Burnout of Rehabilitation Therapists in Long-Term Care Settings

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Abstract

Background: Given the demands of their profession, burnout among healthcare workers is growing, particularly among long-term care staff, along with physical and emotional repercussions. Research is limited on how rehabilitation therapists (occupational, physical, and speech) perceive and experience burnout in long-term care settings. An in-depth understanding of healthcare professionals' experiences with burnout within long-term care settings is necessary to understand and address burnout. ***Objective***: This study investigated the perceptions and experiences of rehabilitation therapists while working in long-term care settings and the potential for burnout. ***Method***: The researcher utilized a basic interpretive qualitative approach to guide semi-structured, individual interviews with rehabilitation therapists. Interviews were audio recorded, then transcribed verbatim. Along with a second researcher, the data was analyzed through a structured coding process, followed by development of overarching themes. ***Results:*** Six themes emerged from the data: causes of stress and burnout, individual ways of managing stress and burnout, systemic changes for managing stress and burnout, COVID-19 and mental health, the definition of burnout, and change over time in work experience. ***Discussion:*** Rehabilitation therapists can feel empowered to advocate for themselves to their employers when discussing issues, and employers will see the importance of changing policies to help reduce the prevalence of burnout in therapists and promote systemic changes from within the companies. One universal policy all participants acknowledged was that productivity expectations were unrealistic. Future research, advocacy, and policy should address systemic and organizational factors related to burnout to relieve the related consequences and promote a thriving therapy workforce.

Keywords: rehabilitation therapists, burnout, long-term care, memory deficits

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With the utmost gratitude,

Christine Hughes

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Burnout of Rehabilitation Therapists in Long-Term Care Settings

Individuals working in helping professions, such as healthcare professionals, are at greater risk for and more susceptible to developing burnout than non-helping professions (Leonardi et al., 2013), with the most recent Medscape National Physician Burnout and Suicide Report reporting a burnout rate of 43% (De Hery, 2020). Symptoms of burnout include anxiety, irritability, a sense of failure, and depression, all of which affect patient care and interaction with others (Leonardi et al., 2013). It is reported that more than half of United States physicians experience symptoms of burnout, with this number being determined before the COVID-19 pandemic (Dyrbye et al., 2017). However, more research is needed to understand the experiences of other members of healthcare professional teams (Dyrbye et al., 2017).

Burnout among nursing and care home staff for older adults is a significant problem worldwide, with repercussions for the well-being of patients, providers, and staff (Harrod & Sulla, 2018). The prevalence of paid caregiver burnout is 50% in geriatric-based facilities (Kandelman et al., 2018), which presents a unique issue for these professionals' health and residents' quality of care. For example, healthcare personnel demonstrating signs of burnout often become desensitized to others (Yıldızhan et al., 2019) and develop negative attitudes toward dementia patients for whom they are providing care (Smythe et al., 2020). Furthermore, they are noted as feeling emotionally and physically exhausted with low levels of feelings of personal success within their work (Yıldızhan et al., 2019).

Additionally, these professionals began to experience the effects of COVID-19 starting in the spring of 2020. Staff in long-term care settings have described working under complex and stressful circumstances during the COVID-19 pandemic, citing fear of bringing the virus home to their family, transmitting the virus to their patients, increased workloads, and increased physical

and emotional burden as some of the reasons for feeling burned out (Prasad et al., 2021; White et al., 2021). These challenges burdened an already struggling workforce and will likely continue contributing to increased burnout and reports of anxiety and depression (Prasad et al., 2021; White et al., 2021). Not only has the current pandemic affected healthcare workers this way, but studies have also found that those with dementia may demonstrate increased adverse behaviors. These behaviors include more anxiety, agitation, and withdrawal due to the stresses of COVID-19, resulting from changes in daily routine and the deaths of familiar residents (Kohn et al., 2021). This may, in turn, exacerbate stressors and burdens on healthcare workers in long-term care settings even further (Kohn et al., 2021).

Problem Statement

An in-depth understanding of healthcare professionals' experiences outside of nursing staff and physicians with burnout within long-term care settings is needed. There is a lack of research on burnout among rehabilitation therapists and their experiences with burnout while working in long-term care with patients with memory deficits. Research is needed to add to the literature to find and support interventions to reduce burnout and job turnover and promote satisfaction within the therapists' role in long-term care. Specifically, there needs to be more research on how physical, occupational, and speech therapy practitioners experience and manage burnout while working in a long-term care setting and with those with memory deficits.

Rehabilitation therapists, including physical, occupational, and speech therapists, have essential roles, including modifying diet, addressing cognition, improving functional mobility, and increasing the ease of participation in daily living tasks like toileting and dressing (Developers, 2021; Hatcher, 2023; Hofmann, n.d.). In addition, as the rate of older adults

entering long-term care settings with memory care deficits grows, it is now more crucial to investigate their experiences with burnout to reduce those rates and ensure job satisfaction.

Purpose Statement

This basic interpretive study aimed to understand healthcare professionals' experiences, specifically physical, occupational, and speech therapists (here forward, collectively as rehabilitation therapists), with burnout while working in a long-term care setting with patients with memory care deficits.

Research Question(s)

- How do rehabilitation therapists experience and manage feelings of work-related stress, known as burnout, while working in long-term care facilities?
    - How has the COVID-19 pandemic changed how rehabilitation therapists felt and managed burnout while working in long-term care facilities?
- How do rehabilitation therapists define their experiences of work-related stress, known as burnout, while working in long-term care facilities?
    - To what extent has COVID-19 redefined burnout for rehabilitation therapists in long-term care facilities?

Significance of the Study

Understanding how rehabilitation therapists experience stress within a long-term care setting will provide insights into burnout and enhance stress management. Implications for this research include creating and tailoring stress management programs for the workplace to reduce stress and prevent burnout in therapists. Workplaces could then provide education on the signs and symptoms of burnout and what to do when feeling these symptoms. This research may aid

rehabilitation therapists and their employers in addressing these symptoms of burnout early on. This allows for continued quality care of their patients.

Definition of Terms

- Burnout: a type of work-related stress that includes a state of physical or emotional exhaustion, a sense of reduced accomplishment, and loss of personal identity (Mayo Clinic Staff, 2021).
- Health professionals: maintain health using evidence-based medicine and caring principles and procedures. Health professionals diagnose, treat, and prevent illness, injury, and other physical and mental impairments (Geneva, 2013).
- Long-term care setting: a facility that provides rehabilitative care to patients or residents in need of assistance…long-term care facilities include nursing homes and personal care homes (MedicineNet, 2021).
- Rehabilitation therapists: these include those who work in long-term care settings, such as speech therapists, occupational therapists, certified occupational therapy assistants, physical therapists, and physical therapist assistants.

Literature Review

The present study aimed to explore healthcare professional burnout, specifically physical, occupational, and speech therapists (here forward known as rehabilitation therapists for conciseness), in long-term care settings while working with memory care patients. A literature search was completed, which resulted in articles referencing burnout among healthcare professionals working in long-term care with patients with memory care deficits and symptoms of burnout in healthcare professionals and how this affected patient care satisfaction. However, there was limited research on how healthcare professionals can manage their symptoms of

burnout or how to prevent such symptoms from occurring. In addition, this researcher observed that the novel virus, coronavirus 2019 (COVID-19), may contribute to burnout by increasing stress in caring for their patients and concerns about bringing it home to their families (Prasad et al., 2021; White et al., 2021).

Burnout

Burnout can be defined as a state of physical and emotional exhaustion involving both negative self-worth and a negative attitude toward a person's job (Kim et al., 2020). Like healthcare professionals, those working in helping professions have a greater risk for burnout than non-helping professions (Leonardi et al., 2013). For example, 43%, or one in three, physicians experience burnout, and 31.5% of nurses cite burnout as the reason for leaving their job (Medscape, 2020; Shah et al., 2021). Burnout amongst healthcare professionals is growing, with up to 50% of those represented by paid caregivers, such as certified nursing assistants (C.N.A.s) and nurses in geriatric care facilities, such as long-term care settings (Harrad & Sulla, 2018). Paid caregiver burnout is growing, but it can lead to severe consequences such as the increased risk of neglect, lower quality of care, and increased abuse, particularly in older populations (Harrad & Sulla, 2018; Kandelman et al., 2018).

