

RESEARCH ARTICLE

Identifying the sources and impacts of caregiver fatigue and burnout among mental health caregivers: A qualitative approach

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ABSTRACT

Introduction: To identify work-related issues to assist mental health caregivers in identifying sources and effects of caregiver burnout; to establish a dialogue between the participants and identified sources of stress in the workplace to address identified problems; and to make recommendations to local area health services to prevent and manage stressors in a mental health caregiver practice. The proposed study will help the sector by pinpointing the causes of caregiver burnout and burnout in the mental health caregiving profession and offering solutions to those causes. **Method:** 20 experienced registered caregivers working as mental health caregivers were recruited using the snowball method, and convenience sampling was used to target study participants interested in finding reasons for caregiver burnout and burnout at work. Semi-structured interviews were used to collect data, in which questions about relative impact are used to help clients focus on factors outside themselves to solve problems. **Results:** Emotional stress and burnout are the overarching themes of studies conducted on the effects of burnout on mental health caregivers in various settings: job insecurity and labor casualization; problems with management and systems; challenges with the nature of work; inadequate resources and services; problems with other health care; aggressive and criminal consumers; and belittling consumers and caregivers. **Conclusion:** The physical and emotional constraints of work all contribute to mental health caregivers' experiences of caregiver burnout. Employees' ability to deal with and respond to pressure in the workplace has been shown to be negatively affected by stress.

Keywords: burnout; carer fatigue; mental health caregivers; qualitative research

1. Introduction

Caregivers' exhaustion and burnout effects have been studied by scholars and practitioners. Caregiver exhaustion and burnout were reflected in professional networks, corroborated by the repercussions identified in the literature. It's no secret that many people working in the medical field struggle with burnout or tiredness from providing care. Gérain and Zech compare "letting oneself dry for others" to caregiver burnout^[1]. People in caring professions often experience or observe in their peers a cognitive and emotional state characterized by emotional weariness, depersonalization, and diminished personal performance. Signs of burnout include low motivation, low self-esteem, increased output with decreased intake, a lack of hope or optimism, an unwillingness to consider other methods of accomplishing goals, a pessimistic outlook, and an overall sensation of exhaustion^[2].

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Historically, mental health nurses have had a bad rap for being overworked and exhausted. Community mental health nurses (CMHNs) and speech therapists matched for first place in a stress rating among National Health Service workers in the United Kingdom^[3], followed by ward-based mental health nurses and general nurses. According to the research, 37% of the sample met the criteria for caseness on the General Health Questionnaire (GHQ)^[3]. A person's "caseness", as measured by the GHQ, indicates how likely he is to suffer from a mental health disorder. 41% of CMHN and 28% of ward-based mental health caregivers scored within the caseness range. The feeling of worthlessness is linked to burnout. 20% of 245 caregivers in the field of mental health indicated low self-esteem^[3]. CMHN and ward-based mental health caregivers were given the Maslach Burnout Inventory and the General Health Questionnaire by Endang et al.^[4] and Sherifali et al.^[5], with the following outcomes: compared to their ward-based counterparts, CMHN showed higher levels of psychological distress, emotional weariness, and moderate depersonalization. Those who work in the wards tend to get better results on the depersonalization and self-actualization scales. Researchers found that those working inward were more likely to feel disconnected from their patients, less likely to feel empathy for them, and more likely to be dissatisfied and pessimistic about their careers. Caregivers in the field of psychiatry often spend a lot of time with, and emotionally invest in, their patients who suffer from serious mental illness, which has been linked to increased stress levels for those^[6]. Acknowledging a number of challenges associated with mental health caregivers and the nature of providing care for seriously disturbed patients in an unpredictable context, some staff members have criticized efforts to preserve professional care standards for mental health caregivers^[7]. The Vaitheswaran research compared the stress levels of community mental health nurses to those of mental health nurses who worked in hospital inpatient wards^[8].

