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The Experience of Burnout of Rehabilitation Therapists in Long-Term Care Settings: A Qualitative Exploration

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The Experience of Burnout of Rehabilitation Therapists in Long-Term Care Settings: A Qualitative Exploration

Abstract

Background: Burnout among health care workers is growing among long-term care staff, with various repercussions. Research about how rehabilitation therapists (occupational, physical, and speech) perceive and experience burnout in such settings is limited. Understanding these experiences with burnout in long-term care is necessary to address burnout. This study investigated rehabilitation therapists' perceptions of and experiences with burnout while working in long-term care.

Method: The researcher used a qualitative interpretive approach to guide audio-recorded and transcribed interviews. The data were analyzed through coding and then themes were developed.

Results: Six themes emerged: 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 should feel empowered to advocate for policies that reduce burnout in the workplace. One policy all of the 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.

Comments

The authors declare that they have no competing financial, professional, or personal interest that might have influenced the performance or presentation of the work described in this manuscript.

Keywords

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

Cover Page Footnote

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Credentials Display

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Individuals working in helping professions, such as health care professionals, are at greater risk for and more susceptible to burnout than non-helping professions (De Hert, 2020; Leonardi et al., 2013). 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). 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 (Harrad & 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 the residents' quality of care. Health care personnel who demonstrate burnout often become desensitized to others (Yıldızhan et al., 2019) and develop negative attitudes toward patients with dementia for whom they provide care (Smythe et al., 2020). Furthermore, they reported feeling emotionally and physically exhausted with low levels of perceived personal success at work (Yıldızhan et al., 2019).

Staff in long-term care (LTC) settings have described working under complex and stressful circumstances during the COVID-19 pandemic, citing fears of carrying the virus and transmitting it to others, as well as increased workloads and physical and emotional burdens (Prasad et al., 2021; White et al., 2021). These challenges burdened the struggling workforce and contributed to increased burnout and reports of anxiety and depression (Prasad et al., 2021; White et al., 2021). Not only did the pandemic affect health care workers this way, but studies have also found that those with dementia demonstrated increased adverse behaviors because of circumstances such as isolation and not seeing familiar family members (Kohn et al., 2021). These behaviors include more anxiety, agitation, and withdrawal because of the stresses of COVID-19, resulting from changes in daily routine and the deaths of familiar residents (Kohn et al., 2021). This may further exacerbate perceived stressors and burdens on health care workers in LTC settings (Kohn et al., 2021).

Research has demonstrated the effects of strain on nursing and physician burnout (Harrad & Sulla, 2018; Kandelman et al., 2018; Medscape, 2020; Smythe et al., 2020). Health care requires a team to operate effectively, and more work is needed to address the experiences of allied health professionals. Further research is necessary on how physical therapists, physical therapist assistants, occupational therapists, occupational therapy assistants, and speech-language pathologists experience and manage burnout while working in a LTC setting and with those with memory deficits. More specifically, there is a lack of research on burnout among rehabilitation therapists who work in LTC settings with patients afflicted with memory deficits.

Rehabilitation therapists are essential for patient care (Developers, 2021; Hatcher, 2023; Hofmann, n.d.). In addition, as the rate of older adults entering LTC settings with memory deficits grows, it is crucial to investigate their experiences with burnout to reduce those rates and ensure job satisfaction. With this in mind, the current study's primary question sought to understand how rehabilitation therapists experience and manage feelings of burnout while working in LTC facilities. Secondarily, the study explored how the COVID-19 pandemic redefined burnout for these professionals and changed how they experienced and managed burnout.

Method

A basic interpretive qualitative method was used to understand the experiences of burnout among rehabilitation therapists working in a LTC setting specific to patients with memory care deficits. This method, grounded in phenomenology, is an approach that dictates open-ended research questions about how one interprets their experiences (Merriam, 2002). The data are collected via interviews, observation, or document analysis and then analyzed to identify recurring themes (Merriam, 2002). The study began

after the researcher received institutional review board approval from the University of Indianapolis. The research was started in the Summer of 2021 and concluded in the Spring of 2022.

Participants

The researcher used 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 where the researcher purposefully sampled therapists from across occupational, speech, and physical therapies (Patton, 1990) from various LTC sites. The researcher recruited participants by approaching rehabilitation therapists on social media groups on Facebook who worked in various LTC settings. Recruitment via social media involved a recruitment post that included information about the study and the researcher's phone number and email address so they could contact the researcher if interested. For inclusion, participants must have been employed as a rehabilitation therapist in a LTC setting, such as a memory-care skilled nursing or assisted living facility. Being employed at a LTC setting during the COVID-19 pandemic was not a requirement, as the researcher wanted to glean information beyond if or how the pandemic caused burnout, such as burnout before the pandemic. The length of time working in a long-term setting was not a requirement for inclusion, as the researcher was interested in seeing if newer graduates from therapy programs had experiences related to burnout similar to those with more work experience.