Similarly, healthcare professionals are showing signs of becoming insensitive to others, such as patients and other staff (Yıldızhan et al., 2019). This is often referred to as compassion fatigue, which can be defined as a "unique form of burnout that affects people in the caregiving profession" (Joinson, 1992). Compassion fatigue tends to occur in healthcare settings while working with ill and often suffering patients (Polat et al., 2020; Recognising fatigue, 2021). Compassion fatigue, if left unresolved, can lead to burnout, impair healthcare professionals' job performance, and cause them to be less diligent in caring for their patients (Abbaszadeh et al.,

2017). Among caregivers, those working with patients with dementia are found to experience a more significant caregiver burden than other caregivers due to the increasing symptoms of the advancing disease, such as behavioral and psychological changes (Hiyoshi-Taniguchi et al., 2018).

Burnout in Long-Term Care Settings

As is true for other healthcare professionals, those who work in long-term care settings, such as nurses and paid caregivers, experience high levels of burnout and compassion fatigue (Smythe et al., 2020). This can lead to negative attitudes toward those being cared for and the provision of poorer quality care (Smythe et al., 2020). One research study revealed that the risk factors for burnout in healthcare professionals working in long-term care settings are strict institutional protocols, working in a profit-making establishment, and the experience of bullying by a resident (Kandelman et al., 2018). Various disciplines work in this setting, including speech, physical, and occupational therapists, with all types of patients, including those with memory care deficits. Depending on the patient's needs, these therapists address various needs within this environment.

The role of an occupational therapist is to help residents develop skills and promote participation in what is known as activities of daily living—self-care tasks such as feeding or dressing (Hofmann, n.d.). Physical therapists work on building strength and endurance, improving flexibility, enhancing coordination, and promoting mobility (Hatcher, 2020). Speech therapists' role includes compensatory strategies for independence during eating and swallowing, diet changes to avoid aspiration, and assessing and training mental status for orientation to surroundings (Developers, 2021). Indeed, being intimately involved in these critical roles with patients with memory deficits happens daily in long-term care settings.

Symptoms of Burnout

Apathy is healthcare professionals' most prevalent symptom of burnout, followed by irritability, anxiety, mood disorders, insomnia, a sense of failure, disillusionment, and depression (Hiyoshi-Taniguchi et al., 2018; Leonardi et al., 2013). These professionals reported feeling emotionally and physically exhausted and having low personal success in their work (Yıldızhan et al., 2019). Furthermore, research has found relationships between the feelings of burden and burnout and a caregiver's lack of free personal time, the hours they devote to patient care, the number of years spent in patient care, and the progression of patients' cognitive deficits (Pudelewicz et al., 2019). Personal health issues that have been shown to accompany burnout include high cholesterol, type 2 diabetes, hospitalization due to cardiovascular diseases, and increased risk of developing musculoskeletal pain, headaches, gastrointestinal issues, and respiratory problems (Salvagioni et al., 2017). Some variables affecting rehabilitation therapists and their feelings of burnout include the inability to detach from work during out-of-work hours, low salary satisfaction, and perceived work overload (Poulsen et al., 2014).

Therapists and Burnout

Physical, speech, and occupational therapists are at high risk of burnout, which is associated with decreased job satisfaction, increased medical errors, and decreased well-being in healthcare professionals (Kim et al., 2020). Larger facility sizes, caregiver gender (women), and younger age (20-30 years old) were identified as major contributing factors affecting burnout symptoms among therapists in these professions (Kim et al., 2020). Therapists are in daily contact with patients' physical and emotional pain as they assist patients with working through various levels of disability (Kim et al., 2020). In addition, a lack of personal achievement or feeling of meaning in their job was reported (Leonardi et al., 2013). Therapists were noted to

have high levels of emotional exhaustion, high levels of cynicism, and low professional efficacy. Reasons leading to such experiences included excessive demands, conflict, and lack of autonomy and respect for their profession (Gupta et al., 2012)

Therapists within the Katsiana study were found to have moderately high levels of burnout, with some having no psychological resilience to these feelings of burnout (Katsiana et al., 2021). This means that therapists struggle to cope with and manage feelings of burnout caused by their jobs. Having no psychological resilience means they have a more challenging time adapting to difficult conditions or trauma in the workplace (Katsiana et al., 2021). Psychological resilience positively adapts to adversity, complex conditions, or trauma (Luthar, 2015). Therapists have been found to have high levels of emotional exhaustion and perceptions that their work is not always respected by others (Brito-Marcelino et al., 2020). Reasons why therapists' burnout has increased include work overload, poor pay, role conflict, and inadequate resources (Evanson, 2003).

Coronavirus 2019 (COVID-19) and Burnout

During the COVID-19 pandemic, more healthcare workers faced (and are still facing) life-threatening situations, virus exposure, and other major changes in work responsibilities and organization (Leo et al., 2021). In recent research studies, healthcare professionals in long-term care settings during the beginning of COVID-19 noted increased feelings of stress and overall physical and emotional burdens on an already strained staff (Prasad et al., 2021; White et al., 2021). An additional study found that half of the healthcare worker participants experienced burnout in some sense during the COVID-19 pandemic (Ghahramani et al., 2021).

During the outbreak, a high incidence of anxiety and depression was reported (Leo et al., 2021). Healthcare professionals' overall emotional and physical well-being plays an important

role in containing the pandemic (Ghahramani et al., 2021). This means that employees may feel exhausted emotionally, have negative attitudes while working and treating patients, and have difficulty carrying out tasks pertinent to their role (Ghahramani et al., 2021). An effect of burnout on employees is a lower quality of the healthcare systems, poor communication, medical errors, and patient outcomes and safety (Leo et al., 2021). The current pandemic affected patients in long-term care settings with memory deficits, such as Alzheimer's disease or dementia, demonstrated by increased adverse behaviors (Kohn et al., 2021). These behaviors include increased anxiety and agitation, thus increasing the caregiving demands of healthcare workers (Kohn et al., 2021).

Burnout Relief

Researchers have found that emotion-focused coping strategies, including acceptance or positive re-interpretation of a situation, have been associated with lower burden levels (Lloyd et al., 2019). Specifically, the use of self-compassion among staff demonstrated positive outcomes in attitude and their well-being with said staff members (Lloyd et al., 2019). Staff with self-compassion have better caregiver outcomes, including better quality care and a more positive attitude toward the residents (Lloyd et al., 2019). Self-compassion is defined as being understanding toward oneself when one suffers or fails (Neff, 2020). One strategy to help with burnout was allowing caregivers to engage in regular leisure tasks (Kendelman et al., 2018). Other ways in which burnout can be relieved and increase job satisfaction are greater autonomy in their position, the ability to contribute to decision-making, and improved workplace orientation (Aloisio et al., 2018).

Having interdisciplinary staff support groups designed to prevent energy depletion and allow employees to feel valued was also shown to reduce feelings of stress or burnout

(Kandelman et al., 2018). A study by Uyar et al. (2019) found that providing education and counseling to caregivers helped to decrease their distress. Similarly, another study demonstrated that staff members' perceived support from their colleagues protects them against feelings of burnout and stress (Costello et al., 2019). This same study found that the more staff perceived that their facility's leadership was adequate, the more they felt they were protected against feelings of burnout and stress (Costello et al., 2019). Evanson (2003) also noted that increased communication from leaders to the employees, improved organizational policies that positively affect a work-life balance, and stress management techniques like education on stress could aid in the reduction of burnout. Other ways therapists manage their burnout better include spending time with family, maintaining a work-life balance, improving control of work-related responsibilities, maintaining a sense of humor, and self-awareness/self-monitoring of emotions (Gupta et al., 2012).