Professional networks reported incidences of caregiver fatigue and burnout, which reflected the trends and effects documented in the literature. Carer fatigue or burnout is an acknowledged danger for health workers. Burnout shares several common features: decreased energy, decreased self-esteem, output exceeding input, a sense of helplessness/hopelessness, being unable to perceive alternative ways of functioning, cynicism, negativism, and a feeling of self-depletion. Mental health caregivers, as a discipline, have always been associated with stress and burnout. The lack of community facilities to refer clients to, the knowledge that clients will likely face wait lists before they can access the service, the isolation that comes with dealing with suicidal clients, the lack of time for study and personal development, the struggle to provide consistently high-quality care, the distractions that come with working in an office setting, the feeling that there is insufficient hospital back-up, etc., all pose difficulties^[9].

Caregivers working in patient wards, on the other hand, reported low morale and a poor atmosphere within the organization, a lack of consultation from management regarding significant structural changes, the knowledge that individual patient care is being sacrificed due to a lack of staff, and working with fewer resources were among the most difficult aspects of their jobs^[10].

The current social and political context of change inside mental health institutions is a major contributor to burnout in most developed countries. After the closure of acute mental wards, a study measuring psychiatric caregiver satisfaction with psychiatric care indicated a considerable drop in morale^[10]. Patient turnover increased significantly with shorter lengths of stay, overcrowding, an increase in disturbed patient behavior, an increase in violent episodes, and a lack of aid during emergencies, all of which contributed to the low morale. Vaitheswaran claims that mental health nurses experience dissatisfaction and burnout as a result of shifts in the mental health system^[7]. As a result of these shifts, patients are increasingly being cared for in the community, which has led to a number of challenges, including a greater consumer burden, understaffed units in institutions, and a greater need for nurses to deal with an increased patient load. Studies have shown that different types of caregivers are faced with varying degrees of stress^[11]. Additional research is warranted when

it was determined in a series of studies on stress in caregivers^[12] that caregivers in a wide range of professions experience stress. More than half of caregivers and midwives in research reported feeling moderate to severe stress^[13]. Caregiver is one of the most stressful professions, as evidenced by the high rate of female caregiver suicide^[14]. Caregiver fatigue and burnout are serious problems that affect all caregivers, but especially those who work with the mentally ill, as evidenced by several studies. The proposed study will help the sector by pinpointing the causes of caregiver burnout in the mental health caregiving profession and offering solutions to those causes.

2. Method

Given the collaborative character of the study aims, a qualitative approach guided by the storytelling or self-narrative therapeutic methods of Yunitasari was selected as the methodology of choice^[11]. In the field of mental health, the relevant discourses that inform practice provide the framework for interpreting and making sense of experience. Consequently, mental health professional burnout is the result of professional experiences understood within the mainstream narrative of emotional stress and weariness.

2.1. Ethical repercussions

Prior to the initiation of the project, both the university and the local health department had granted ethical permission. The researchers guaranteed the project's ethical integrity by adhering to the standard precautions on anonymity and confidentiality, especially given the possibility of identifying participants locally.

2.2. Accessing individuals

All necessary ethical reviews of the project have been concluded in advance of its release. The study lasted from the beginning of 2022 to the end of that year. Participants were registered caregivers working in the mental health care field who self-identified as caregivers and were willing to talk about their experiences with caregiver exhaustion. They also had to speak English or offer an English translation. Twenty seasoned, trained caregivers from both the medical and community sectors took part in the study. There were five men and fifteen women. The participants' ages ranged from 25 to 50, and they had, on average, five years of experience in the field of mental health. Participants interested in the reasons for caregiver stress and burnout in mental health caregiving were identified through a combination of the snowball recruitment method and convenience sampling. Caregiver fatigue, not burnout, was the focus of the application drive. Some caregivers may have avoided the term "burnout" because of its negative connotation. It has come to be associated with being utterly overwhelmed by job stress, instead opting to recognize varied degrees of caregiver burnout. According to the principles of qualitative research, which highlight the context-dependent features of process, experience, and language, the sample size was adequate^[15]. As a result, the goal of this study was not to collect data from a massive sample in order to draw conclusions or make predictions, but rather to gauge the depth to which people's experiences varied. With the shift in emphasis to the lessons that participants acquire in the course of the research itself, the methodology itself became as crucial as the results that were originally anticipated.