The researcher reviewed the informed consent document with each participant during the consent process to ensure their understanding before consent was obtained verbally. The participants were told that the interviews would be audio-recorded and 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.

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 used 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 to15, allowing for representation of various LTC settings and the three disciplines across the participates involved.

Data Collection

The primary researcher, who was trained in qualitative research methods, conducted individual, semi-structured interviews about the participants' experiences with and perceptions of stress and burnout while working with individuals with memory care deficits in a LTC setting. The researcher developed and used a semi-structured interview guide (see Table 1). Each interview began with a broad question about the topic and then proceeded with prompting and follow-up questions. Each subsequent question delved deeper into the participants' experiences, feelings, and perceptions about stress and burnout in their work settings. The interviews lasted between 30 and 55 min. The researcher used memoing from the beginning of data collection to examine perceptions about the data, including how patterns were developing and as a form of reflexivity (Birks et al., 2008).

Table 1

Interview Guide

What has it been like working in a long-term care setting for you so far in your career?
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?
What is your approach to working with those with memory deficits in long-term care?
Tell me a little more about your role at the facility.
What are some challenges and successes you have faced within your work?
How do you handle or cope with challenges or unexpected changes as you encounter them?
What does your day-to-day look like while at work?
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?
Do you feel you also experienced stress while working with patients with memory deficits?
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?
What do you think about burnout concerning working in long-term care and with those who have memory care deficits?
How do you feel burnout could be prevented or better managed by therapists?

Data Analysis

The primary researcher transcribed the audio recordings from the interviews using Temi, an online transcription service, and then cleaned and de-identified the transcripts. Consistent with a basic interpretive approach, thematic analysis was used by the researcher to understand the experiences, thoughts, and behaviors of the participants (Kiger & Varpio, 2020). This analysis involves a 6-step process completed by the researcher: familiarizing with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the analysis (Kiger & Varpio, 2020).

The data analysis process began with a reading of each transcript by the primary researcher; this was done multiple times to allow for immersion in the data. The researcher then used Dedoose (version 9.0.85) data analysis software to begin coding the data on each transcript by highlighting words, phrases, or longer segments of data relevant to the research question and assigning them a label. During this process, the primary researcher worked with a second researcher with expertise in qualitative research to aid in the data analysis. The primary and secondary researchers each coded a transcript independently and then compared their codes until they reached 100% agreement. The primary researcher worked to develop the foundational codebook that was further developed and refined throughout data collection. Both researchers worked together throughout data analysis to discuss the primary researcher’s development of the codebook and overarching themes.

The primary researcher grouped codes into categories and identified overarching themes through the creation of a theme table. The table included quotes illustrative of each theme and its location in the data. The researcher then conducted member checking to elicit participant feedback on the themes to ensure an accurate representation of their experiences. The researcher asked that the participants provide their feedback within 1 week via email. The primary researcher then made any necessary adjustments.

Trustworthiness

Trustworthiness was established by including strategies that supported Lincoln and Guba’s model of 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 was conducted at the end of the data analysis by making the transcript and theme identification available for participant review.

Transferability, or ensuring the results can be applied to a similar sample in a comparative context, was supported by providing a detailed description of the sample and contextual information about their experiences (Henderson & Rheault, 2004). Dependability, or the stability of findings over time, and confirmability, minimizing researcher bias, were supported using triangulation, reflexive journaling, and a code-recode procedure (Henderson & Rheault, 2004; Korstjens & Moser, 2017).

Results

Participants

Sixteen rehabilitation therapists completed the current study, including a speech-language pathologist, occupational therapists (and occupational therapy assistants), and physical therapists (and physical therapist assistants). Career longevity ranged from 4 to 27 years. See Table 2 for the demographic characteristics of the sample.

Table 2

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 Language Pathologist	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

Overarching Themes

Six overarching themes (see Table 3) emerged from the interview data and created a picture of the therapists' experiences with stress and burnout in LTC settings. These included stress and burnout causes, individual ways of managing stress and burnout, systemic changes for managing stress and burnout, COVID-19 and mental health, the definition of burnout, and changes over time in work experience.

