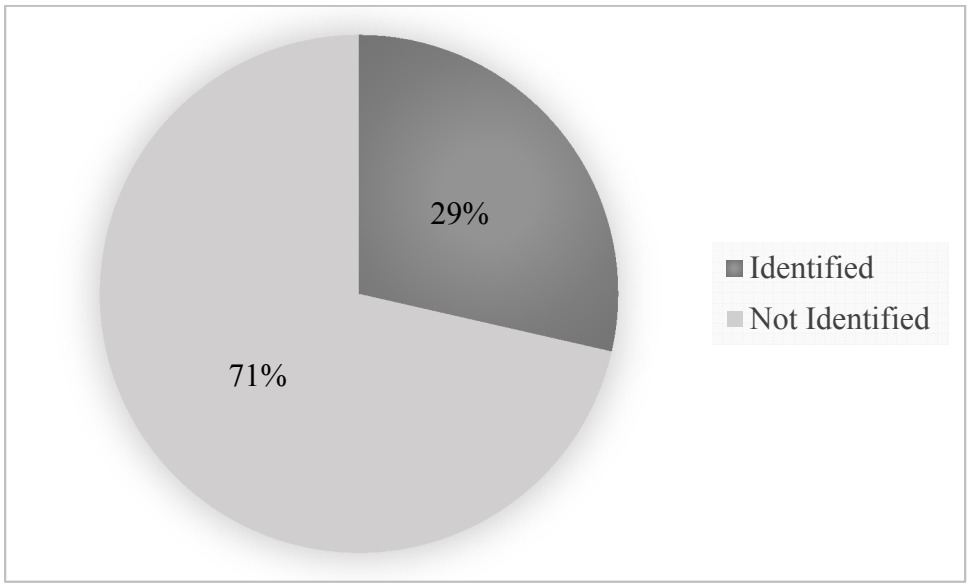

Figure 19. Percentage of participants who identified that a manageable caseload was a resource that protected against burnout.

Increased flexibility was the second code that fell into the theme of system-level resources to protect from burnout. Increased flexibility was brought up in terms of work schedule, with four of the 14 psychiatrists citing this as a protective resource. Figure 20 depicts this percentage visually. Some psychiatrists had flexible schedules, and this was noted as a valuable resource that helped reduce their perception of burnout. For example, participant P104802 noted that his organization has "done things like change people's work schedules so that they work four days a week instead of five days a week," which he thought was helpful in protecting against burnout. Participant P104472 discussed,

> Once I transitioned to a telepsych position I was able to work from my home office, which was a tremendous relief, just you know, not having to drive both directions in traffic and being able to pick my kids up from school.

Participant P104380 was experiencing a cumbersome work schedule and noted that more flexibility would be a welcomed resource for reducing burnout. He discussed,

> There is just no opportunity for work-life balance with the schedule. I feel guilty, and I know others do too, for taking time off and putting that work onto my peers, like I had an appointment scheduled the other day and I canceled it because I felt I couldn't get off work without impacting, well my coworkers and the patients too, so yeah, I think flexibility in being able to take some time off when needed is lacking and a change to that would be beneficial to me and others.

Having flexibility in their schedule was a resource that was cited by psychiatrists as helping to protect from burnout. Increased flexibility in schedule and a manageable caseload are two tangible resources provided or facilitated by the organization that help to protect psychiatrists from burnout**.**

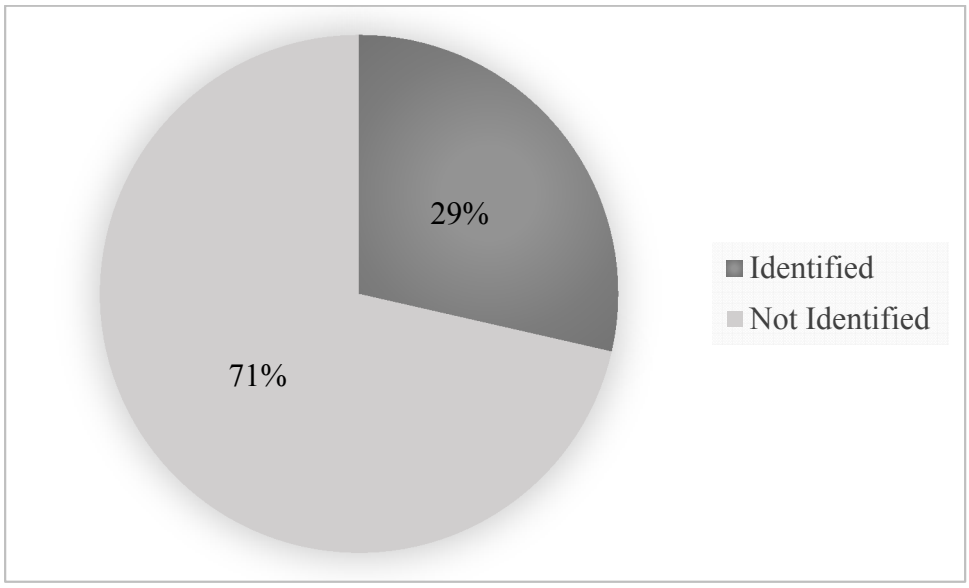

Figure 20. Percentage of participants who identified that increased flexibility was a resource that protected against burnout

Research Question 4

RQ 4 - From the perspective of a sample of psychiatrists working in the public or private sector in Arizona, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming, or Colorado and self-identifying as having experienced burnout, how does burnout affect perceived health consequences?

One interview question was used as a basis to gather data for analysis regarding research question four. The codes and themes that emerged from raw data are presented in Appendix F. As described in Chapter 4, through the process of coding, there were eight codes identified for the fourth research question. These codes were then grouped into two themes that described the perceived health consequences from burnout for this sample. The two final themes identified were labeled physical manifestations and mental manifestations.

Theme 1: Physical manifestations. The first theme identified was physical manifestation of ill-health as a consequence of burnout. Physical ill-health referred to reports of acute or chronic bodily health issues that psychiatrists perceived were a consequence or contributing factor of being burnt out. It's important to note that physical ill-health issues were categorized separately from mental health issues. Five codes comprised this theme; migraines, gastrointestinal upset, compromised immune system, weight gain, and no physical manifestation. Of the 14 psychiatrists, five reported some type of physical ill-health issue as a response or consequence of their burnout. Interestingly, the remaining nine psychiatrists specifically reported they did not experience any symptoms of physical ill-health. This distribution is shown in Figure 21.

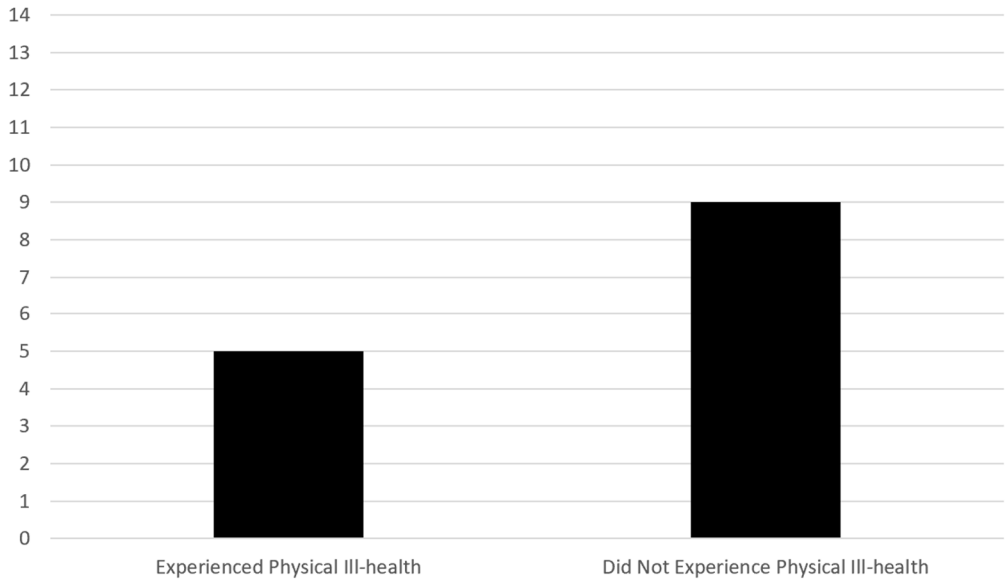

Figure 21. Number of participants who did and did not experience symptoms of physical ill-health as a perceived consequence of burnout.