Summary

Overall, a limited amount is known about burnout in occupational, physical, and speech therapists who work in long-term care. Specifically, only a small amount is known about burnout in these therapists. Such therapists need to be aware of the experiences of burnout and look toward developing coping mechanisms and strategies to combat, manage, and reduce the rates of burnout within these professions. Further qualitative research that delves into the therapist's perspective of burnout in long-term care must be pursued to understand better and maintain the level of professionals within the long-term care setting. The qualitative approach of this study will result in in-depth information about how care and burnout are perceived, experienced, and managed. The researcher of this current study will utilize a basic interpretive approach to answer

the research question: How do occupational, physical, and speech therapists experience stress while caring for those with memory care deficits in long-term care settings?

Method

Study Design

A basic interpretive qualitative methodology was used to understand the experiences of rehabilitation therapists with burnout while working in a long-term care setting with patients with memory care deficits. A basic interpretive approach is used to understand how people make meaning of their experiences (Merriam, 2002), making it an appropriate design for this study. The study began after the researcher received Institutional Review Board approval from the University of Indianapolis.

Participants

For inclusion in this research study, participants must have been currently employed in a long-term care setting, such as a skilled nursing facility or an assisted living facility, and worked as a rehabilitation therapist, such as a physical therapy practitioner, speech therapist, or occupational therapy practitioner.

Procedures

Sampling and Recruitment

The researcher utilized a purposeful sampling strategy for participant selection. A sample, when chosen purposefully, allows for the strategic selection of the participants to inform an understanding of the stated research problem (Palinkas et al., 2015). Specifically, maximum variation sampling was used whereby the researcher sampled from various long-term care sites, looking for an equal number of rehabilitation therapists across occupational, speech, and physical therapies (Patton, 1990). To this end, the researcher recruited participants from various long-term

care facilities and disciplines by approaching therapists from social media groups on Facebook specific to those working in long-term care settings.

Recruitment via social media involved posting a recruitment post that included information about the study and the researcher's phone number and email address for them to contact the researcher if interested (see Appendix A). This information sheet also included confidentiality procedures, potential benefits and risks, statements about the voluntary nature of the study, and the fact that they could withdraw their consent at any time.

When an individual contacted the researcher about the study, they were reminded about the study's purpose, participation requirements, and methods to protect participant confidentiality. Participants were also told about the time commitment expected and the methods through which the researcher will collect and analyze the data. Individuals who expressed interest in participating were then emailed the study information sheet (Appendix B), so they could review it before agreeing and scheduling the interview. Also, in this email communication, participants were asked to share information about the study with other rehabilitation therapists they knew and met the inclusion criteria.

The interviews were scheduled with those who agreed to participate in the study based on availability. The interviews were held via telephone to reduce the risk of COVID-19 virus exposure due to the researcher's and participants' employment in a long-term care setting. The sample size was determined using information power, which examines sample adequacy, the study aim, data quality, and variability of relevant events to gauge the number of participants needed (Malterud et al., 2016). This study had a narrow study aim, and the sample the researcher sought was dense (highly specific), requiring fewer participants to achieve information power (Malterud et al., 2016). A cross-case analysis strategy was utilized because the researcher was

looking to examine the experiences with stress and burnout across the different disciplines and make recommendations for preventing and managing stress in the work environment (Malterud et al., 2016). Based on information power, an appropriate range of participants was approximately 10-15, allowing for various long-term care settings and ensuring all three disciplines are represented in the therapists' agreeing to participate.

Informed Consent

Informed consent was obtained verbally from each participant after reviewing the study information sheet and scheduling the interviews. Consent was also reaffirmed before beginning each interview. During the consent process, the researcher reviewed the study information sheet with each participant to ensure their understanding. Specifically, the participants were told about the study's purpose, their expectations regarding the interview process and member checking, the potential benefits and risks, and the methods by which confidentiality will be maintained. The participants were also informed that the interviews would be audio-recorded. Finally, the researcher informed the participants that they could ask questions at any point, decline to answer any question the researcher asked, and withdraw from the study at any time without penalty.

Data Collection

The researcher conducted individual, semi-structured interviews about rehabilitation therapists' experiences and perceptions of stress and burnout while working with individuals with memory care deficits in a long-term care setting. Memoing was utilized from the beginning of the data collection to examine the researcher's thoughts about the data, including how the themes are coming together and how the patterns are developing (Birks et al., 2008). The memoing process helped clarify thinking on a research topic by examining one's thoughts about the data. It allows for articulating assumptions and perspectives to develop themes (Birks et al., 2008). A

semi-structured interview guide developed by the researcher was used during the interviews (see Appendix C). The questions guided the conversation versus reading each question directly. Prompting and follow-up questions were used to probe further based on the participants' responses.

After reestablishing informed consent, the interview questions began with a broad question about the topic, with prompting and follow-up questions thereafter. The interview continued, with each question becoming more detailed about the participants' experiences and feelings, building on one another. Interviews were recorded using a Voice Recorder application on the researcher's password-protected MacBook and their password-protected iPad to ensure no data was lost due to technology failure. Interviews took between 30-55 minutes, depending on the participants' responses. Each interview concluded once all the interview guide questions had been asked and answered, and the participants had no other questions or comments to contribute.

Data Management and Analysis

Audio recordings from the interviews were transcribed using Temi, an online transcription service. Specifically, the researcher used Temi's audio-to-text service, cleaning up and de-identifying each transcript before downloading it using identification numbers instead of participant names to protect privacy. Each transcript was saved in an encrypted space on the researcher's Google Drive in a transcript-specific folder and deleted once the research was completed. The interview recordings are stored on the Voice Recorder application on the MacBook, the password-protected Temi website, and Dedoose version 9.0.85, a qualitative data analysis web application that is also password-protected. The data analysis process began with the researcher reviewing each transcript multiple times to immerse herself in the data, which occurred throughout the data collection and analysis process. The researcher then began coding

by reviewing the interview transcripts again, line-by-line, highlighting relevant words, phrases, or segments of data relevant to the research question and assigning them a label (Creswell & Poth, 2018). During this process, the researcher worked with a second researcher with expertise in qualitative research to aid in the data analysis. The primary researcher took a transcript, coded it independently, then compared the codes with the second, outside researcher. The analysis expert of this dissertation served as the second researcher. They coded one transcript with the researcher to develop the foundational codebook. The analysis expert was engaged throughout the process as the external auditor. Upon completing this step, the researcher created a codebook to document the codes developed.

The researcher reviewed the codes again to make adjustments as needed. Then, the researcher grouped the codes into categories before creating the theme table. The table included quotes illustrative of each theme and its location in the data (Creswell & Poth, 2018). The researcher then conducted member checking to seek participant feedback on the themes found from interpreting the data to ensure an accurate representation of their experiences. The researcher asked that the participants provide their feedback within one week via email. The researcher made any necessary adjustments based on their feedback.

Rigor/Trustworthiness

Trustworthiness, or the study's rigor, was established by including strategies that support credibility, transferability, dependability, and confirmability (Connelly, 2016; Henderson & Rheault, 2004). Credibility, or confidence in the study, was maintained through reflexivity, triangulation, and member checking (Connelly, 2016; Henderson & Rheault, 2004). Triangulation, in which credibility is supported by involving other researchers to verify the results (Henderson & Rheault, 2004), was incorporated by engaging an experienced qualitative

researcher throughout data analysis. Member checking occurred at the end of the data analysis portion by making the transcript and theme identification available for review, once completed, by the participants (Henderson & Rheault, 2004).