2.3. Data collection

Semi-structured interviews were used to compile the data, with the questions asked serving as the initial stage of the narrative therapy approach proposed by Yunitasari^[11], in which relative influence inquiry is used to externalize the issue. The scope of the questions about relative importance was limited to "mapping the problem's effect". Emotional exhaustion and stress were the prominent themes in the questions on the effects of burnout on mental health caregivers in various settings. The interviewer might have said something like,

“We welcome your involvement in our study”, to kick things off. If you are a mental health caregiver and are feeling burnout, please participate in this study. Your participation in this study is essential to its success.

Research participants were asked to share their experiences through practice stories once the study’s goals and methods were outlined. Caregiver exhaustion was explored through three sets of questions: (i) How does your mental health caregiver practice affect your experience of caregiver fatigue? (ii) How has your caregiver’s exhaustion impacted your role as a mental health caregiver? and (iii) What are some of the ways you have sought to manage your caregiver fatigue? Participants were given the opportunity to share their experiences; if they were having trouble keeping the story moving, moderators would ask follow-up questions such as “What happened then?” or “Who was responsible?” In response to “What was your role?” and “How do you feel about that?”, we provided a few possible answers. The interviewer has a doctorate and has worked with sensitive topics before. We started the interview by getting basic information like age, job title, and years of experience. Initial interviews with each subject lasted around an hour as researchers sought to identify the root causes of exhaustion among caregivers. Due to the fact that the data validation method was given sufficient time during the original interview, no follow-up interviews were necessary. It was decided to tape-record the interviews so that they could be transcribed afterward. No one seemed to mind that the meeting was being recorded.

2.4. Data analysis

Once, right after the interview, via clarification, and again later, using data analysis procedures, the data was evaluated and interpreted. While discussing the interviewees and interviewer’s actual work experiences, interesting insights naturally emerged. The second level of analysis required participants’ rapid recognition of these notions and reporting them as part of the audiotaped data. Computer-assisted theme analysis was used to read and reread the transcriptions and evaluate the data. The identified themes and subthemes shed light on the experiences of caregivers and informed recommendations for the Area Health Service’s Mental Health Division.

After the interviews were conducted, the participants’ stories were transcribed onto a computer disk, pseudonyms were used and identifying information was changed to protect identities, and the interviews were analyzed separately to determine the causes and consequences of caregiver burnout. Researchers decided not to provide any information about the study’s context or individual analyses thereafter to protect the privacy of those who had admitted to experiencing caregiver tiredness and burnout.

3. Result

The following paragraphs will go through what stress is, what causes it, what symptoms it may produce, and what you can do about it. Caregiver fatigue and burnout in the mental health field are caused by a number of factors, including but not limited to employment insecurity and casualization of the workforce; problems with management and the system; difficulties inherent to the work itself; insufficient resources and services; difficulties with other Health Care; consumers who are aggressive and criminal; undervaluing consumers and caregivers; and the physical and emotional constraints of the job.

3.1. Employment insecurity and casualization of the workforce

Participants voiced their worries about job security. Despite only working two days per week, Participant 1 has been at their current contract job for the past year. As for what will happen after the contract expires in two weeks, Respondent 1 said he was unsure. Although the individual had already applied for another post, they stated:

It's really difficult to get work in a rural area, and I doubt I'll be offered this position because I assume it's already been filled. That's just going to make things more difficult.

The growing fatigue felt by caregivers can be directly linked to the trend toward a more casual work environment. Following is an excerpt from the interview that shows why this is a cause for concern.

While in this rural, I've held a number of different jobs. The high unemployment rate in the area is exploited by the contract system, which places workers on temporary contracts. Your chances of getting the next contract go down if you take too many sick days, complain too much, or any of a number of other factors. If you complete the task, if you do extra work if asked of you, if you don't complain, and if you don't open your mouth, you will be offered another contract. (Participant 15).