Of the five participants who did experience symptoms of physical ill-health, two reported migraines, one reported gastrointestinal upset in addition to immune system

compromise, and two reported weight gain. These represented the codes in the physical manifestation theme. Participant P104397 described her perception of the health consequences of burnout:

> I've absolutely experienced health issues recently from this, yes. I used to get headaches, oh every other month or so, but recently I have been getting horrible migraines about once a month, if not more. Really nothing else has changed except my level of stress and my PCP says this is likely the contributing factor.

Participant P104703 discussed his experience with gastrointestinal issues and compromised immune system,

> I have IBD and I have noticed that when I do feel more burnout that my symptoms are significantly worse, I won't do into all the gross details, but yeah, it impacts that, and also, another physical thing I seem to get is that I always get sick much more often when I am under that type of stress. Just colds, so nothing like, extreme, but still.

Additionally, participant P104279 noted,

> I guess, yeah, I did gain a lot of weight. It didn't impact me much in terms of like, my blood pressure didn't skyrocket or anything, but I knew the long-term consequences of being overweight if I didn't get it under control and although I've lost some, I'm still actually trying to lose it all.

Interestingly, of the five participants who reported a physical health consequence of burnout, two of them reported that after a change, in which their burnout decreased, their physical symptoms dissipated. For example, participant P104472 discussed, "Probably

only that I gained some weight, but I lost it once I changed positions and had more time to exercise and eat healthier."

Although five participants noted physical symptoms of ill-health as a consequence of their burnout, it is important to note that the other nine psychiatrists specifically reported no symptoms of physical ill-health, putting this experience in the majority. For example, participant P104802 discussed, "I don't think that it ever necessarily affected my physical health in terms I wasn't getting sick or I didn't get injured." Participant P104059 noted, "I don't think it had a lot of impact on my physical health. I mean, I was eating more unhealthy during that time period but I didn't have any long term health consequences from that." Thus, physical symptoms of ill-health were reported as a consequence of burnout by some psychiatrists, but the majority of participants reported no symptoms of physical ill-health.

Theme 2: Mental manifestations. The second theme identified was mental manifestation of ill-health as a consequence of burnout. Mental ill-health referred to reports of negative mood, thinking and behavior that psychiatrists perceived were a consequence or contributing factor of being burnt out. Three codes represented this theme; anxiety and depression, mood instability, and no mental manifestation. Mental ill-health was more frequently cited as a consequence of burnout than physical ill health with eight of the 14 psychiatrists reporting negative mental health issues. Of the 14 psychiatrists, six reported not experiencing any mental health consequences. This distribution is depicted in Figure 22.

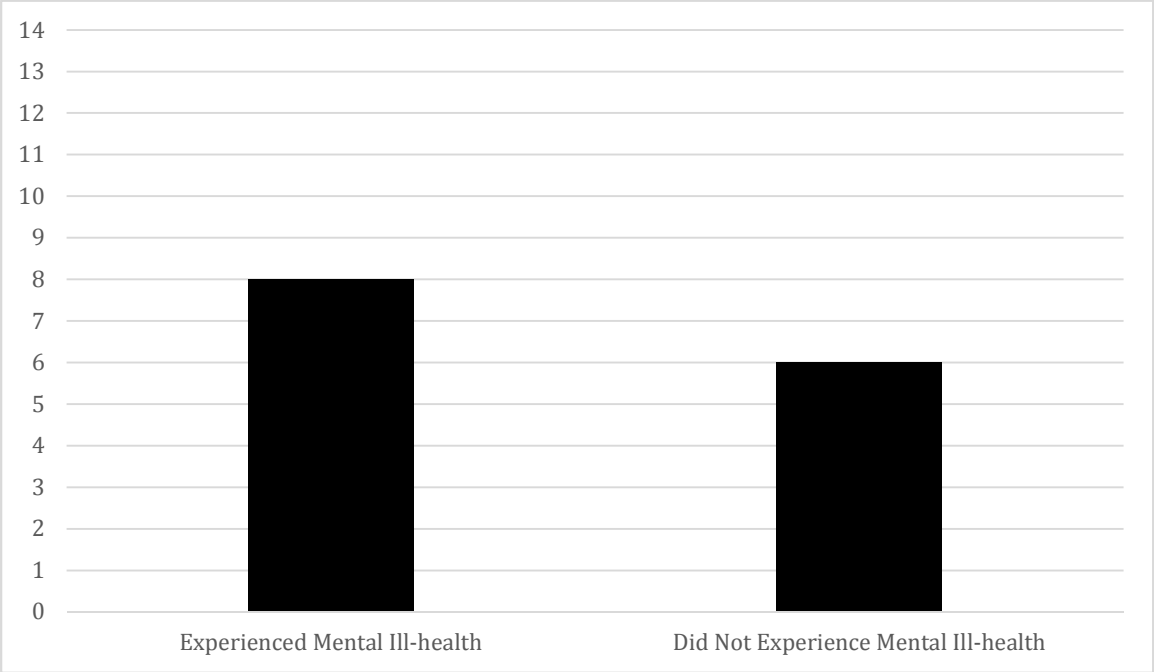

Figure 22. Number of participants who did and did not experience symptoms of mental ill-health as a perceived consequence of burnout.

Of the eight participants who did experience symptoms of mental ill-health, five reported issues with an increase in severity of anxiety or depression symptoms and three reported issues with mood instability. These represented the codes in the mental manifestation theme. In alignment with the anxiety and depression code, participant P104246 described, "Yeah, I mean, it definitely wasn't good for my anxiety and depression. I would say it was worse during those times when I was more burnout." Additionally, participant P104082 noted, "Thinking about that time, I was quite a bit more anxious and didn't really always manage it as well as I could potentially now. I think that, that was probably the primary manifestation." Finally, in reference to the mood instability code, participant P104380 stated, "Well, yeah, I think I am more

irritable and withdrawn, I wouldn't necessarily say it would be clinically diagnosed depression, but my mood has been impacted."

Of the eight psychiatrists, seven had experienced mental consequences in the past and were not presently experiencing symptoms of mental ill-health. Interestingly, of these seven participants, all of them discussed that after their burnout ended, their experience will mental manifestations of ill-health also improved. Participant P104680 shared:

> I would say the mental health at that time, definitely, I mean it just built on itself it snowballed. I didn't want to go to work and I didn't feel like I had any life outside of what was being taken up in my emotional space at the hospital and so it was, yeah it was tough but I wouldn't say that I had any lasting effects. It was very situational so thankfully once I was out of that situation, I no longer experienced any lingering emotional effects from it.

Thus, it seemed that while most participants experienced mental distress during their times of burnout, it was not a health consequence that continued after the period of burnout ended.

As mentioned, although most participants did report some mental ill-health consequence of being burnt out, six participants expressly did not report this. This could have been due to their perception of minimal burnout on the burnout survey. For example, participant P104557 stated, "Hum, I mean my burnout was pretty minimal even though I would say I experienced it, but yeah, no, I don't think I would say it had any impact on my mental health at all, no." Participant P104985 also noted, "No, I didn't experience physical or mental issues with health during that time." Although some

participants did not report any symptoms of mental ill-health, it is important to emphasize that most of the psychiatrists did report symptoms of mental ill-health during their time of burnout.

Summary

This section addressed results for the four research questions in this qualitative, multiple case study. The four questions answered were (a) how was the burnout process described and explained, (b) what factors contributed to burnout, (c) what resources helped alleviate burnout, and (d) how burnout affected the perception of health consequences in a population of psychiatrists. To summarize results, psychiatrists described the burnout process as one that gradually progresses over time, is precipitated by work stress, and is a multidimensional experience. The factors psychiatrists reported contributed to their burnout were intrapersonal factors, interpersonal factors, and system-level factors. Resources that psychiatrists discussed as protecting from burnout included individual resources, system-level emotional support, and system-level tangible resources. Finally, psychiatrists perceived both physical and mental symptoms of ill-health as a result of burnout, although mental manifestation was more prevalent. The following chapter will discuss the conclusions and recommendations resulting from these findings.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this qualitative study, which utilized an exploratory multiple-case design, was to explain (a) how the burnout process was described and explained, (b) what factors contributed to burnout, (c) what resources helped alleviate burnout, and (d) how burnout affected the perception of health consequences in a population of psychiatrists. According to the APA, in 2018, two out of five psychiatrists reported experiencing professional burnout (APA, 2018a); however, as described in Chapter 2, little is known about the process, factors, resources, and health consequences of burnout among psychiatrists as a unique population (Heinemann & Heinemann, 2017; Schwenk & Gold, 2018). This study aimed to explore these gaps.