Transferability, or the process of ensuring the results can be applied to rehabilitation therapists and other healthcare professionals who work in long-term care, was supported by ensuring that relevant peers find meaning in the results and associate the results with their own experiences (Cope, 2013; Korstjens & Moser, 2017). In doing so, the researcher provided a detailed description of the sample of participants and contextual information about their experiences. This increased the likelihood that the results could be applied to a similar group of people in similar circumstances. During each interview, probing questions provided detailed insight to answer the research question. Dependability, the stability of findings over time, and confirmability, the degree that other researchers confirm the findings, were supported using triangulation, reflexive analysis, external auditing, and a code-recode procedure (Henderson & Rheault, 2004; Korstjens & Moser, 2017). The researcher used reflexive analysis via journaling about their potential biases. Another outside researcher did an external audit to see if they came to the same conclusion as the first researcher after studying the same data. Code-recoding is when the researcher codes some data, waits, recodes, and compares the results found (Henderson & Rheault, 2004). The analysis expert of the dissertation served as the second coder and external auditor and stayed in contact periodically with the researcher to review the analysis, determined the need for any modifications to the codebook, and aided in the initial development of themes.

Results

Sixteen participants were interviewed for this study. All participants were therapists who had worked or were currently working in a long-term care setting. The sample consisted of

speech therapists, occupational therapists, occupational therapy assistants, physical therapists, and physical therapist assistants. The longevity of their career as therapists ranged from one year to 27 years. See Table 1 for the demographic data. Six significant themes (Table 2) emerged from the interviews that created a picture of the therapists' experiences in long-term care: causes of stress and burnout, individual ways of managing stress and burnout, systemic changes for managing stress and burnout, COVID-19 and mental health, the definition of burnout, and change over time in work experience.

Theme 1: Causes of Stress and Burnout

Participants expressed their frustrations throughout the interviews about the causes of their stress and burnout while working in long-term care. The situations that caused stress and burnout varied and included delivering the news that a patient is recommended to remain in the long-term care facility, patient deaths, and productivity standards.

Participant 1 talked about being the "bad guys" because the therapists often have to determine when the patient is not safe to go home. Participant 6 also talked about unsupportive family members and that the therapists then said the patient could not go home because the family could not provide care. Participant 1 also spoke about the death of the patients in this setting, noting that "…you need to be prepared when you work in long-term care because you are at these people's end of life, but it still hits you hard." Participant 13 spoke about patient death: "sometimes the death…depending on your personality, it can affect you."

Productivity standards are something that a therapy company uses to measure billable treatment time against time in the facility on a typical eight-hour day (480 minutes). This standard expectation varies from company to company, but the usual range, as noted by interviewees, was 80% to 93%. This means that of 480 total minutes in the facility, a therapist

must have 384 to 446 minutes that are billable to a patient's insurance. Many participants spoke during interviews about how this is their number one cause of stress in their working environment. For instance, participants 2 and 5 reflected on how all expectations forced upon them make it difficult to focus on actual patient care. Participant 2 stated, "The productivity of the therapist…and all of the metrics they force on you is hard, and it's sort of gotten so far away from patient care," while participant 5 noted, "…there are some days when everybody's call light is going off…and I am torn between, do I just stick to my job and get my productivity or do I stop and help this person."

Additionally, participant 9 expressed that everything in their day would need to run perfectly to meet their required productivity without doing anything that "could be considered questionable [fraudulent] or not skilled [not billable]." One participant, 11, raised concerns about how such high productivity standards could be achievable and how these expectations are undoubtedly linked to fraud. Participant 14 related it to feeling like a machine: "We are not machines that can go at the same speed every day… the spreadsheet, by money counters are controlling it." In participant 1's facility, each set of staff has its own standards related to patient care and productivity, leaving participant 1 to feel as if they are at odds with the nursing staff or social services staff; "…that disconnect of us versus them, the facility staff versus therapy staff and getting staff to understand because like the nursing staff doesn't have a productivity standard; they have their patients."

Theme 2: Individual Ways of Managing Stress and Burnout

Individual strategies for managing stress and burnout were an emphasis within the interview questions. Eight participants mentioned that having other rehabilitation therapists to talk to was helpful because they [the other therapists] would understand. Other coping

mechanisms were more straightforward; Participant 5 mentioned that they drink alcoholic beverages to cope, and participants 6 and 10 said they rely on mental health therapy and antidepressants to make it through. Four participants spoke about time off to cope and clear their heads. Participants 1, 4, and 6 stated that they exercise to relieve some of their stress.

On the other hand, participant 1 also said that sometimes, they "shove it [stress] down and keep going because I have to." Participant 8 said they often try changing jobs to alleviate stress, which "hasn't been super successful." Participant 10 talked about how they tried to change their perspective, "I had to remind myself that these are not only my friends, but they are my co-workers. I had to remind myself that I support myself and love these patients; they still need help."

Theme 3: Systemic Changes for Managing Stress and Burnout

Participants' thoughts about how burnout and stress for therapists could better be managed through systemic changes developed as a theme throughout the interviews. Many participants mentioned wanting recognition for their work, to be acknowledged by their company/corporate/director, and improved communication from their company. Participants 16 and 2 suggested more open communication between the employees (the therapists) and upper management to know that the employees' concerns are heard and that changes are discussed before implementation. An idea expressed by participant 2 was to "…humanize some of these changes and give you [the employees] a chance to talk it out. Or if you would feel that somebody would listen to you, care what you have to say."

Many participants also brought up increased pay/raises for and autonomy of the therapists. Participant 6 was frank in that they felt they "needed to be paid more overall" and that improved autonomy and recognition from upper management would alleviate the burnout.

Participant 9 recognized that this work may be more stressful but that a "significant pay raise would make it feel like the hard work is appropriately compensated."

Many of the participants also went back and spoke about productivity standards in the workplace. They collectively felt that removing these expectations would improve the quality of care and reduce burnout among the therapists. The participants echoed one another in that being able to provide the treatment that is appropriate for the patients in the time that is deemed appropriate by them, the therapists, would result in better patient care and reduced stress and burnout in the therapists. Participant 3 thought, "well, I think productivity needs to go out the window. That would be the number one thing because you should be able to go in, do what the patient needs, and not worry about hitting a certain number." Participant 5 added that:

At least for me, having that human element where you can sit with the patient. If they're saying, "I need to go to the bathroom," instead of saying, "hit your call bell, and I'll be back, bye," you can actually take the time to sit there and help them and do things like we used to do, or "my sock is crooked, could you take my sock off and put it back on?" Instead of me being like, that's not billable for me. It will affect my productivity.

Theme 4: The Impact of COVID-19 Overall

Participants clarified that the COVID-19 pandemic changed their work in long-term care settings. A number of the participants spoke about the impact of the death toll of the residents and patients they had known for years. Participant 2 talked about how seeing the patients they had known for years die suddenly and, with no emotional support, they felt overwhelmed, "…you were seeing patients that you knew for many years, and of the few long-term residents we had, we lost 50 [died of COVID-19]. So that alone and without emotional support…everybody was sad. Everybody was overwhelmed." Participant 5 touched on watching

COVID sweep through their building and seeing "halls full of people you love die…in a short period." They also said they were used to losing people, used to dying, but not to that extent, not that amount at once. Participant 6 related COVID-19 to being in hell: "At the end of 2020, like October, November when it was starting to hit us, and then starting to see people getting sick and dying. I was in hell, and like there's no other way to describe it."

Participants also reflected on how COVID-19 affected their coping mechanisms. Participant 8 said, "…but it took away all of our ways outside of work to decompress 'cause you're not allowed to go anywhere or do anything." Three participants also noted how COVID affected staffing within the already struggling settings. Comments were made about how they [therapists] were regaled as heroes during COVID, though now there is a crisis because there has been no reprieve from issues before COVID-19. For example, participant 13 said, "There are many people who have been in it for so long, and they don't feel like they are heard, and nothing is being done about it. We had that whole, like "you guys are heroes, you're doing a fantastic job," and now there is such a staffing crisis." Participants described that the shortage of nurses and certified nursing assistants had put more burden on therapists to provide services outside their true scope of practice. Participant 2 talked about the shortage, "We're just continuing through the motions without any break in the action because now there is no staff, no CNAs. There's nobody." Participant 10 spoke about how they are doing work that's not their job and is not billable, but they are still expected to do it.