3.2. Issues with management and the system

There were a lot of people who had issues with management. One common theme that emerged was that the “system” itself was to blame for people's exhaustion.

The culture of the system as a whole is my main interest, not any specific users. The bottom line, I guess, is that some people are to blame. For whatever reason, the sum of the parts is more than the sum of the parts. I can't see how one would go about altering the society. I can't say for sure whether or not my actions have influenced the cultural change. In my experience, I have found that there is a general policy of quiet amongst employees here. It sets the bar for institutional paranoia very, very high. It's not like I'm completely alone. Unfortunately, it has worn me down to the point of exhaustion. In its place of isolation, it renders you helpless. (Participant 8).

3.3. Difficulties with the nature of the work

Regarding role activities, lack of time, the nature of chronicity, worry for clients, unpredictability, perceptions, and expectations, lack of continuity, and the thankless character of the labor, the nature of the work was a major cause of caregiver tiredness and burnout.

Paperwork was mentioned while discussing Participant 1's job obligations. *I understand the value of records, but I'd rather be out in the field helping actual people. They have started keeping track of an unanticipated daily need. The current work restrictions preclude us from doing so, but even if we could, it would have been agony for me. To become proficient with a system, one must first learn it. Ultimately, if I had to choose between entering my data and spending 30 minutes with a client, I would always choose to spend time with the client.*

Participants described how time constraints hindered their practice. *As an illustration, I frequently experience anger and anxiety when I am unable to assist others. You are aware that they would benefit from you spending more time with them or assisting them with activities... You simply hurry about. I frequently forget to drink and urinate since I'm so busy going around and trying to get things done. I lack the time to adequately compose the reports. (Participant 1).*

The chronic character of a number of mental disorders adds to the daily strain of providing care for individuals. *I find it difficult to fathom, for instance, the persistence of mental illnesses and the extent to which some people are tormented. Some of them are extremely wretched, with no remedy or improvement possible. It seems as if certain individuals are destined to be miserable regardless of what they do; the struggle they endure... The thing that disturbs me the most is the torment that some people endure due to their voices and madness, with no relief no matter what they take. This is what makes my heart ache. That is, they receive some respite. Medicine does assist. (Participant 10).*

Participants discussed how their care for clients played a significant role in their careers and, in turn, contributed to their exhaustion as caregivers. One of the participants (5 out of 6) reported feeling emotionally invested in the consumers:

Those who struggle with mental health issues are resilient. Whatever the future holds, they will be able to weather it. Topics related to mental illness have never been popular. They have no community to lean on for help. If you look at what our community mental health centers are doing, you'll see that it's grown. In addition to the outright animosity, there is also the emotional toll of having so much invested in patients who ultimately will not succeed despite your best efforts. At times, it may be really irritating and infuriating.

Participant 18 said, “*We regularly see persons that are pretty disruptive in the community,*” referring to unruly customers in the area. *The majority (95%) of the world's population needs to be locked up. They are most comfortable in an institutional setting because to their long history of receiving care there. To my mind, there will always be a select few who need the loving attention of a caretaker. But because that's not the case, we need to keep them around.*

Job stress is increased by the irregular nature of the work. Challenges in daily planning, as expressed by Participant 9:

As new students enter the classroom, you must be alert to their presence even as you carry out your own duties. Students are expected to study, but it may be challenging to structure their time in a way that allows them to really do so. Due to the rarity of scheduled meetings, here... I drove to (a neighboring city) this morning to visit with two Aborigines who had medicinal needs. After over two hours of searching, I finally found one. That's just going from one person's house to another. Every week, in an attempt to discover new customers, this takes place. It's safe to say that I've been to every house in (another town). My next stop is (another city), where I want to carry out the same steps. At times, the pressure might seem insurmountable... You're always on the lookout for something better.

Participants discussed the mental health caregiver role from their own and others' perspectives. Example 17: “There is a lot of duty but not a lot of rights”, as stated by a participant:

Sometimes, and I feel this is the true in all areas of caregivers, you have a tremendous degree of obligation but little rights. They're in charge of making sure patients have their prescriptions filled, but we can't write prescriptions ourselves. Patients' safety is our first priority, yet we lack the discretion to choose who is admitted. Even when you are disabled or disenfranchised due to these factors, you are still responsible for some things.