The current study's results indicated that psychiatrists described burnout as a process that progressed gradually, a process precipitated by work stress, and a multidimensional experience. Psychiatrists reported that intrapersonal factors, interpersonal factors, and system-level factors contributed to their burnout. The resources that psychiatrists characterized as protective against burnout included individual resources, system-level emotional support, and system-level tangible resources. Finally, although psychiatrists identified both physical and mental symptoms of ill-health as a result of burnout, mental manifestations were more prevalent. In this chapter, I interpret the study results in the context of the conceptual framework and literature addressed in Chapter 2. Additionally, in this chapter, I discuss study limitations, recommendations, and implications.

Interpretation of the Findings

Research Question 1

From the perspective of a sample of psychiatrists working in the public or private sector in Arizona, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming, or Colorado and self-identifying as having experienced burnout, how do these individuals describe and explain the process of burnout?

As described in Chapter 4, the data analysis confirmed that for the psychiatrists in this sample, the burnout process occurred gradually and was precipitated by work stress. Additionally, the data analysis determined that psychiatrists viewed burnout as a multidimensional process with components of emotional exhaustion, depersonalization, and reduced personal accomplishment. These findings both confirm and extend existing knowledge in the field. Studies have shown that psychiatrists experience a high rate of burnout (Garcia et al., 2015; Shanafelt, Hasan, et al., 2015; Volpe et al., 2014), but there is a gap in the literature regarding the process of burnout itself. In a systematic review, Sibeoni et al. (2019) found no qualitative studies that explored physicians' burnout experiences. Moreover, no studies to date have explicitly explored the burnout experiences of psychiatrists. Thus, this study's findings contribute to current research in the field on the burnout process by extending findings to a psychiatrist population.

The results also aligned with the MTB, a component of this study's conceptual framework. Maslach et al. (2001) described burnout as a multidimensional outcome that consists of emotional exhaustion, depersonalization, and reduced personal accomplishment. The results confirmed that psychiatrists view burnout as a

multidimensional process: 42.8% of the sample identified all three constructs of burnout as pertaining to their experience. Further, all psychiatrists in the sample reported that their experience was characterized by at least two of the three burnout constructs, highlighting the multidimensional nature of burnout.

Additionally, the results aligned with the JD-R model, another component of the conceptual framework. The results confirmed that psychiatrists experience burnout as a process precipitated by work stress, although the types of stress vary. The JD-R model describes job demands as challenging conditions in a work environment that require sustained physical, emotional, or cognitive effort (Chirico, 2016). When job demands exceed job resources, the outcome is job strain, otherwise termed burnout in this model (Demerouti et al., 2001). In other words, the model posits that job demands in excess of resources lead to burnout. This study confirmed the JD-R pathway because psychiatrists reported that job demands in excess of resources were a precipitating factor in the burnout process.

Research Question 2

From the perspective of a sample of psychiatrists working in the public or private sector in Arizona, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming, or Colorado and self-identifying as having experienced burnout, what factors do these individuals identify as contributing to their burnout?

As described in Chapter 4, psychiatrists identified various factors as contributing to their burnout, including intrapersonal factors, interpersonal factors, and system-level factors. The results of this dissertation both confirm and extend knowledge in the field

and support the conceptual framework. The results of previous studies on factors that contribute to burnout exhibit important similarities with the findings of the current study.

Intrapersonal factors. In this study, psychiatrists reported only one intrapersonal factor that contributed to burnout: feelings of ineffectiveness. This finding echoes the results of previous studies on factors that contribute to burnout. According to Kim et al. (2017), primary care physicians' perceptions of the ineffectiveness of interventions exacerbated their perceptions of burnout. In this dissertation, psychiatrists reported feeling that they "can't do a lot for them [their patients]," which contributed to the perception of burnout. This finding aligns with the MTB, in which reduced personal accomplishment, characterized by feelings of inadequacy, is a construct of burnout (Maslach et al., 2001).

Interpersonal factors. Compared to intrapersonal factors, interpersonal factors, which stem from formal or informal social interactions, networks, or support systems (ACHA, 2019), were more prominently reported as contributing to burnout. In this study, psychiatrists discussed the "frustration" of challenging social interactions, including demanding patients and difficult-to-manage expectations of family members. This result supports the findings of previous research on populations of medical physicians, who identified patient interactions as a factor contributing to burnout (Beng et al., 2015; Hasbrouck & Waddimba, 2017; Kim et al., 2017). This finding also aligns with the JD-R model, according to which burnout occurs when job demands, such as difficult patient interactions, exceed resources (Demerouti et al., 2001).

A second interpersonal factor reported by psychiatrists in the current study was lack of appreciation, particularly from patients. Similarly, studies of physicians in other specialties have found that lack of appreciation aggravates the perception of burnout (Harolds, Parikh, Bluth, Dutton, & Recht, 2016; Okorie, Trockel, & Bhargava, 2016). Moreover, this dissertation's finding that lack of appreciation precipitates emotional exhaustion aligns with the MTB, in which emotional exhaustion is a construct of burnout (Maslach et al., 2001).

A final interpersonal factor psychiatrists described as contributing to burnout was exposure to secondary trauma. Studies of other physician populations have offered comparable results. Isobel and Angus-Leppan (2018) confirmed both that psychiatrists have a unique vulnerability to secondary trauma due to the nature of their profession and that this secondary trauma can contribute to burnout (Sherba, Linley, Coxe, & Gersper, 2018). The current study confirmed that secondary trauma contributes to burnout in psychiatrists. Moreover, this dissertation's finding that secondary trauma contributes to emotional exhaustion lends support to the MTB.

System-level factors. The most frequently noted factor contributing to burnout in this sample of psychiatrists was system-level issues, which included excessive work demands, insufficient organizational support, and burnout culture. In previous literature, excessive work demands were commonly reported as a factor contributing to burnout in a wide variety of physician specialties (Busis et al., 2017; Hasbrouck & Waddimba, 2017; Sibeoni et al., 2019), including psychiatry (Garcia et al. (2015). In the current study, psychiatrists reported feeling burnt out as a result of excessive work demands, including

time pressure, unmanageable caseloads, and administrative tasks. These results also confirm the process of burnout outlined by the JD-R model, in which work demands that outweigh resources lead to burnout (Demerouti et al., 2001). Similarly, in this dissertation, insufficient organizational support was a frequently cited system-level factor that contributed to burnout.

Previous studies have demonstrated that psychiatrists perceive lack of support from management and organizational administrators as a factor contributing to burnout (Evans & Young, 2017; Kumar, 2016; Rotstein & Jenkins, 2017). This dissertation offers parallel findings. Psychiatrists felt that insufficient emotional support, such as not having an approachable manager, and insufficient tangible support, such as absence of beneficial policy changes, contributed to their burnout. The COR theory categorizes support as a condition resource, which is a structure or state that allows access to other resources (Hobfoll, 1989). Through organizational support, including emotional support and tangible support, psychiatrists can rely on the organization to offer the resources they lack and thus to mitigate stress and burnout.

A final system-level factor that contributed to burnout among psychiatrists was burnout culture. Burnout culture is characterized by unwavering and entrenched attitudes and values promoted within the work environment that contribute to employees' perception of emotional exhaustion, depersonalization, and reduced personal accomplishment (Anjum et al., 2018; Ledingham et al., 2019). In an article regarding the Mayo Clinic, Shanafelt and Noseworthy (2017) argued that organizational culture can either contribute to burnout or promote employee engagement. Social and cultural

factors, such as the medical hierarchy, contributed to burnout among the psychiatrists in this dissertation's sample. This type of negative organizational culture has also been shown to correlate with increased burnout in other physician populations (Mijakoski et al., 2015) and to contribute to physicians' work stress (O'Dowd et al., 2018). This finding aligns with the JD-R model, which characterizes job demands as challenging conditions within a work environment that create stress for individuals (Demerouti et al., 2001). In the case of psychiatrist burnout, the challenging work environment is exemplified by a negative organizational culture that propagates burnout. In summary, the findings of this study regarding Research Question 2 contribute to current research in the field on burnout factors by confirming the findings of previous studies and extending them to a psychiatrist population. The implications of these findings will be discussed in greater detail at the end of this chapter.

Research Question 3

From the perspective of a sample of psychiatrists working in the public or private sector in Arizona, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming, or Colorado and self-identifying as having experienced burnout, what resources protect against the effects of burnout?

As indicated in Chapter 4, psychiatrists identified various resources as protective against burnout, including individual resources, system-level emotional support, and system-level tangible resources. The findings of this study both confirm and extend knowledge in the field and support the conceptual framework. The results of previous

studies on factors that contribute to burnout demonstrate parallels with the findings of the current study.