Theme 1: Causes of Stress and Burnout

The participants expressed their frustrations about the causes of their stress and burnout while working in LTC facilities. Participant 1 talked about being the "bad guys" because therapists often determine when the patient is unsafe to go home. Participant 6 mentioned unsupportive family members and the family's inability to 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 peoples' 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."

Table 3

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)
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 some of the best things that help are 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)
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 significant pay raises that, knowing that you're getting into the trenches and it's gonna be 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)
The Impact of COVID-19 Overall	"I mean, I did what many healthcare workers did or tried. I 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 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)
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)
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 well. I know the residents and 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 disappointed in AOTA, APTA." (Participant 16)

Productivity standards are a metric for billable treatments based on a therapist's time in the facility on a typical 8-hr day. Many of the participants spoke during the interviews about how this is the primary cause of stress in their working environments. For instance, Participants 2 and 5 reflected on how expectations made it difficult to focus on 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?"

In addition, Participant 9 expressed the impossibility of meeting required productivity unless everything ran perfectly without doing anything that "could be considered questionable [fraudulent] or not skilled [not billable]." 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 mechanics: "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 had its standards related to patient care and productivity, leaving Participant 1 to feel as if they were 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 emphasized in the interview questions. Eight of the 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 of the participants spoke about time off to cope and clear their heads. Participants 1, 4, and 6 stated that they find relief through exercise. Participant 1 also said that sometimes, they "shove it [stress] down and keep going because I have to." Participant 8 said they often try to change jobs to alleviate stress, which "hasn't been super successful." Participant 10 talked about how they tried to change their perspective, saying, "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

The participants' thoughts about how burnout and stress for therapists could better be managed through systemic changes developed as a theme throughout the interviews. Many of the 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 of the participants also brought up increased pay and raises for and the 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 spoke about workplace productivity standards. They collectively felt that removing these expectations would improve the quality of care and reduce burnout. The participants echoed one another in that providing the appropriate treatment for the patients in the appropriate time frame would result in better patient care and reduce stress and burnout. Participant 3 stated, "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:

> 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 take the time to sit there and help them and do things like we used to do, instead of me being like, that's not billable for me.

Theme 4: The Impact of COVID-19 Overall

Although working in a LTC setting during COVID-19 was not an inclusion criterion, many, if not all, of the participants discussed the impact of COVID-19 on their work and clarified that the COVID-19 pandemic changed their work in LTC settings. Many of the participants spoke about the impact of the residents' death toll and connections to the patients for whom they had cared for years. Participant 2 mentioned seeing the patients they had known for years die suddenly and, with no emotional support, they felt overwhelmed, saying,

> 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 the building and seeing the "halls full of people you love die . . . in a short period." They also said they were used to losing people, used to death, but not to that extent, not that number 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."

The participants also reflected on how COVID-19 affected their coping mechanisms. Participant 8 said, "It took away all of our ways outside of work to decompress 'cause you're not allowed to go anywhere or do anything." Three of the participants noted how COVID-19 affected staffing in already struggling settings. 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. Participant 13 said,

> Many people 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 a staffing crisis.

The participants described that the shortage of nurses and certified nursing assistants had put more burden on the 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 16 brought up how working with patients with COVID affected their work/life situation:

> A big slap in the face was being mandated to work with patients with COVID. And then, when you tested positive for COVID and did not get paid, you had to use your PTO. That was 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 health care workers did or tried. I 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 that working in a LTC setting had on each participant was evident throughout the interviews. 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 it was valued. They described dread and feeling like they could not escape. Participant 16 reflected on deep feelings of trauma and 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 wanted to discuss changes in their work experiences. Many spoke about the types of patients with whom they work, but several described expectations set on 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 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 "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 of the participants also reflected on how other health care 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 said they have felt stripped of their skill as a therapist in the last few years, such as having a minimal say in everything from plans of care to discharge plans.

Participant 16 revealed how they no longer felt respected by other health care professionals, saying, "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] don't respect our authorities as professionals with higher degrees."

Not all work experiences the participants spoke about have been entirely unpleasant. One participant talked about how rewarding it was to work in LTC 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 of the 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 and the staff, and there have 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."

In addition, the participants spoke about perceptions of their work environment changing from when they were in school 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 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 of the 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. They [Participant 12] mentioned that even other clinicians and administrators are not standing up for the therapy profession and are succumbing to the pressure to just accept the way it is now. Participant 12 said they had even reported to AOTA their concern about fraudulent billing practices. But, because they were not members of the organization, they [AOTA] did not want to speak to them.