Participant 16 brought up how working with COVID patients affected their work/life situation:

> A big slap in the face was being mandated to work with COVID patients. And then, when you tested positive for COVID and did not get paid, you had to use your PTO. That was definitely a big contributor to the burnout. I had two COVID "vacations" that way.

Participant 1 touched on pandemic fatigue and how trying to stay healthy and clean was straining:

> I did what a lot of healthcare workers did or tried. I basically lived away from my family. I was in a completely separate room. I did not touch the stuff they touched. I came home. I showered immediately after I got home from work. I did not wear the same clothes to work as I did coming out. And I worked long hours and stuff like that. And I mean, it was hard. And I mean, everyone's going through pandemic fatigue.

Theme 5: Definition of Burnout

The impact working in long-term care had on each participant was evident throughout the interviews. Within these accounts, each participant defined what burnout meant to them. Participant 1 said, "I think of frustration and exhaustion, and it's not just physical; it's mental and emotional more than anything." Participant 3's definition was, "I guess like just done with it, over with it, like needing a break. But when you go back, it will be the same." One familiar note in many was the dread of going to work. Participant 11 said, "I think of dreading going to work. I think of wondering how you're going to make it through the day. Sometimes it can feel like there is no escape." Participant 5 talked about their inability to "pour from their pitcher."

> I think of those days when I wake up and don't even want to get out of bed because I know I've got to go to work. If I'm the pitcher pouring out the water, there are just days when I'm burned out; my pitcher is empty. I don't have any to pour from.

Participants 9 and 14 described their feelings of burnout as stress, fatigue or not being engaged, not having any passion, just sucking it up, and no longer feeling that they can do that or that that was valued. They described dread and feeling like they could not escape. Deep feelings of trauma felt by participant 16 reflected how burnout made her think:

> I've never been in the service, but it might be a little bit of how people feel after a war. Like those people I went through that with, there's a different level of connection.

Theme 6: Change Over Time in Work Experience

Along with discussing burnout and stress, most participants wanted to discuss changes in their work experience. Many spoke about the types of patients they work with, but several described expectations set upon them by their companies and how it has changed over their years of working. Participant 2 said that over her 27 years of experience, things changed from when there were no restrictions to the amount of therapy you could provide to a patient. In contrast, now the companies have much more regimented allotments. They went on to explain how there was not the kind of "pressure" put on therapists back when they started; the pressure now is to see them [the patients] for as short of a time as possible and get them in and out as quickly as possible. Participant 5 made similar remarks, noting that, over the past few years, there has been a shift in how care is delivered, "from person-centered care to minutes-centered care…and it's just gone from being able to make judgments about when you need to spend more time on something to just being very regimented."

Some participants also reflected on how other healthcare professionals no longer valued their clinical therapist experience. Participant 6 said, "I think it's that lack of autonomy; treated as cogs in a machine or as robots, we are dehumanized." Participant 16 told the researcher how they

have felt stripped of their skill as a therapist in the last few years, such as having a minimal say in everything from the plan of care to the discharge plan.

Participant 16 revealed how they no longer felt respected by other healthcare professionals, "…because I feel like it used to be 15, 20 years ago, we were very respected. Physicians respected us. Nurses respected us." Participant 6 stated they felt that their educational background was no longer a symbol of status; "[I] feel like they [upper management and other professionals] really don't respect our authorities as professionals with higher degrees. Like I have a master's degree."

Not all work experiences the participants spoke about have been entirely unpleasant. One participant talked about how rewarding it was to work in long-term care because they were with the residents during the sunset of their life. Becoming the residents' form of family and comfort and the closeness with other staff was a strong sub-theme throughout various interviews. Two participants talked about how they became like family with their fellow staff and residents and how rewarding it is to ground someone and calm them down. Participant 5 said, "There's a lot of good things too, where I get to know the people well. I know the residents, I know the staff, and there's been good opportunities to sort of make friendships and good rapport with people." Participant 11 mentioned, "a lot of times you become these people's family members and give them a lot of that emotional support and can kind of be someone who helps to calm them down or somebody helps to kind of ground them."

Additionally, participants spoke about their perception of their work environment changing from schooling to their first days to now. Participant 14 brought up advocacy and how they felt they were "…constantly battling for people's quality of life and rights; so much more of it is advocacy than I realized it would be." Participant 11 brought up the recent reimbursement

changes and that the therapy setting is bleak, such as pay cuts for the therapists and reduced treatment time with the patients, "And sometimes it feels like the whole therapy setting, the outlook is very bleak with the assistant [pay] cuts and just general changes in reimbursement and PDPM, sometimes it can just feel very daunting." Two participants spoke about professional organizations, like the American Occupational Therapy Association (AOTA) and the American Physical Therapy Association (APTA), and how they do not feel supported by these organizations. Participant 12 said that professional organizations must stand up and advocate for therapists against predatory employers and insurance companies. They mention that even other clinicians and administrators are not standing up for the therapy profession and are succumbing to the pressure to accept that it is just the way it is now. Participant 12 said they had even reported to AOTA their concern about fraudulent billing practices. Because they were not members of the organization, they [AOTA] did not want to speak to them.

Though the participant interviews were conducted one-on-one, the results demonstrated consistency between the therapists regarding their perception of stress, burnout, COVID-19, coping mechanisms, and work experience. The themes identified throughout the coding process create a particular picture of the experiences these therapists have had during their careers.

Discussion & Conclusion

Rehabilitation therapists include physical, occupational, and speech therapists and assistants for this study. Because of the nature of the job and the level of clinical skill required, rehabilitation therapists commonly find themselves experiencing feelings of stress and work-related stress, known as burnout (Mayo Clinic Staff, 2021). While it is considered that stress that can be managed or enhances one's functioning is defined as good stress (or "eustress"), there is also stress that cannot be addressed or cannot be resolved through coping mechanisms or

adaption; this is considered bad stress (known as distress) (Anjum & Zhao, 2022; Selye, 1975). This study sought to look at burnout in rehabilitation therapists who work in long-term care.

Research Question 1

This research study aimed to answer four questions. The first question was to determine how rehabilitation therapists experience and manage feelings of work-related stress, known as burnout, while working in long-term care facilities. Participants referred to their burnout experience in situations such as poor communication between other staff and employers, staffing issues affecting patient care, and feelings of underappreciation or lack of advocacy by their employers. These experiences are consistent with the literature, which found that if staff perceived their leadership to be adequate, the more they felt they were protected against feelings of burnout (Costello et al., 2019). Evanson (2003) also noted that increased communication from leadership to the employees and improved organizational policies that positively affect a work-life balance aid in the reduction of burnout. The research discusses that employers/companies that aim to build bonds among their employees lead to increased collaboration and responsiveness, ensuring their organization's success (Anjum & Zhao, 2022). Suggestions by participants about ways to make a bond and establish support for employees included an overarching theme of communication. Examples of communication to increase support included having the therapists' voices and concerns heard by their employer and allowing for staff input on changes for each building instead of blanket changes. Other suggestions provided by the participants in this study include bringing in a lecturer of the therapists' choice, counseling those affected by burnout, recognizing the work and successes within the department, and offering stress-reducing activities that acknowledge the therapists' feelings of burnout.

The two most prevalent experiences related to burnout throughout the study were unrealistic productivity standards and the death of their patients. Consistent with the literature, it was found that many skilled nursing facilities (SNFs) see these relationships as functional or transactional and fail to acknowledge the grief that results when residents die (Harrad & Sulla, 2018). The failure to recognize these relationships may impede therapists from effectively moving through the grief process (Harrad & Sulla, 2018). It would be advantageous for facilities and companies to address this phenomenon to reduce burnout from this specific instance.