Individual resources. In this dissertation, psychiatrists identified several important individual resources that helped to prevent burnout, including relational support, self-care practices, and cultivating self-awareness. The perception of relational support—in other words, support from friends and family (Pilcher & Bryant, 2016)—was paramount in easing the perception of burnout among the psychiatrists in this study's sample. These results are similar to what has been found in other populations of physicians. Shanafelt et al. (2014) and Starmer et al. (2016) found that married physicians are less likely to report burnout, which seems to be a result of having sufficient time with and support from their spouse. Moreover, Hyman et al. (2017) found that stronger personal and professional support scores are associated with lower scores for emotional exhaustion at statistically significant levels in a population of physicians. The results of the current study confirmed that psychiatrists perceived support from their spouses, friends, and children as a resource that protected against burnout. The finding that relational support can protect against burnout also aligns with the COR theory and thus supports the conceptual framework of this dissertation. Hobfoll (1989) proposed that individuals under stress have limited resources. However, through social support, such individuals can rely on others to offer the resources they lack or remove them from stressful circumstances so they can regain the necessary resources (Hobfoll, 1989).

The psychiatrists in this dissertation's sample also commonly recognized the practice of self-care as an individual resource that was protective against burnout.

Participating in physical activity was the most frequently mentioned self-care practice. This finding parallels that of Starmer et al. (2016), who showed that pediatricians who "met" or "exceeded" federal exercise recommendations had a lower burnout prevalence than pediatricians who reported not meeting such recommendations. The results of this dissertation extend this finding to a population of psychiatrists. Additionally, although physical activity was the most frequently cited self-care practice among the psychiatrists in this study's sample, they also identified eating healthily, participating in hobbies, playing music, practicing mindfulness, and reading as activities that protected against burnout; all of these activities have been found to reduce or protect against burnout in other physician populations (American Medical Association [AMA], 2019; Karr, 2019; Lacy & Chan, 2018; Patel, Sekhri, Bhimanadham, Imran, & Hossain, 2019). The finding that practicing self-care can protect against burnout also aligns with the COR theory. Self-care practices can be identified as condition resources because they are structures or states that allow access to other resources. For example, a participant described eating healthily as "helping me lose a little weight" and participating in physical activity as "a great stress reliever." The COR theory would define these self-care activities as condition resources that gave this individual access to better health (another resource) through weight loss and stress mitigation.

Finally, psychiatrists identified enhancing self-awareness as an individual resource that was protective against burnout. Practicing mindfulness was a commonly mentioned practice for enhancing self-awareness. Research on other physician populations has also found that cultivating self-awareness through mindfulness protects

against burnout (Loiselle, 2018; West et al., 2014). This dissertation's population of psychiatrists identified participating in individual therapy as another protective resource. Older studies of psychiatrists have suggested that individual therapy can be a useful intervention for burnout (Kumar, 2007), and more recent studies have confirmed the protective nature of individual and group therapy in other physician populations (Nunez, Motheral, Pomeroy, Camp, & Johnson, 2018; Romani & Ashkar, 2014). The COR theory would characterize cultivating self-awareness as a personal characteristic (Hobfoll, 1989), that is, a skill or trait that aids in dealing with stress. Psychiatrists actively practiced the skill of enhancing self-awareness, which in turn decreased their perceived burnout.

System-level emotional support. In addition to individual resources, various system-level resources were found to protect against burnout among psychiatrists. This dissertation revealed that system-level emotional support was one such factor. System-level emotional support was characterized by the assistance or ability to provide compassion, empathy, and support in the workplace. Specifically, this theme pertained to emotional support offered by upper management and executives in the form of collaborative communication and recognition and appreciation of psychiatrists' contributions. Psychiatrists noted that collaborative communication was a protective resource. Specifically, psychiatrists expressed wanting to be involved in the conversation regarding burnout prevention. Penberthy et al. (2018) showed that cultivating communication skills is associated with decreased burnout perceptions among physicians; the results of this dissertation expanded on the role of communication

identified by that study. The results of the current study confirmed that psychiatrists cared about how burnout in their organization was being addressed and that they wanted to be involved in the discussion. Additionally, an article on burnout mitigation in the Mayo Clinic argued that "being willing to listen demonstrates that the problem is recognized at the highest level of the organization" (Shanafelt & Noseworthy, 2017, p.133). Although this statement does reflect the desire of psychiatrists in this dissertation's sample to be "heard" in addition to merely listening, psychiatrists wanted to be involved in collaborative discussions about the solution. This is new empirical evidence regarding burnout prevention; however, it does align with the COR theory, because effectively communicating about burnout prevention is a skill that can aid in dealing with burnout (Hobfoll, 1989).

Lack of appreciation was a factor that propagated burnout in this population; conversely, psychiatrists reported that feeling noticed and appreciated by their organization helped to reduce their perception of burnout. Maslach and Leiter (2017) noted that building a culture of appreciation in the medical field involves organizational leaders providing recognition of physicians' contributions, which in turn helps to engage physicians in their work and prevent burnout. Likewise, Shanafelt and Noseworthy (2017) and Shanafelt, Gorringe, et al. (2015) showed that personal recognition of positive events at work is a tool that can be used by the organization and management to bolster physician job satisfaction and reduce burnout. The results of this dissertation contribute to the knowledge in the field by extending these findings to psychiatrists. Furthermore, and similarly to social support, feeling noticed and appreciated is characterized by the

COR theory as a condition resource. Receiving recognition and appreciation helped psychiatrists cope with the general stress of their jobs, and the sample described this resource as helping to prevent burnout.

System-level tangible resources. Psychiatrists in this study's sample identified system-level tangible resources as a final protective factor. System-level tangible resources were characterized as any systematic changes within the organization reported by psychiatrists as helping to protect against burnout. Perceiving a caseload as manageable and having a flexible schedule were the two system-level tangible resources cited by psychiatrists as protective against burnout. In this dissertation, psychiatrists reported that perceiving a caseload as manageable was a factor that bolstered their job satisfaction; if a caseload was perceived as unmanageable, this precipitated burnout and a desire to leave the position. It should be noted that "manageable" is a subjective quality and that this dissertation did not quantify it in terms of caseload. However, this finding indicates that psychiatrists view caseload as an important issue that can impact perceived burnout. Other studies have provided comparable findings. In a variety of physician populations, a manageable caseload has been shown to improve satisfaction and reduce burnout (Gutsan, Patton, Willis, & Coustasse-Hencke, 2018; Patel et al., 2018). It is unsurprising that perceiving a caseload as manageable serves as a burnout-prevention resource, because psychiatrists in this dissertation's sample reported that an unmanageable caseload, including high patient volume, was a factor that contributed to burnout. The identification of a manageable caseload as a burnout-prevention resource aligns with the JD-R model. The JD-R pathway indicates that if job demands do not

exceed resources, individuals will not be at risk for burnout and will be engaged in their work (Demerouti et al., 2001). This dissertation's findings confirm the JD-R pathway, because psychiatrists who felt their caseload was manageable reported that this was a factor that helped to prevent burnout.

Research has shown that the presence of schedule flexibility, including starting the workday earlier or later and working longer hours per day but fewer days per week, is a resource that reduces burnout among physicians (Patel et al., 2018; Rabatin et al., 2015; West et al., 2018). The results of this dissertation are in agreement with such findings: Psychiatrists reported that a flexible work schedule, including working four longer days rather than five shorter ones and flexible scheduling for vacations and appointments, helped to protect against burnout. Like a manageable caseload, increased flexibility aligns with the JD-R model, because the presence of plentiful resources (e.g., a flexible schedule) resulted in reduced burnout and encouraged engagement. Moreover, in terms of the COR theory, having a flexible schedule could be considered a condition resource, because such flexibility gave psychiatrists access to other resources (such as time off for a vacation or a medical appointment). In summary, the findings of this study support current research in the field regarding resources that protect against burnout by extending findings to a psychiatrist population. The implications of these findings will be discussed in greater detail at the end of this chapter.

Research Question 4

From the perspective of a sample of psychiatrists working in the public or private sector in Arizona, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming, or Colorado

and self-identifying as having experienced burnout, how does burnout affect perceived health consequences?

The data analysis confirmed that psychiatrists felt that burnout had negative consequences for both physical and mental health. Physical-health consequences included migraines, gastrointestinal upset, compromised immune system, and weight gain. Mental-health consequences included anxiety, depression, and mood instability. The findings of this study both confirm and extend the knowledge in the field, and they support the conceptual framework. The results of previous studies on factors that contribute to burnout exhibit important similarities with the findings of the current study.