Some people's workplace tension comes from the fact that they don't know whether they'll ever see the same customer service rep again. *When you take time off, patients may no longer require your services since their acute care has been resolved. You seem to be providing temporary bandages rather than serious medical attention. In this case, too, the fault is with the system itself. In a team setting, we do follow-ups on acute cases, but there are times when I wish we could give the patient a little more time. Unfortunately, time constraints and the need to work solo on certain shifts prevent us from doing so.* (Participant 7).

Mental health workers are underappreciated, participants agreed. *For instance, I understand that some of the dissatisfaction is inherent to the work itself, and I realized early on that the payoffs were little. It was the sight of flowers and chocolates left for caregivers by appreciative patients and their loved ones in every regular hospital ward that first convinced me of this. After (many years of) watching children, I remember once getting a box of cigars and a few cans of beer from a relative who was grateful that we kept watching her kid. This is*

just the way reality works. However, it is nice to have a job every once in a while, when your efforts are recognized. (Participant 16).

3.4. Because of little funding and support

The participants all agreed that there was a lack of time to engage with customers, a paucity of staff, and a general lack of services and resources. Concerns voiced by participants included the following:

Whether you agree with it or not, the mentally ill are scared of the public, and the general population is frightened of them. This highlights the need for proper treatment and locations where they may feel secure. (Participant 5).

Neither of these things are available to you. You want to alter the way a team operates, but you can't since we've already spent too much. Such inconsequential matters. No major needs on my end. There has been no change to the status quo. I need a companion, educational opportunities, and supportive individuals in my immediate vicinity. (Participant 9).

When I think about what stresses me out at work, it's the time restrictions. We have a fixed amount of time and a list of jobs to do, but not enough people to get it done. My sole source of anxiety is that. Staffing constraints now require us to work longer hours than is ideal. (Participant 7).

The biggest failure of caregiver, in my opinion, is a lack of time for communication with patients. You are too busy to have meaningful interactions with patients. They are so attentive in (here) that it often hinders conversation since nothing they say makes sense. It's heavily reliant on pharmaceuticals and paperwork; as a result of the high admissions rate and the many calls we get, people are unable to benefit from it. (Participant 20).

3.5. Relational issues in medical care

The participants all agreed that there was a lack of time to engage with customers, a paucity of staff, and a general lack of services and resources. Concerns voiced by participants included the following:

Well, I've noticed that sometimes healthcare providers focus too much on the medical aspect of care and neglect the emotional needs of patients. It's crucial to have a strong patient-caregiver relationship for holistic care. (Participant 5).

I've seen instances where patients feel rushed during appointments or don't receive clear explanations about their conditions and treatment options. This lack of communication can lead to confusion and decreased trust in the caregiver. (Participant 8).

Caregivers often sacrifice their own well-being to support their loved ones. They face immense physical and emotional demands, which can lead to burnout over time. This affects their ability to provide effective care. (Participant 7).

Caregivers should be encouraged to prioritize their own well-being and seek support from others. Providing respite care, counseling services, and support groups can be helpful in preventing burnout. (Participant 20).

3.6. Negatively aggressive and illegal buyers

Numerous comments were made on the members' need to serve as guardians of criminals, and several accounts of potential and actual acts of violence by aggressive customers were reported.

There have been so many demands under Section 33 that our team has begun to resemble a forensics group. Those who aren't crazy may be safely disregarded. We get them sent here. It's not uncommon for

them to hang around for a minimum of 48 hours. They are not mad in the eyes of the law, but they are looking for proof that they were not solely responsible for the crime they committed. At the very least, this is frustrating since it means a bed is being denied to someone who is truly unwell but has the means to check in. (Participant 5).

3.7. Consumers and caregivers are undervalued

Consumers and caregivers in the field of mental health were not seen as separate and united groups, according to participants.