All 16 participants in the study widely noted unrealistic productivity expectations of the employers. Berry et al. (2022) found that those with any productivity standard had lower job satisfaction and satisfaction regarding the nature of work. Tammany et al. (2019) completed a study on productivity expectations and unethical behaviors and found that productivity goals in rehabilitation practice are related to the rate of unethical behavior observed. Those in the study mentioned above who worked in skilled nursing facility (SNF) settings reported higher frequencies of observing unethical behaviors (Tammany et al., 2019), which resounded in these participants' feelings of productivity creating unethical workplaces.

Participants spoke about managing these feelings by venting frustrations to co-workers, taking personal time off, meditating, drinking alcohol, and doing mental health therapy. Concerning individual manners of managing, many participants brought up ways that policy could be changed to reduce or control feelings of burnout.

The secondary question examined how the COVID-19 pandemic changed how rehabilitation therapists felt and managed burnout while working in long-term care facilities. Participants mentioned that they could not do what they preferred to manage their burnout, such as dance class, gym, or socializing with friends because of COVID. Overall, it did not appear

that COVID-19 changed how therapists felt about burnout, but more so exacerbated the feelings from pre-pandemic.

Research Question 2

The second research question was to determine how rehabilitation therapists define their experiences of work-related stress, known as burnout, while working in long-term care facilities. Participants described their burnout experiences as being physically, mentally, and emotionally exhausted, run-down, over-tired, and having feelings of dread. These findings validated the prior research regarding burnout symptoms felt among healthcare professionals. For instance, the signs of burnout in previous research (Hiyoshi-Taniguchi et al., 2018; Leonardi et al., 2013) are echoed in this current study; participants in this study felt anxious, depressed, and irritable, and some had insomnia. The burnout symptoms noted in this research do not differ from other health professionals, making the treatment of burnout applicable to them if the appropriate steps are taken by all involved. Additionally, the participants in this study described emotional exhaustion, feeling cynical, and lack of professional autonomy. This aligns with prior research by Gupta et al. (2012) that noted therapists with high levels of emotional exhaustion, high levels of cynicism, and low professional efficacy was caused by excessive demands by employers, conflict, and lack of autonomy and respect for their profession.

The secondary question concerned how COVID-19 has redefined burnout while working in long-term care facilities for rehabilitation therapists. After carefully reviewing the data, COVID-19 did not redefine burnout for the current study's therapists working in long-term care facilities. It did, however, add another layer of burnout for reasons such as increased personal protective equipment (PPE) to manage, constantly changing rules about infection control, being mandated to work with COVID-19 patients, worrying about bringing COVID-19 home to their

families, and sharp increases in death of their patients. The participants in the study discussed how COVID-19 added a layer to the feelings of burnout that already existed, which agrees with prior research on other healthcare professionals from 2019 to 2021 that noted increased feelings of stress brought on by fear of bringing the virus home to their family, giving the virus to their patients, and overall physical and emotional burdens (Prasad et al., 2021; White et al., 2021).

It is the responsibility of the employers, the long-term care facilities themselves, and the national and state-level professional organizations to address the different needs and situations of the therapists to promote successful performance in the work environment and reduce employee burnout. Appropriate efforts should be in place to cultivate effective coping mechanisms for work-related stress. Current evidence-based, pre-pandemic techniques that effectively relieve burnout within the workplace include various ideas, for example, using emotion-focused coping strategies, which include acceptance or positive re-interpretation, or cognitive reframing to change the perspective of a situation (Lloyd et al., 2019). These strategies can be implemented in the workplace during staff meetings, when discussing a difficult situation with a patient, their co-workers, and superiors. Burnout can be relieved while increasing job satisfaction by providing therapists greater autonomy and the ability to contribute to decision-making (Aloisio et al., 2018). Creating interdisciplinary staff support groups allows the employees to feel and reduce feelings of burnout (Kandelman et al., 2018). A study by Uyar et al. (2019) found that providing education and counseling to caregivers in long-term care settings helped to decrease their distress.

Some findings within the literature discussed various ways in which burnout could be prevented or remedied. One finding notes that income satisfaction was protective against burnout (Shin et al., 2022), which correlates to the feelings expressed by participants' in the current study

about not being paid enough for their work. Professional associations, mentors, and educators may help therapy practitioners advocate for appropriate salaries to prevent or reduce burnout. Shin and colleagues (2022) also noted that having higher levels of supervisor support for the therapists and therapists themselves having higher educational status (doctorate, master's degree) protected against burnout. The current study supported Shin's findings about higher levels of supervisor support, given that most participants in this study expressed that having increased support from their employers/supervisors would decrease their work stress and burnout. Regarding higher level of education and burnout, the participants in this study had various levels of education, including doctorate, masters, and associates degrees, and all reported similar feelings and experiences of burnout, which did not support Shin's findings that higher levels of education protect against burnout.

Although there is no universal solution to ensure therapist success, understanding what the therapists are experiencing will provide insight to inform the development of best strategies for burnout relief. Regarding the current study, if the therapists can engage with their employers about their feelings or concerns before they are burnt out, they may be more inclined to adhere to the policies and procedures when they feel advocated for and heard. The lack of existing research on burnout in rehabilitation therapists limits the ability of current employees and companies to identify early symptoms of burnout, understand how to manage it, and acknowledge the need for change.

Burnout can significantly affect the quality and effectiveness of the care provided by therapy practitioners, and it can have profound implications for practitioners, clients, and healthcare organizations (Shin et al., 2022). Most participants noted that their employers were either unaware of the burnout felt by the participants or did not care, as evidenced by the

increased push in productivity expectations and reluctance to approve paid time off before and throughout COVID-19 and beyond. Overall, frustration, exhaustion, and disappointment from the lack of resources offered by employers and little to no understanding from their employers left all participants in this study searching for answers on how to reduce levels of burnout.

Study Limitations

Limitations exist in this study. The primary researcher was an occupational therapist who experienced burnout in the long-term care setting. With this in mind, researcher triangulation and memoing were used to address potential researcher bias during data collection and analysis. Using maximum variation and snowball sampling, the goal was to recruit a wide variety of participants who could contribute information from various experiences. Ultimately, the sample included few speech therapists, as only one participated, and more may have offered different insights into their experiences. Selection bias may have affected the study results. Specifically, the therapists who volunteered to participate in the interviews may have had strong opinions on the subject matter due to personal experience. Another potential limitation is that the interviews were conducted via telephone, reducing social interaction and visual communication between the participants and the researcher.

Implications for Future Research

Despite the limitations, the findings from this study have implications for rehabilitation therapists, rehabilitation therapy companies, and professional organizations. After reading and realizing others feel the same, rehabilitation therapists may feel empowered to advocate for themselves to their employers when discussing issues or concerns. After reflecting on this study, employers may also see the importance of changing their policies to help reduce the prevalence of burnout in these therapists and promote systemic changes from within the companies.

Changes to policy regarding time off for mental health days are encouraged, as only two participants spoke about mental health days. Alternately, the rest of the participants talked about the frustrations they felt that PTO was not typically encouraged or that they needed to make up their time off.

Future research into burnout in rehabilitation therapists is needed to expand on the themes found in this study. Including more therapists would allow for a deeper exploration of the phenomenon explored in this study and the use of standardized burnout and stress assessments to quantitatively track the burnout levels in therapists that work in long-term care. Another possible area of research is the concept of rehabilitation therapy companies' expectations of the therapists and the potential for drastically overhauling the policies and procedures to benefit the company, the therapists, and the patients by providing better resources.

One universal rehabilitation policy all participants in this study acknowledged was that the productivity expectations were unrealistic. Productivity standards are a metric that a therapy company uses to measure billable treatment time against time in the facility on a typical eight-hour day (480 minutes). This standard expectation varies from company to company, but the usual range, as noted by interviewees, was 80% to 93%. This means that of 480 total minutes in the facility, a therapist must have 384 to 446 minutes that are billable and documented to a patient's insurance. Therapists felt that with these expectations, patient care suffered. Support from the administration that could help with this issue includes having therapists, instead of corporate staff, determining the appropriate treatment time, as well as allowing for individualized treatment time for each patient. Another way administration could affect productivity standards is by eliminating the standards altogether. Having to count each minute in the day has proved to be stress-inducing for the participants interviewed, and being able to provide the care, treatment,

and any other day-to-day that go into working in long-term care facilities without being concerned about hitting a specific number would ensure patient care is effectively met.