Physical manifestations. As noted in Chapter 2, there is a paucity of empirical research on the negative physical-health consequences suffered by burnt-out physicians. Although studies have found all the aforementioned health consequences in other populations of working adults (Johnson, Degenhardt, Smith, Wolf, & Peterson, 2018; Kaeding et al., 2017; Polyakova, Petrova, Mironova, & Semenov, 2018), to the best of my knowledge, this dissertation is among the few studies that have explored the health consequences specific to burnout among psychiatrists. Interestingly, although the aforementioned physical health consequences were present in this study's population, 64% of participants reported that they did not suffer any negative physical-health consequences as a result of their burnout. However, this finding does not disconfirm the burnout–health relationship posited by the JD-R model, which served as a component of this dissertation's conceptual framework. This is because all the psychiatrists who reported no physical consequences of burnout rated their perceived burnout as low or

moderate, whereas the five individuals (36%) who did report negative health consequences had more severe levels of burnout. This indicates that negative health consequences of burnout are more prevalent in individuals who experience a higher degree of perceived burnout severity, which does confirm the findings of prior studies (Kaeding et al., 2017). Thus, this dissertation's findings regarding burnout and health consequences both confirm the results of research in the field and extend those results to a psychiatrist population.

Mental manifestations. In this study's population of psychiatrists, mental-health consequences were more frequently and prominently described as a health consequence of burnout than were physical-health consequences. In this dissertation, 57% of psychiatrists reported the presence of mental health issues, including anxiety, depression, and mood instability, during times of burnout. These mental manifestations of burnout are well documented in other physician populations (Ilić et al., 2017; Lee et al., 2013; Vandenbroeck et al., 2017). Moreover, this study's findings confirm the burnout–health relationship in the JD-R model, which proposes that negative health outcomes, both mental and physical, are a product of burnout (Demerouti et al., 2001).

Moreover, in this dissertation's sample, the reported frequency of negative mental-health consequences was greater than that of negative physical-health consequences: 57% of the participants reported experiencing the former, and 36% reported experiencing the latter. This finding indicates that for this population, burnout exerts a stronger influence on mental well-being than on physical well-being. To the best of my knowledge, this is a new finding in the burnout literature. It should also be noted

that 36% of psychiatrists did not report any symptoms of mental ill-health. However, similarly to the psychiatrists who reported no symptoms of physical ill-health, those who reported no negative mental-health consequences also reported a lesser severity of burnout (low or moderate), which could have resulted in fewer or no negative health effects. In summary, although psychiatrists identified negative consequences for both physical and mental health as outcomes of burnout, the frequency of negative mental-health consequences was greater than that of negative physical-health consequences. Those who did not report any symptoms of physical or mental ill-health had lower self-reported severity of burnout. The implications of these findings with respect to each of the research questions will be discussed at the end of this chapter.

Limitations of the Study

Limitations are constraints of study methodology and design (Simon & Goes, 2017). A significant limitation of qualitative research, and thus of this dissertation, is its weak transferability to other populations (Merriam & Tisdell, 2015). As discussed in Chapter 3, this dissertation took measures to augment transferability. Nonetheless, its results may not be applicable to populations of psychiatrists outside of the Western United States. Additionally, because this dissertation was limited to psychiatrists, its results should not be extended to other physician specialties, because psychiatrists have a position and role in medicine that are dramatically different from those of other physician specialties (Jovanović et al., 2016).

Small sample size was another limitation of the study. Yin (2014) noted that there are no precise rules governing sample size in multiple-case studies and that the point at

which data collection should cease should be based on discretionary, not formulaic, judgment. Although data from 14 participants were collected, it should be noted that the small sample size could affect the validity and generalizability of the study (Vasileiou, Barnett, Thorpe, & Young, 2018). Additionally, out of the sample, 85% of participants reported mild to moderate levels of burnout severity, whereas only 15% reported severe levels. The finite number of participants who reported severe burnout was a limitation as it restricted comparison between participants with various levels of burnout.

Furthermore, it should be noted that the demographic data collected in this study only identified that participants were from one of the Western states and did not specify which state. This was a limitation as different states could have had different types of support available to psychiatrists. Another limitation of this study is the applicability of results due to the assumption that professional burnout and personal burnout can be viewed as distinct from one another. Although burnout is classified as an occupational phenomenon by the World Health Organization (WHO, 2019), burnout is a complex and multidimensional process, where professional burnout may often be augmented by personal stressors (Khamisa, Peltzer, Ilic, & Oldenburg, 2017).

A final limitation of this study was its reliance on self-reported data. Psychiatrists completed a survey and an interview about their experience of burnout. Self-reported data can be subject to response bias, which could have influenced the results of this study (see Althubaiti, 2016). Although it is important to acknowledge limitations, this dissertation carefully applied strategies to minimize the impact of potential limitations on the findings, as discussed in Chapter 3.

Recommendations

This qualitative multiple-case study was designed in response to the research gaps documented in a synthesized review of the literature, and it aimed to more deeply explore the phenomenon of burnout among psychiatrists and to address the gaps in the literature regarding burnout factors, resources, and health implications in this population. Previous researchers have focused mainly on quantifying burnout prevalence among psychiatrists (Garcia et al., 2015; Shanafelt, Hasan, et al., 2015; Volpe et al., 2014) but have devoted little attention to the underlying reasons for burnout, the resources that may mitigate burnout, and the health consequences of burnout. By addressing these gaps, this study confirmed and extended the results of previous research in the field. Based on the results of this dissertation and the current literature, various recommendations can be made for future research.

First, this study only utilized participants from the Western United States, including Arizona, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming, and Colorado. Because regional culture can influence health and health care (Srinivasan, 2016), future research could expand the geographic locations to determine whether and how geography contributes to factors of burnout. Additionally, 85% of this study's sample did not report experiencing severe levels of burnout. Thus, there is an opportunity to investigate the experiences of psychiatrists who do report severe levels of burnout, rather than mild to moderate levels of burnout, to determine whether the results differ significantly from those of this study. This research direction would play a particularly important role in further understanding the relationship between burnout and health

consequences, because previous research has shown an association between increasing levels of burnout and worsening physical- and mental-health outcomes (Kaeding et al., 2017; Moodie et al., 2014; Zhang et al., 2018). Additionally, there is an opportunity to expand the research to compare between states and between genders. Comparison between genders might be particularly justified as the rate of physician suicide is significantly higher in female physicians than males (Duarte et al., 2020).

Furthermore, because this was a qualitative, exploratory multiple-case study, it points to extensive opportunities for future quantitative research. Using the outcomes of this study as variables or hypotheses, a quantitative researcher could use statistical analysis to test and confirm relationships. For example, a longitudinal study could be developed to determine the extent of a correlational relationship between burnout severity and negative physical- and mental-health outcomes over a longer period of time. Moreover, utilizing a larger sample size in a quantitative study would provide an opportunity to enhance the reliability of the results (Faber & Fonseca, 2014). In a quantitative study with a larger sample, patterns and trends could be statistically deduced so further assumptions could be made and intervention points better identified.

Finally, in a report on burnout among psychiatrists, the APA noted the need for randomized controlled trials that evaluate the efficacy of interventions for the reduction of burnout among psychiatrists (APA, 2018b). The results of this dissertation could provide an empirical foundation for burnout-prevention programs targeting psychiatrists, which could then be analyzed in a randomized controlled trial. In summary, future

research could broaden the geographic locations, investigate psychiatrists with severe levels of burnout, and analyze these factors using a quantitative design.

Implications

This study has implications for positive social change. The results of the study showed how psychiatrists described the process of burnout, and it identified the factors that contributed to their burnout. Additionally, the study addressed the resources that were protective against psychiatrist burnout and the physical- and mental-health consequences of such burnout. These findings have the potential to positively affect social change at the individual, organizational, and societal levels. Below, the study's implications will be discussed with respect to each of the four research questions.

Research Question 1

The findings related to the first research question demonstrated that psychiatrists experienced burnout as a process that progressed gradually, a process precipitated by work stress, and a multidimensional experience. At the individual level, psychiatrists who are able to recognize that burnout is a gradual process triggered by work stress may be better able to identify the indicators and progression of burnout. In other words, psychiatrists might be able to improve their awareness of the process and recognize the experience in its early stages in order to avoid the problems that result from burnout. Additionally, understanding that burnout is a multidimensional experience, characterized by feeling emotionally exhausted, cynical, and unaccomplished (Maslach et al., 2001), may help psychiatrists identify the emotions commonly associated with burnout. Ultimately, recognizing and intervening in the burnout process in its early stages could

mitigate the individual and organizational consequences of burnout (Patel et al., 2018). In addition to implications at the individual level, the findings from the first research question could also affect social change at the organizational level.