The themes identified throughout the coding process create a particular picture of the experiences these therapists have had during their careers.

Discussion

Because of the nature of the job and the level of clinical skill required, rehabilitation therapists commonly find themselves experiencing feelings of stress, specifically work-related stress, known as burnout (Mayo Clinic Staff, 2021). While some stresses can be managed or challenge one's function, known as good stress (or "eustress"), there are stresses that cannot be remediated or resolved through coping mechanisms or adaption; this is considered bad stress (known as "distress") (Anjum & Zhao, 2022; Selye, 1975). Much of what contributes to burnout reflects distress because of the inability to control the stressors on the job. This study investigated stresses experienced by rehabilitation therapists who work in LTC facilities. The findings are consistent with the literature in that if staff perceived their leadership as adequate or provided a stress buffer, they felt protected from burnout (Costello et al., 2019). Evenson

(2003) also noted that increased communication from leadership to the employees and improved organizational policies positively affect work-life balance and aid in the reduction of burnout. The research discusses that employers and companies that aimed to build bonds among their employees saw increased collaboration and responsiveness, ensuring their organization's success (Anjum & Zhao, 2022). The participants suggested establishing support for employees and bonding among team members, which was 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. Both of these contribute to a sense of control over the job stressors.

The two most prevalent experiences related to burnout throughout the study were unrealistic productivity standards and the death of patients. Consistent with the literature, it was found that many skilled nursing facilities see these relationships as functional or transactional and fail to acknowledge the grief that results when residents die (Harrad & Sulla, 2018). Disenfranchised grief may impede therapists from effectively moving through the grief process (Harrad & Sulla, 2018).

All 16 of the participants in the study widely noted unrealistic expectations of employers for productivity. Berry et al. (2022) found that those with any productivity standard had lower job satisfaction and lower 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 settings reported higher frequencies of observing unethical behaviors (Tammany et al., 2019), which resounded in these participants' feelings of productivity creating unethical workplaces. Overall, it did not appear that COVID-19 changed how therapists felt about burnout but instead exacerbated the feelings from pre-pandemic.

The participants described their burnout experiences as being physically, mentally, and emotionally exhausted, run-down, over-tired, and having feelings of dread. These findings validated previous research regarding burnout symptoms felt among health care professionals. The findings in this study echo the signs of burnout in previous research (Hiyoshi-Taniguchi et al., 2018; Leonardi et al., 2013): the participants felt anxious, depressed, and irritable, and some had insomnia. The burnout symptoms noted in this research do not differ from those of other health professionals, making the treatment of burnout applicable to them if the appropriate steps are taken by all involved. In addition, the participants in this study described emotional exhaustion, feeling cynical, and a lack of professional autonomy. This aligns with prior research by Gupta et al. (2012) that noted high levels of emotional exhaustion, high levels of cynicism, and low professional efficacy among therapists were caused by excessive demands by employers, conflict, and a lack of autonomy and respect for their profession. After carefully reviewing the data, we found that COVID-19 did not redefine burnout for the current study's therapists working in LTC facilities. It did, however, add another layer of burnout for reasons such as increased personal protective equipment to manage, constantly changing rules about infection control, being mandated to work with patients with COVID-19, 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 to the feelings of burnout that already existed, consistent with research on other health care professionals from 2019 to 2021 that noted increased feelings of stress brought on by fear of the virus and overall physical and emotional burdens (Prasad et al., 2021; White et al., 2021).

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 therapists, and it can have profound implications for practitioners, clients, and health care organizations (Shin et al., 2022). Most of the participants noted that their employers were either unaware of the burnout they felt or did not care, as evidenced by the increased push in productivity expectations and reluctance to approve paid time off (PTO) 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 of the participants in this study searching for answers about how to reduce levels of burnout.

Limitations

Limitations were evident in the current study. The primary researcher was an occupational therapist who experienced burnout in the LTC setting. With this in mind, researcher triangulation and memoing were used to address potential researcher bias during data collection and analysis. The goal was to use maximum variation and purposeful sampling to recruit a wide variety of participants who could contribute information from various experiences. Ultimately, the sample included few speech-language pathologists, as only one participated, and more may have offered different insights into their experiences. Selection bias may have affected the study results, such as selecting participants that reached out to the researcher based on their willingness to participate, resulting in a sample that is biased toward certain groups or characteristics that are more easily reachable or cooperative and exclude others that are harder to access or less willing to participate. Another example is when the participants decide whether to participate in the study based on their own interests, motivations, or preferences. This can result in a sample that is biased toward those who have a strong opinion or experience and excludes those who are indifferent, unaware, or reluctant to share their views or experiences. Specifically, the therapists who volunteered to participate in the interviews may have had strong opinions on the subject matter because of 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 that others experience similar feelings of burnout, 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. The rest of the participants discussed frustrations that PTO was not typically encouraged or that they needed to make up their time off. This indicates that employees and employers should use PTO appropriately and without guilt, such as when ill to prevent sicknesses from entering the LTC facility or