The respondent said that people with mental illness are politically silenced. Never in the history of this month have they been a best-seller.

In the second discussion, participant 2 voiced his or her opinion that both caregivers and recipients are underappreciated:

My main worry is that we don't have enough people and aren't being given enough value. Our patients are also being underappreciated. They are parents, siblings, and children who are unable to spend time with their loved ones because of sickness or other hardships. Since the caregivers as a whole possess an extraordinary depth of knowledge, it is hard to feel underappreciated. It must be tremendously disheartening to see their knowledge and ability to identify a patient just by walking into a room disregarded.

3.8. Physical and emotional constraints of the work setting

The participants agreed that the workplace's physical constraints were a factor in the exhaustion they experienced as caregivers.

My impression is that morale is low since (work place) is always at the bottom. This must be an awful experience for the patients, yet it is also very boring. It undoubtedly affects your mood, even if just subconsciously. (Participant 17).

Hand-to-hand violence between caregivers.

Participants reported that interactions with other caregivers were both meaningful and taxing on their mental health. Participants expressed their worries about their coworkers, their beliefs that their coworkers do not look out for their interests, and the need for introspection in the following ways:

I will draw aside a worried caregiver. But because of how long I've been here and how often I've had to do it; I've learned to take a step back and look at things like that... That much is evident. Your direct question to them is, "Hey, do you have to do all that for that client?" Please hold up. It's okay to ask the client to chip in. The reason for this is that there comes a time when doing it yourself is quicker than letting the client do it. (Participant 9).

For the most part, I don't think my colleagues and I are capable of looking out for ourselves. There is a widespread stigma that attaches itself to showings of fragility, with the implication that the person in question is helpless. (Participant 14).

There are probably a few tweaks that could be made, but they're not that appealing in my opinion. Our routine has to be scrutinized. Instead of focusing on what the government or other healthcare groups are doing, we should examine our own methods to see where we can improve. (Participant 20).

When it comes to horizontal violence, I am always trying to resolve fundamental problems. Nothing is spoken to the person directly; instead, all comments are either backhanded or critical of others. (Participant 9).

3.9. Dealing with and reacting to the effects of stress

People opened up about their own methods for dealing with stress and the impact that stress from work has had on their lives outside of the office. Weakness and inability to sleep, establishing limits and constraints, trying new methods of coping, considering other career options, and dealing with unique personal concerns were some of the responses.

The following is a compilation of participant-reported data that has been abstracted as far as feasible to safeguard individual privacy. The tension has made me a little short-tempered. I might get short and irritated with people if this situation drags on for too long. I have been known to cry in public on rare occasions, usually when I am feeling really uncomfortable or trapped. When I do get into bed at night, I have a hard time falling asleep, which is a major cause of distress for me. It does not happen every single night. It's gotten bad, and it might become worse yet (suggests a reason). (Participant 10).

For (a lot of) years, I've worked as a mental health nurse. My parents and teachers always stressed the importance of not bringing work home with you. As I was leaving, I made one last-ditch effort. My rule was to never take work to the house. There are benefits and drawbacks to it. The upside is that you won't become attached to your patients' problems and let them affect your own life when you go home. Even though I am lucky in that I am able to express my feelings to my partner, I have a tendency to keep them bottled up within. (Participant 5).

Without a loving (partner) to talk to when I get home, I fear I would go nuts. Many times, during the day, I find myself feeling quite down. No longer do I care about food or comparable activities. In a word, it makes me sad. Having my (partner) there to talk to is quite useful, as I've said before. At home, I tend to have a bad mood rather often. Clients are not an outlet for my anger. (Participant 6).

In spite of the fact that I think I'm still doing a good job and that my interpersonal skills are strong, I'm starting to think about exploring other options rather than sticking with the current one. (Participant 14).

4. Discussion

All of our concerns in this study point to the origins and outcomes of stress in the workplace for caregivers. It's amazing to see how the 20 people involved in this project's local themes reflect those found in the national and international literature on mental health care and mental health caregivers.