The JD-R model demonstrates that burnout is triggered by work stressors that exceed resources (Demerouti et al., 2001), a process confirmed by this study. The findings of this dissertation and the evidence from the empirical literature discussed in the implications section of this chapter demonstrate that psychiatrists can use person-centered approaches, such as self-care, to manage work stressors that exceed resources. However, in many cases, psychiatrists cannot change the working conditions or demands that cause excessive stress. Thus, organizations have a responsibility to support burnout prevention through job-centered interventions (Lemaire & Wallace, 2017). Because burnout is a multidimensional experience (Maslach et al., 2001), burnout-prevention programs should be tailored to identify and target organizational factors that may cause emotional exhaustion, depersonalization, and reduced personal accomplishment. Implementing job-centered approaches in order to combat burnout early in the process could help to mitigate and prevent the negative consequences for both physicians and health-care systems (West et al., 2018).

Research Question 2

The results pertaining to the second research question indicated that intrapersonal, interpersonal, and system-level factors, including the perception of ineffectiveness, challenging patient interactions, lack of appreciation, exposure to secondary trauma, excessive work demands, insufficient organizational support, and burnout culture, all

contributed to burnout among psychiatrists. At the individual level, understanding the intrapersonal and interpersonal factors of burnout, including the perception of ineffectiveness, challenging patient interactions, lack of appreciation, and exposure to secondary trauma, could help psychiatrists prepare for situations that cause burnout. Although psychiatrists may be unable to avoid situations involving challenging patient interactions or exposure to secondary trauma, they could certainly gather and prepare resources that would help them confront and overcome these burnout factors. For example, knowing that secondary trauma is a factor of burnout and a potential outcome of working with a unique patient population (Isobel & Angus-Leppan, 2018), psychiatrists could prepare for this possibility by seeking out their own therapist. Although understanding burnout factors could help individual psychiatrists, the potential for social change is more prominent at the organizational level, because psychiatrist burnout is precipitated mainly by organizational factors.

Increasing the depth of knowledge about particular factors that contribute to burnout among psychiatrists could support health promotion specialists' design and implementation of health education programs aimed at reducing burnout in this population. Health education programs originate from an understanding of the unique needs of a population, but they are also supported by theoretical and empirical research (Fernandez, Ruiter, Markham, & Kok, 2019). Although best practices would suggest that a needs assessment should always be conducted when planning a health education intervention for a particular population, the factors of burnout identified in this study could provide foundational knowledge for such interventions. Furthermore, having an

empirical basis regarding the causes of burnout among psychiatrists could allow organizations to assess and address the working conditions and situations that may be contributing to burnout in their organization. Specifically, organizations should explore providers' experiences of excessive work demands, insufficient organizational support, and burnout culture. Lemaire and Wallace (2017) suggested that to remedy the situation, organizations must change the working conditions that actually cause stress. Support and leadership from executives and managers are also imperative to facilitating changes that can successfully reduce burnout (Reith, 2018). Without an in-depth understanding of the factors contributing to stress, organizations lack the foundational knowledge needed to justify changes. The findings related to this research question offer much-needed empirical evidence regarding factors that contribute to burnout among psychiatrists.

Research Question 3

Understanding the process of and factors involved in burnout helps to answer the questions of how and why psychiatrists are burnt out. Identifying the resources that prevent burnout among psychiatrists can point to effective means of burnout reduction. In this study's population, relational support, self-care practices, cultivating self-awareness, collaborative communication, feeling noticed and appreciated, a manageable caseload, and having a flexible schedule were identified as resources that protected against burnout; these findings were also supported by empirical research, as discussed in the interpretation section. At the individual level, psychiatrists could gather and cultivate these resources. For example, they could actively seek out supportive relationships, engage in self-care, and practice self-awareness. These sources of protection against

burnout should also be cultivated at the organizational level (Reith, 2018). Although these individual-level resources were found to be beneficial, psychiatrists more frequently mentioned the importance of system-level resources. Thus, the potential for social change may be more prominent at the organizational level.

The JD-R model indicates that job resources can mitigate or prevent burnout (Demerouti et al., 2001), which was corroborated by this study. At the organizational level, the resources of collaborative communication, feeling noticed and appreciated, a manageable caseload, and having a flexible schedule were all found to prevent burnout among psychiatrists. Organizations can use this information to address and strengthen these influential resources. If organizations offer sufficient resources for psychiatrists to cope with their work stress, burnout in the population may decrease. This has broad implications for the organization and society. It has been estimated that physician burnout costs health-care organizations between $500,000 to over $1 million per doctor (AMA, 2018). Moreover, as mentioned in the significance section in Chapter 1, there is a shortage of practicing psychiatrists in the United States (NCBH, 2017; USHHS, 2016), and studies have shown that burnout is a contributing factor to psychiatrists quitting their jobs, their intent to leave, and their early retirement (Dewa et al., 2015; Huber et al., 2018; Miyasaki et al., 2017; Schwarzkopf et al., 2017). Providing adequate resources would likely reduce burnout among psychiatrists, which could, in turn, save organizations money and ultimately reduce the likelihood of psychiatrists leaving their jobs or retiring early due to burnout. Keeping psychiatrists working in the field would combat the

shortage of these important physicians and contribute to positive social change at the societal level.

Research Question 4

Finally, the results pertaining to the fourth research question indicated that burnout has negative consequences for both physical and mental health but that the mental-health effects are more prominent. This finding has implications for organizational change because it confirms that burnout can result in health concerns, which indicates a need for health promotion programs. Clearly, health issues can affect physicians individually, but they also have ramifications for organizations as well. Previous research has confirmed that poor physician health due to burnout has a negative financial impact on organizations due to increased absenteeism and reduced productivity among providers (AMA, 2018; West et al., 2018). Thus, the health issues of individual providers can burden organizations, which would provide justification for addressing and mitigating burnout through health promotion programs.

Conclusion

Previous research has quantified burnout among psychiatrists, showing the extent and severity of the issue (Garcia et al., 2015; Grisham, 2018; Shanafelt, Hasan, et al., 2015). However, few studies have explored why psychiatrists are experiencing burnout, what resources mitigate burnout in this population, and how burnout can affect perceived health consequences, both physical and mental, among psychiatrists (Heinemann & Heinemann, 2017). By addressing four research questions, this study explored these research gaps in a qualitative manner. The results of the study are significant because

they confirm and advance previous empirical findings in the burnout literature, which could be used to improve tailored health education programs. This study's results also have the potential to support positive social change at various levels, including individually, organizationally, and at the societal level. Ultimately, if utilized to develop tailored burnout-prevention programs, the findings of this study could facilitate the reduction of burnout among psychiatrists, which could reduce the number of psychiatrists who leave the field due to burnout.

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Appendix A: Invitation to Participate

Hello. My name is Brittany Plaven, and this email (or phone call) serves as an invitation to consider continuation of participation in a study I am conducting to complete my doctoral degree in Health Education and Promotion. The following information delineates participation details, should you decide this study is a good fit for you.

Purpose of the study

Burnout has been defined as a process of systematic emotional and physical exhaustion caused by a prolonged period of stress and frustration (Garcia et al., 2015; Shanafelt et al., 2015). In 2018, the American Psychiatric Association reported that two out of five psychiatrists in the United States experienced professional burnout (APA, 2018a). Professional burnout has organizational, patient-related, and individual consequences (Patel, 2018). Although the burnout literature in physicians is robust, studies specific to physician specialties, such as psychiatrists, are scant. In order to support psychiatrists in the prevention and mitigation of burnout, a full understanding must be gathered regarding (a) how is burnout described and explained, (b) what factors contribute to burnout, (c) what resources help alleviate burnout, and (d) how does burnout affect perception of health consequences. The purpose of this study is to engage in a conversation about these topics.

Participation Criteria:

To participate in the study, you must be:

- A board-certified psychiatrist currently working in the public or private sector.

- Licensed to practice in either Arizona, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming, or Colorado.
- Have experienced professional burnout either currently or sometime within the previous 5 years.

Procedures:

Upon your agreement to participate in this study, the subsequent procedures would be followed.

1) You would be asked to participate in a short, 13 question survey with a combination of open and close-ended questions. This will take approximately 10 to 30 minutes to complete.
1) You would be asked to participate in a telephone interview with Brittany that will be audio recorded. This would take approximately 30 to 60 minutes.
2) You would be asked to verify the transcript of our audio recording to ensure I have captured your exact words or clarify any miscommunication. You will have 14 days to provide feedback. This would take approximately 30 minutes.

Benefits and Risks:

Being in this type of study involves some risk of the minor discomforts that can be encountered in daily life, such as becoming upset. Being in this study would not pose risk to your safety or well-being.

Upon completion of this study, you would be awarded a $55 gift card to compensate for your time. Additionally, there could be benefits to the psychiatric community at large through the results of this research.