For example, one participant spoke about the pressure of a patient asking for help (needing to use the bathroom, needing water) and feeling like they cannot help that patient because it is not something in their plan of care, thus not billable, thus affecting their productivity if they do it. Another participant mentioned that if they talk to nursing about the patient, need to call the family, or attend a care meeting; these tasks are all non-billable and non-productive time. While non-productive time is "built" into every day, circumstances may affect the overall productivity of said therapist, causing disciplinary action to occur. Additional studies could address these unrealistic expectations and find ways to remedy this. Companies should evaluate policies regarding productivity requirements to ensure adequate levels of employee job satisfaction are maintained and to improve employee recruitment and retention. Participants related these feelings of frustration with productivity expectations toward unethical behaviors.

Broad intervention approaches addressing factors could reduce burnout among rehabilitation therapists in the United States. Future research, advocacy, and policy should address systemic and organizational factors related to burnout to relieve the related consequences and promote a thriving therapy workforce. In summary, action steps taken based on the responses from this study can be used by therapists, rehabilitation companies, and professional organizations to form cohesive and standard policies and improve overall patient care and therapist performance through radical changes.

Conclusion

Burnout in rehabilitation therapists is a real problem many long-term care workers face. Evidence-based strategies must be implemented aimed at reducing the likelihood of burnout.

More specifically, employers should look to understand the sources of stress from the workforce's perception and be proactive in tackling it in collaboration with their staff. Patient care and self-care may prove more complicated when therapists cannot manage their stressors caused by work experiences. This study provides insight that for therapists experiencing burnout, the ability to engage in stress-relieving activities or communicate concerns with their employers is essential for providing quality patient care. It is not only the employer's responsibility to deliver that ability but also the responsibility of the therapists to take an active role in advocating for improved working situations. This study identified potential gaps in the employee-employer relationship and opportunities for improvement in the long-term care therapy system.

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Table 1

Participant Demographics

Participant Number	Job	Years of Experience
1	Physical Therapist Assistant	5
2	Occupational Therapist	27
3	Physical Therapist Assistant	26
4	Certified Occupational Therapy Assistant	5
5	Speech Therapist	10
6	Occupational Therapist	13
7	Certified Occupational Therapy Assistant	26
8	Physical Therapist	9
9	Physical Therapist	13
10	Occupational Therapist	5
11	Physical Therapist	4
12	Occupational Therapist	20
13	Physical Therapist Assistant	7
14	Occupational Therapist	5
15	Occupational Therapist	16
16	Occupational Therapist	22

Table 2

Themes

Theme	Example quotes
Causes of Stress and Burnout	"I mean, we have to be the bad guys sometimes that says, no, you can't go home anymore. No, you can't go back and live with your family because your family can't take care of you." (Participant 1) "…you need to be prepared when you work in long-term care because you are at these people's end of life, but it still hits you hard sometimes [when the patients die]." (Participant 1) [regarding productivity standards] "…it just sort of feels like you're just being whipped and just being like run faster, run faster, run faster until you just can't run anymore." (Participant 5)
Theme	Example quotes
Individual Ways of Managing Stress and Burnout	"I run, I drink [alcohol], we [the therapists] vent to each other." (Participant 1) "When I feel burned out, I request a day off, whether it's just an extra day so I have a three-day weekend to de-stress or clear my head. It could be like going for a walk." (Participant 4) "I've also tried meditation, but really some of the best things that help are just sleeping and hanging out with friends. I used to have hobbies, but now I have kids, like playing with kids, going on play dates, and doing things that fill me back up if possible. And, therapy and antidepressants." (Participant 5)
Theme	Example quotes
Systemic Changes for Managing Stress and Burnout	"But having more realistic expectations of what the therapist can do within a time period would be a deciding factor because I hear about all these people that are doing, co-treat like treating three people at a time and doing all this stuff. And no matter how well scheduled, there's only so much you can do, and having these high productivity standards where you feel like a machine, just putting stuff out, makes it hard." (Participant 5) "Much of it goes back to what I was saying earlier: we need appropriate autonomy and recognition from the

	people above us. Frankly, we need to get paid more." (Participant 6) "I think preventing burnout with a significant pay raise that, knowing that you're getting into the trenches and it's gonna be really hard every day. But knowing that you're getting a higher pay rate than other settings in the therapy world would be beneficial. It's almost like you're choosing the hard thing to do with somewhat of a payout, that I think feeling more compensated for how hard you work." (Participant 9)
Theme	Example quotes
The Impact of COVID-19 Overall	"I mean, I did what many healthcare workers did or tried. I basically lived away from my family. I was in a completely separate room. I did not touch the stuff they touched. I came home. I showered immediately after I got home from work. I did not wear the same clothes to work as I did coming out. And I worked long hours and stuff like that. And I mean, it was hard. And I mean, everyone's going through pandemic fatigue." (Participant 1) "…you were seeing patients that you knew for many years. Of the few long-term residents we had, we lost 50. So, alone and without emotional support, everybody was sad. Everybody was overwhelmed." (Participant 2) "At the end of 2020, like October, November when it was really starting to hit us and then starting to see people really getting sick and dying. I was in hell, and like there's no other way to describe it" (Participant 6) "…but it took away all of our ways outside of work to decompress 'cause you're not allowed to go anywhere or do anything." (Participant 8)
Theme	Example quotes
Definition of Burnout	"I think of those days when I wake up and don't want to get out of bed because I know I've gotta go to work. If I'm the pitcher pouring out the water, there are just days when I'm burned out; my pitcher is empty. I don't have any to pour from." (Participant 5) "The first thing that comes to my mind is stress, fatigue or not engaged, not having any passion, really just kind of sucking it up or getting through each day that you've tried previously so hard and worked so hard and no longer feel

	that you can do that or that that was valued." (Participant 9) "I think of dreading going to work. I think of wondering how you're gonna make it through the day. Sometimes it can feel like there is no escape, or you have to escape if that means quitting and finding somewhere else. Just knowing that you can't go on for so much longer and like something will have to, for one reason or another." (Participant 11) "I've never been in the service, but it may be how people feel during a war. Like those people that I went through that with are, there's just like a different kind of level of connection." (Participant 16)
Theme	Example quotes
Changes Over Time in Work Experience	"…[with PDPM] there's no room for an individualized treatment plan. It's just here; this is the number of minutes you can see them." (Participant 2) "There's a lot of good things to it where I get to know the people really, really well. I know the residents, I know the staff, there's a lot of carryover, and there have been good opportunities to make friendships and rapport with people." (Participant 5) "I think it's that lack of autonomy. Literally treated as cogs in a machine or as robots, we are dehumanized, and that's a strong word to use, but I absolutely a hundred percent stand behind using it. It was dehumanizing, and not just because of COVID." (Participant 6) "Our professional organizations are not asking these questions. They're not standing up for us. We have other clinicians working for people like Navi health, who are just buying into the system. We have administrators telling us this is how it is to get used to it. Everybody is coming at us. This is how it is. Get used to it. I feel like nobody wants to hear my voice. Nobody wants to know the reality of it. And nobody's like advocating for us. And I'm really disappointed in AOTA, APTA." (Participant 16)

Appendix A

Recruitment Post on Social Media

Hello! My name is Christine Hughes and I am conducting a research study for the University of Indianapolis in Indiana. My dissertation is on burnout in occupational, physical, and speech therapists who work in long-term care settings. I am looking to recruit physical, occupational, and speech therapists that currently work in long-term care settings (such as skilled nursing facilities or personal care/assisted living settings). There are no significant risks to participating and no direct benefits of participation. Upon completion of the study, whomever participated will be gifted a $10 Starbucks gift card. The commitment will be a 30-60-minute-long interview via Zoom or FaceTime as well as a follow-up email communication approximately 2-3 months after the interview to verify study themes. If this is something that interests you or if you know someone that may be interested, please message me via email tietsworthc@uindy.edu or Facebook messenger so I can go over my study in more detail.