Nursing professionals working in the field of mental health are especially at risk for experiencing burnout and caregiver weariness^[6], investigated the causes of this national issue. In response to "widespread concern about the mental health caregiver workforce in Australia," the Australian Health Minister's Advisory Council asked them to conduct a scoping assessment of the Mental Health Caregiving System Down Under. The researchers arrived at this result after reviewing a variety of sources, such as national and foreign literature, consumer organizations, and other stakeholders^[16]. Those in the mental health industry report experiencing immense stress on the job. Caregiver stress and burnout are linked to (i) the rapid pace of change in mental health services, (ii) the belief that the caregiver's personal safety is at risk in acute units and the community, and (iii) the belief that mental health services are needlessly bureaucratic; and (iv) the need to reform caregiver education. Recent research indicates that Bachelor of Caregiver programs are not providing adequate preparation for entry-level mental health nurses. In addition, the attitudes of some mental health providers discourage students from pursuing careers in the area^[17].

The first theme is based on the experiences of our participants and includes things like problems with the nature of the work, aggressive and criminal customers, physical and emotional constraints of the work environment, employment insecurity and casualization of the workforce, flawed management and systems, and a lack of resources and services. It is possible that some of the stressors experienced by the majority of our study's participants were directly related to a lack of educational preparation in mental health caregivers, despite the fact that these participants were qualified, experienced clinicians whose primary problem was a lack of recognition by other members of the Health Care team of what they knew and how they practiced. Due to a lack of domestic studies in the field of mental health caregiving, we evaluated international studies and found that 18 out of 20 problems could be solved by improving communication between caregivers^[18]. Yunitasari compiled a list of the stresses experienced by mental health caregivers in the community and hospitals with emergency patients, based on findings from studies performed in various countries and published in academic journals^[19]. There was a correlation between the organizational, environmental, and professional difficulties experienced by caregivers^[20] in acute admittance hospitals and caregivers in the community mental health setting (CMHN). Our study's mental health caregivers identified all of the stressors compiled by Greenhawt et al. from international literature, and participant accounts of these stressors are included in this article, despite our not trying to differentiate between acute inpatient and community mental health work contexts in our study^[21].

Conclusions from our research indicate that burnout syndrome is associated with the after-effects of occupational stress^[22]. Participants discussed the many ways in which emotional exhaustion, depersonalization, and diminished personal accomplishment manifest in their lives, such as through physical symptoms like fatigue and insomnia, the setting of limits and boundaries, the adoption of coping mechanisms, the exploration of new professional opportunities, and the development of new personal problems.

The recommendation of this study is to explore further issues related to prevention and suitable treatment for caregivers so that they do not carry out effective coping. The research contribution is very large from the point of view of caregivers who experience burnout, so it becomes a consideration for junior caregivers, researchers, and policymakers.

5. Discussion

Although the study's descriptions of stressors and stress effects were supplied by just 20 local mental health clinicians, they are representative of national and international results. This study's reemergence of old problems in mental health caregivers is indicative of the pervasiveness of stress in the workplace and the seeming impotence of research to produce real and permanent change in individuals and their environments. This study highlights the power of ingrained work cultures and organizations that are resistant to significant change despite the personal sacrifices suffered by the caregivers involved.

This article examines the extent to which mental health caregivers experience burnout and tiredness, as well as their attempts to discuss the sources of their professional stress. The participants' motivation to take part in the research implies they are looking for ways to understand the sources of their stress and work to reduce them. In addition to increasing caregiver stress and exhaustion, several participants worried that taking part in the research would make them easier targets for their oppressors. According to the stated goals, suggestions were given to the regional health office regarding working hours and wage policies for mental health caregivers. However, the readers of this book may use the information in this chapter as a general reference for strategies to improve mental health services by improving the system of recruiting, training, and placing caregivers. Regular forums for open, direct discussion of problems among all parties and ensuring mental health respect were proposed as a means of relieving the stress that caregivers experience on the job.

Staff members' competence in practice may be improved by participation in relevant committees and promotion to leadership roles in the organization's hierarchical structure.

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Conflict of interest

The author declares no conflict of interest.

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