This study will add to the existing body of knowledge on the field of professional burnout and could be used as empirical evidence to better support psychiatrists in burnout prevention and mitigation. If you are willing to participate, please complete the consent form and burnout survey. Thank you for taking the time to consider participating in this study.

Sincerely,

Brittany Plaven, M.A., CHES
Ph.D. candidate, Health Education and Promotion
Walden University

Appendix B: Burnout Survey

Survey Questions:

1. Are you a board-certified psychiatrist (Yes or No). Yes continue. No end survey.

2. Are you licensed to practice in either Arizona, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming, or Colorado? (Yes or No). Yes continue. No end survey.

3. Are you currently practicing within a public or private sector of the state you are licensed in? (Yes or No). Yes continue. No end survey.

4. Have you experienced burnout at any point in time within the previous 5 years or currently? (Yes or No). Yes continue. No end survey.

5. On a scale of 1 to 5, with 1 being minimal burnout and 5 being severe burnout, in the last 5 years, how would you rate your level of burnout? (Likert scale selection 1, 2, 3, 4, 5).

6. On a scale of 1 to 5, with 1 being minimal burnout and 5 being severe burnout, in the last year, how would you rate your level of burnout? (Likert scale selection 1, 2, 3, 4, 5).

7. On a scale of 1 to 5, with 1 being minimal burnout and 5 being severe burnout, in the last 30 days, how would you rate your level of burnout? (Likert scale selection 1, 2, 3, 4, 5).

8. In the last 30 days, how many days have you experienced burnout? 0-5 days, 6-10 days, 11-25 days, more than 25 days.

9. Please describe what a typical day might look like where you feel burnt-out. (open-ended)

10. How long have you been practicing as a psychiatrist? 0-5 years, 6-10 years, 11-20 years, more than 21 years.

11. Gender. (Male, Female, Other, Rather Not Say)

12. Age. Under 25, 25-35, 36-45, 46-55, 56-65, over 65.

13. Please describe the patient population(s) you work with: (open-ended)

Appendix C: Confirmation Email

Hello,

You are receiving this email to remind you of an interview scheduled for (insert date and time) with researcher, Brittany Plaven. As a reminder from the definitions presented to you in the previous survey, here is a list of terms and definitions important to this interview:

Public or Private Sector: Working for/with: government organizations, not-for-profit, or for-profit companies. Excludes individuals working only in private practice.

Burnout: Chronic work stress characterized by emotional exhaustion.

Also, this email serves as a reminder that participation in this interview is voluntary. You may stop at any time. Should you have further questions may contact the researcher by responding to this email or calling. If you want to talk privately about your rights as a participant, you can call the Research Participant Advocate at my university. I look forward to speaking with you soon.

Sincerely,

Brittany Plaven, M.A., CHES
Ph.D. candidate, Health Education and Promotion
Walden University

Appendix D: Interview Guide

Thank you for being willing to participate in the interview portion of this study. Although this interview will not be anonymous, all the information will be confidential and none of the information you share will be presented in a way that would identify you. It is important to note that you may discontinue the interview now, or at any time during the interview. Participation in this study is voluntary and the information collected will only be used for the purpose of this study. If you consent, I would like to turn on the audio recorder and begin the interview.

Research Question 1: From the perspective of a sample of psychiatrists working in the public or private sector in Arizona, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming, or Colorado and self-identifying as having experienced burnout, how do these individuals describe and explain the process of burnout?

1. What does the term burnout mean to you?
2. Please describe some of the feelings of burnout that you may have experienced in the past or present.
3. Please describe how you perceived the burnout process.

Research Question 2: From the perspective of a sample of psychiatrists working in the public or private sector in Arizona, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming, or Colorado and self-identifying as having experienced burnout, what factors do these individuals identify as contributing to their burnout?

4. What factors or situations gave rise to your perception of burnout?

Research Question 3: From the perspective of a sample of psychiatrists working in the public or private sector in Arizona, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming, or Colorado and self-identifying as having experienced burnout, what resources protect against the effects of burnout?

5. What resources or tools have you used to manage or prevent burnout?
6. Did you notice a difference in your burnout when you didn't have adequate resources?
7. Where do you get support or assistance from when you feel burnout?
8. Have you received any training on how to cope with burnout?

Research Question 4: From the perspective of a sample of psychiatrists working in the public or private sector in Arizona, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming, or Colorado and self-identifying as having experienced burnout, how does burnout affect perceived health consequences?

9. What impact would you say your burnout has on your physical or mental health?

Appendix E: Permission to Use Job-Demands Resources Figure

Below is the written permission to use the JD-R figure, by Dr. Schaufeli, in my dissertation.

Initial email communication, Monday, March 4th, 2019

Hello Dr. Schaufeli,

My name is Brittany Plaven and I am a Ph.D. student at Walden University. I am working on the literature review of my dissertation and would like to include the JD-R figure. I use the JD-R model in my dissertation to discuss the health impairment process and the motivational process. My chair noted that I need to get written permission to use the figure in my literature review above just the citation. Is this something you would be comfortable with providing? Thank you!

Brittany Plaven

Email response from Dr. Schaufeli, Friday, March 8th, 2019

Dear Britany,

No problem, you can use the figure in your dissertation.

With kind regards,

Wilmar Schaufeli

Wilmar B. Schaufeli, PhD | Full Professor of Work and Organizational Psychology | *Social, Health & Organizational Psychology* |

Appendix F: Charts Depicting Raw Data to Themes

Thematic Analysis Example: Research Question 1

Transcript Excerpt	Codes	Theme
"Well, I would say that the process started almost imperceptibly, with little things, like, um, you know, being asked to cover patients for a coworker who was sick, which you agree to and then, it's like, ok, you're being asked more and more. I think it just developed gradually, almost like, like a glacier retreating. I don't know, the glacier retreating represents me being asked to do more and more things, but over a longer period, so I am almost not even aware how much everything is adding up and weighting on me until it's too late." "You know, burnout just doesn't happen overnight. I think people assume that burnout is like, this thing that occurs in a short time span due to a particularly stressful patient or event, and that's part of what contributes to it [burnout], but really, it almost starts with things you don't even notice, like staying 15 minutes late to finish up your notes, and then, over time it, it's like, wow, I	- Cumulative effect - Gradual process	Gradually Progresses Over Time

have been staying late every day this week, and that really wears on you over time."		
"Part of what I think contributed was that the environment we were in was short-staffed. And so everybody was feeling like this increased pressure to pick up the pieces and still deliver high-quality care." "Definitely. I can 100% say that my burnout started from the various work pressures I was under. I remember there were multiple challenging patients and also challenging family members, and um, I was definitely staying late most days, so I think all those things combined contributed." "That experience was at a period of time when there was a lot of work demand and I felt like I was constantly falling behind." "I had an extremely high patient load, with a lot of complicated cases and I didn't feel I had adequate time or support to handle that. There was never a break."	- Work stress as initiating factor. - Unable to meet demands	Process Precipitated by Work Stress
"It feels like a drain to go to work every day and	- Characteristics of emotional exhaustion	Burnout as a multidimensional experience

drain to continue to care for patients." "My feelings of burnout were being less motivation to go to work, having lower energy at work and after, kind of more irritability, and less patience at work." "There were definitely days when I didn't want to go to work and it felt like a drain just having to get up in the morning and make myself go to work." "What I was feeling, was more along the lines of feeling like there is some kind of purposelessness going on in terms of what my expectations with my role was and what was actually going on in the role." "I think specific to psychiatry, I think the thing that happens a lot with psychiatry patients is either they get better really quick or there's not a lot you can always do to get them better or it takes forever. Then it's like, did I even actually do anything or were they just going to get better anyway?" "I would say there were feelings of disillusionment and demoralization."	- Characteristics of depersonalization - Characteristics of reduced personal accomplishment	

"The experience was at a period of time when there was a lot of work demand and I felt like I was constantly falling behind and unable to be emotionally present with my patients and therefore I started feeling worse that I wasn't able to help them to the ability that I knew I could."		