This research project has been approved by the University of Indianapolis Institutional Review Board (IRB). Approval date 3/14/22 Approval number 01615.

Thank you!

Christine

Appendix B

Study Information Sheet

UNIVERSITY of INDIANAPOLIS

Minimal Risk UIndy Study # 01615
Study Version: 1 Study Version Date: 3/14/22
Informed Consent Form (ICF) Version: 1 ICF
Version Date: 3/14/22

Department of Interprofessional Health and Aging Studies

KEY INFORMATION FOR POTENTIAL RESEARCH PARTICIPANTS

Consent is being sought for a research study and participation is voluntary. The purpose of this study is to understand the experiences of healthcare professionals, specifically those who are physical, occupational, and speech therapists (here forward known collectively as rehabilitation therapists), of burnout while working in a long-term care setting with patients who have memory care deficits. The expected duration s 30-60 minutes of virtual interview time coupled with a follow-up email communication to verify study themes 2-3 months post-interview. A potential risk is psychological risk is stress due to participation and discussion of experiences. There are no direct benefits for participation in this study.

CONSENT TO PARTICIPATE IN RESEARCH STUDY

Burnout of Rehabilitation Therapists in Long-Term Care Settings

Study Principal Investigator (PI): Lisa Borrero, PhD
UIndy Email: borrerol@uindy.edu
UIndy Telephone: 317-791-5944

Lisa Borrero, from the Department of Interprofessional Health and Aging Studies at the University of Indianapolis (UIndy) and Christine Hughes MSOT, OTR/L are conducting a research study.

You were selected as a possible participant in this study because you are currently employed in a long-term care setting, such as a skilled nursing facility or an assisted living facility; work as a rehabilitation therapist, such as a physical therapy practitioner, speech therapist, or occupational therapy practitioner; and work with patients who have memory care deficits. Your participation in this research study is voluntary.

Why is this study being done?

The purpose of this study is to understand the experiences of healthcare professionals, specifically those who are physical, occupational, and speech therapists, of burnout while working in a long-term care setting with patients who have memory care deficits.

What will happen if I take part in this research study?

If you volunteer to participate in this study, the researcher will ask you to do the following:

• Participate in a 30-60 minute virtual interview (via Zoom or Facetime) with the researcher, which will be audio recorded.

- Interview questions will be open-ended and will allow for a semi-structured discussion of the participant's experiences and feelings.

• Participate in a follow-up email communication approximately 2-3 months after the interview to clarify and discuss the researcher's interpretations of the themes drawn from the initial interview.

How long will I be in the research study?

Participation in the virtual interview will last approximately 30-60 minutes. Participants will also engage in a follow-up email communication approximately 2-3 months after the interview that involves verification of interview themes.

Are there any potential risks or discomforts that I can expect from this study?

Although there are no anticipated risks for participation in this study, you may feel emotional or experience psychological distress when considering some of the interview questions. However, you may skip any interview questions or terminate the interview at any time, for any reason.

Are there any potential benefits if I participate?

You will not directly benefit from your participation in the research.

Will I be paid for participating?

You will receive at $10 Starbucks gift card sent via email after your participation is completed.

Will information about me and my participation be kept confidential?

The results of this study may be published in a scholarly book or journal, presented at professional conferences or used for teaching purposes. However, only aggregate data will be used. Personal identifiers will not be used in any publication, presentation or teaching materials. Your responses to this interview will be anonymous. Every effort will be made by the researcher to preserve your confidentiality including the following:

- Assigning code names/numbers for participants that will be used on all research notes and documents.
- Keeping notes, interview transcriptions, and any other identifying participant information in a password-protected MacBook in the personal possession of the researcher.

Participant data will be kept confidential except in cases where the researcher is legally obligated to report specific incidents. These incidents include, but may not be limited to, incidents of abuse and suicide risk.

Will the data from my study be used in the future for other studies?

Your data will not be used or distributed for future research studies even if there is no way for your data to be linked with any information that could identify you.

Will my data be shared in any other way?

Your data will not be shared in any other way.

What are my rights if I take part in this study?

- You can choose whether or not you want to be in this study, and you may withdraw your consent and discontinue participation at any time.
- Whatever decision you make, there will be no penalty to you, and no loss of benefits to which you were otherwise entitled.
- You may refuse to answer any question/s that you do not want to answer and still remain in the study.

Who can I contact if I have questions about this study?

The Research Team:

If you have any questions, comments or concerns about the research, you can talk to the one of the researchers. Please contact: Christine Hughes at tietsworthc@uindy.edu or Lisa Borrero at borrerol@uindy.edu.

The Director of the Human Research Protections Program (HRPP):

If you have questions about your rights as a research participant, or you have concerns or suggestions and you want to talk to someone other than the researchers, you may contact the Director of the Human Research Protections Program, by either emailing hrpp@uindy.edu or calling 1 (317) 781-5774 or 1 (800) 232-8634 ext. 5774.

You will be given a copy of this information to keep for your records.

You do not need to sign this, or any other document to indicate your consent. Participation in the interview indicates that you are willing to participate.

Appendix C

Interview Guide

Introductory Paragraph

Thank you for agreeing to be interviewed for this study. This interview is being conducted to meet the requirements of my dissertation research study at the University of Indianapolis. As such, the results of this interview will be disseminated via my dissertation manuscript, a class project.

This study aims to investigate rehabilitation therapists' experience managing stress while working in a long-term care setting with patients with memory deficits. The questions you will be asked today will focus on your experiences with direct provision of care in the long-term care (nursing home, skilled nursing facility) setting. The questions will focus on the knowledge and management of stress associated with working with patients with memory deficits.

There are no known risks associated with this study. The expected benefits of the study are the potential to understand rehabilitation therapists' experience with stress, investigate how to manage stress, and reduce the risk of potential burnout.

The interview should take between 30 and 60 minutes, and all information discussed in the interview will remain confidential, meaning your name, credentials, and place of work will not be associated with the research findings. Please know that you may stop the interview at any time to ask questions or clarify content. You may also skip any question that you are not comfortable answering. Do you have any questions before we begin? If you agree, today's interview will be recorded, allowing me to capture everything said. Can I start the recording?

Interview Questions

1. What has it been like working in a long-term care setting for you so far in your career?

- Can you elaborate on your experiences?

2. What are the types of patients you work with in this setting?
    - Can you describe your experience working with patients with memory care deficits, like dementia and Alzheimer's disease?
        1. How do you feel about working with such patients?
        2. What is your approach to working with those with memory deficits in long-term care?
3. Tell me a little more about your role at the facility.
    - What are some challenges and successes you have faced within your work?
        1. How do you handle or cope with challenges or unexpected changes as you encounter them?
4. I want to get more specific now. What does your day-to-day look like while at work?
5. Can you tell me about stressful situations or patient experiences while working in a long-term care setting?
    - Given the experience(s) you described above, what do you think about the experience of stress in long-term care settings?
        1. Do you feel you also experienced stress while working with patients with memory deficits?
        2. If so, could you elaborate?
6. What do you think of when you hear the word “burnout?”
    - To what extent might you have experienced the feeling of burnout?
    - How have you dealt with the feeling of burnout?

7. What do you think about burnout concerning working in long-term care and with those who have memory care deficits?
8. How do you feel burnout could be prevented or better managed for therapists in long-term care settings working with those with memory care deficits?

Your interview data will be managed by recording the interview on the Voice Recorder app on my password-protected MacBook laptop. The interview will then be transcribed via a Temi app and stored on my MacBook laptop. All interviews will remain stored this way during data collection, analysis, and dissemination, and once the final project is complete, they will be erased from the computer's hard drive. Every person's interview will be assigned a numeric identification code in place of their name to protect their identities.