Thematic Analysis Example: Research Question 2

Transcript Excerpt	Codes	Theme
"And then you get the patients that come in and want a lot of help. They want a lot of things and they expect a lot from you. They expect that you can do a lot for them and I sometimes find myself feeling like I can't do a lot for them." "I think one of the most difficult parts of being a psychiatrist is seeing what our limitations are and not being able to help people. Having someone come to you who is really sick and despite the medications and therapy they just don't get better and they are relying on you to help them change, but they don't get better and so, you feel like you aren't good at what you do."	- Perception of ineffectiveness	Intrapersonal factors
"I would say, generally, at least 3 out of 7 weekdays,	- Challenging interactions	Interpersonal factors

including weekends, I receive after-hours patient emails demanding an immediate response, which can be challenging when it happens so much." "People come in and they're med seeking and then those are ugly interactions." "Then a month later they're back in the hospital. And then you have to go see them again, and you know it's going to be, be the same conversation over and over again. And I think that's really frustrating." "most of what I have seen is more emergency rooms stuff and dealing with families and patients that really did not even really want me involved let alone were appreciative of things." "It's hard because I put in so much effort, I really do care about my patients, and sometimes I don't really feel like it is appreciated at all." "A majority of the patients I work with have had extremely traumatic experiences and it's my job and desire to try and help them in whatever way I can, but it's also often hard	- Lack of appreciation - Exposure to trauma

for me to let those stories go. At one point in time, I found myself thinking about a particular situation more frequently than was healthy, and so I started working with a psychotherapist to mitigate negative repercussions. It's helped working with my therapist, but in terms of your question for factors of burnout, this was a huge factor for me."		
"Well part of it was, initially in the beginning, was that I sought support from one of my supervisors at the time and felt like my concerns were minimized." "There is a disconnect between the physicians and the organizations. I think that, for me at least, I felt that when there was an issue, policy change was extremely slow or didn't happen at all. That's probably just the outcome of being in a large organization, it's hard to change things quickly, but yeah, there was an issue with that. These organizations have a ton of money and power and I just find it hard to believe that they can't change a simple policy. I feel like it is mostly about them and the bottom line than the well-being of patients or staff"	- Insufficient organizational support - Excessive work demands - Burnout culture	System-level factors

"There wasn't much support from the organization at all. I think for me, that is often where burnout came from."
"felt like there just wasn't as much support from my supervisors as there had initially been from when I was hired. So that contributed to it [burnout]."
"The institution was operating under an idea that a certain amount of patients needed to be seen and therefore we were the ones to do it regardless of anything. And they struggled to recruit and instead of reducing the census they just put more on their doctors"
"and there was really so little time with every patient and pressure to see more patients. Like how you do possibly understand the complexity of someone's GAD [generalized anxiety disorder] in 15 minutes?"
"You're sort of thrust into this situation and it's actually seen as sink or swim. There's a sense from people higher in the hierarchy that, oh we all

did this and we turned out fine." "I'm not sure if they just didn't know how burnt out I, and not just me, but a lot of my peers were feeling, or maybe they just didn't care. There is a culture in medicine where, like, you're viewed as a machine." "When I think about it, I think it was such a heavy burden was because it was seen by the organization as an individual failure, that was how it was being essentially being told. And, I think the struggle was that individually everybody was doing that. And it was tough for people because they didn't feel like they personally could make a change to impact how they were feeling."		

Thematic Analysis Example: Research Question 3

Transcript Excerpt	Codes	Theme
"Just talking with friends. A lot of my friends went to med school in various medical specialties and so they get some of these frustrations and we vent or joke about things." "My wife is also a physician, and so being able to bounce ideas off one another and talk about	- Relational support - Self-care - Enhancing self-awareness	Individual resources

work, both the good and bad, and things we are grateful for and things that are more challenging, with someone else who understands that has worked as well." "I certainly use my wife as a support." "And my kids. It's not like I mull over the hardships of my job with them, but, ok, for example, one of my kids woke up early and made me French toast for breakfast the other day. It was terrible, but a really kind gesture of appreciation and support." "I try to get to the gym or a yoga class every day. Yoga especially is a great stress reliever for me and eating a whole food, plant-based diet, I recently changed my diet and it has helped me lose a little weight, which motivates me to exercise more." "I exercise daily. I've actually started riding my bike to work more, which is another helpful thing. "Also hobbies. I like to exercise and I play music in a group." "Eating healthy and practicing mindfulness."		

"I also like to read fiction before I go to bed to let go of the stress of the day." "Well I think one of the things that helped me even at that time was sort of trying to personally recognize that this was not an internal flaw." "I started to practice mindfulness-based meditation, and then when I was in a stressful situation, to just be able to take a breath and step back from it for a moment to clear my head" "Individual therapy has definitely been positive in recognizing and listening to how I see and react to situations."		
"Everyone in management talks about burnout and prevention measures, it's a hot topic right now and they seem to care, but rarely are we asked our opinions and what we think could help. Like, it's so interesting, since we are the ones on the ground experiencing it. Then, we have these burnout prevention programs like every so often that generally focus on what we can do individually, like taking care of ourselves and such, but that really	- Collaborative communication - Notice and appreciation	System-level emotional support

seems to just put the problem on us when really, there are many other things, mostly organizational related things, that need to be addressed. It's kind of a copout, like hey, we are giving you a burnout program so just go exercise and stop complaining." "I think what would be beneficial is being part of the process in deciding how to best prevent burnout instead of just being, like something that is acted upon, if that makes sense. I talk to my organizational leaders about this, but I just don't feel like they hear my concerns." "One of the things that was effective was really, being open and honest with the people that I could trust and did have good mentorship with and that was really what was instrumental." "Yeah, definitely, so our manager just took my team and our significant others out to dinner recently and it was really nice, he praised all of our hard work and successes and even though there are things to work on, it was nice to be		

appreciated and acknowledged." "Another thing that helps is that my boss is really supportive and verbally tells me she is grateful to have me on staff." "I find that when my managerial staff shows some appreciation, like even little things like just saying a quick thanks in the hallway, like I'm not asking to me nominated as employee of the month."		
"The position I am in now does have a pretty good patient workload, like I don't feel as overworked as I previously did which is helpful." "Yeah, the patient load I had was unsustainable for me as we were short-staffed and they were having issues hiring and this was a big reason I left that position. My current position is much more sustainable in this way." "Finding a position that was more suited for, well that I feel had a better balance of patient workload was important." "done things like change people's work schedules so that they work four days a	- Manageable caseload - Increased flexibility	System-level tangible resources

week instead of five days a week" "once I transitioned to a telepsych position I was able to work from my home office, which was a tremendous relief, just you know, not having to drive both directions in traffic and being able to pick my kids up from school." "There is just no opportunity for work-life balance with the schedule. I feel guilty, and I know others do too, for taking time off and putting that work onto my peers, like I had an appointment scheduled the other day and I canceled it because I felt I couldn't get off work without impacting, well my coworkers and the patients too, so yeah, I think flexibility in being able to take some time off when needed is lacking and a change to that would be beneficial to me and others."		

Thematic Analysis Example: Research Question 4

Transcript Excerpt	Codes	Theme
"I've absolutely experienced health issues recently from this, yes. I used to get headaches, oh every other month or so, but recently I have been getting horrible migraines	- Migraines - Gastrointestinal upset - Compromised immune system - Weight gain	Physical manifestations

about once a month, if not more. Really nothing else has changed except my level of stress and my PCP says this is likely the contributing factor." "I have IBD and I have notice that when I do feel more burnout that my symptoms are significantly worse, I won't do into all the gross details, but yeah, it impacts that, and also, another physical thing I seem to get is that I always get sick much more often when I am under that type of stress. Just colds, so nothing like, extreme, but still." "Probably only that I gained some weight, but I lost it once I changed positions and had more time to exercise and eat healthier." "Well I gained about 10 pounds." "I don't think that it ever necessarily affected my physical health in terms I wasn't getting sick or I didn't get injured." "I don't think it had a lot of impact on my physical health. I mean, I was eating more unhealthy during that time period but I didn't	- No physical manifestation	

have any long term health consequences from that." "No, I didn't experience physical or mental issues with health during that time."		
"Yeah, I mean, it definitely wasn't good for my anxiety and depression. I would say it was worse during those times when I was more burnout." "Thinking about that time, I was quite a bit more anxious and didn't really always manage it as well as I could potentially now. I think that, that was probably the primary manifestation." "Well, yeah, I think I am more irritable and withdrawn, I wouldn't necessarily say it would be clinically diagnosed depression, but my mood has been impacted." "So I think that that's probably the biggest effect that I had, it was just like being burnt out and screwing up my schedule, and then I'm just not sleeping well and becoming more irritable." "I would say the mental health at that time, definitely, I mean it just built on itself it snowballed. I didn't want	- Depression and anxiety - Mood instability - No mental manifestation	Mental manifestations

to go to work and I didn't feel like I had any life outside of what was being taken up in my emotional space at the hospital and so it was, yeah it was tough but I wouldn't say that I had any lasting effects. It was very situational so thankfully once I was out of that situation, I no longer experienced any lingering emotional effects from it." "Hum, I mean my burnout was pretty minimal even though I would say I experienced it, but yeah, no, I don't think I would say it had any impact on my mental health at all, no." "No, I didn't experience physical or mental issues with health during that time." "Um, I don't think so."		