when the therapists are feeling burnt out. This is particularly important if there are future public health crises to ensure all staff are healthy and can perform at the top of their license.

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. The use of standardized burnout and stress assessments would quantitatively track the burnout levels in therapists who work in LTC facilities. 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 of the 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 8-hr day (480 min). 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 mins in the facility, a therapist must have 384 to 446 min that are billable and documented to a patient's insurance. The 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 determine the appropriate treatment time and allowing for individualized treatment time for each patient. Another way the administration could affect productivity standards is by eliminating the standards. Having to count each minute of the day has proved stress-inducing for the participants interviewed. Patient care is effectively met when therapists can provide the care, treatment, and other day-to-day responsibilities of working in LTC facilities without being concerned about achieving a specific number of billable hours.

Burnout in rehabilitation therapists is a real problem many LTC workers face. Evidence-based strategies aimed at reducing the likelihood of burnout must be implemented. More specifically, employers should understand the sources of stress from the workforce's perspective 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 delivering quality patient care. Practical ways to manage therapist burnout are through open communication with their employer (without fear of retaliation), taking PTO for physical and mental health reasons, and for therapists to identify ways to relieve stress, such as meditation, exercise, or other forms of leisure that provide relief. This ensures that if or when a public health crisis occurs, therapists can continue to provide quality care to their patients and take care of themselves. It is the employer's responsibility to facilitate that ability and the therapists' responsibility 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 LTC therapy system.

References

Anjum, A., & Zhao, Y. (2022). The impact of stress on innovative work behavior among medical healthcare professionals. *Behavioral Sciences*, *12*(9), 340. https://doi.org/10.3390/bs12090340

Berry, J. W., Schurhammer, N. L., Haugen, T. J., Piche, S. E., Buskness, S. L., & Wentz, J. L. (2022). Job satisfaction and productivity requirements among physical therapists and physical therapist assistants. *Journal of Allied Health*, *51*(1), e33–e38.

Birks, M., Chapman, Y., & Francis, K. (2008). Memoing in qualitative research. *Journal of Research in Nursing*, *13*(1), 68–75. https://doi.org/10.1177/1744987107081254

Connelly, L. (2016). Trustworthiness in qualitative research. *MedSurg Nursing*, *25*(6), 435. https://link.gale.com/apps/doc/A476729520/AONE?u=anon~af58f98b&sid=googleScholar&xid=4194e033

Costello, H., Walsh, S., Cooper, C., & Livingston, G. (2019). A systematic review and meta-analysis of the prevalence and associations of stress and burnout among staff in long-term care facilities for people with dementia. *International Psychogeriatrics*, *31*(8), 1203–1216. http://dx.doi.org.ezproxy.uindy.edu/10.1017/S1041610218001606

Developers, C. (2021). Speech & language therapy in long-term care facilities. Camelot Senior Living. https://camelotseniorliving.com/speech-language-therapy-in-long-term-care-facilities/

De Hert, S. (2020). Burnout in healthcare workers: Prevalence, impact and preventative strategies. *Local and Regional Anesthesia*, *13*, 171–183. https://doi.org/10.2147/LRA.S240564

Evenson, G. (2003). Preventative measures for burnout with occupational therapists who work in a long-term care setting. *Occupational Therapy Capstones*, 60. University of North Dakota Scholaryl Commons. https://commons.und.edu/ot-grad/60

Gupta, S., Paterson, M. L., Lysaght, R. M., & Von Zweck, C. M. (2012). Experiences of burnout and coping strategies utilized by occupational therapists. *Canadian Journal of Occupational Therapy*, *79*(2), 86–95.

Hatcher, T. L. (2023). *Skilled Nursing Facility Physical Therapy*. Relias. https://www.relias.com/blog/physical-therapy-in-skilled-nursing-facilities

Harrad, R., & Sulla, F. (2018). Factors associated with and impact of burnout in nursing and residential home care workers for the elderly. *Acta bio-medica: Atenei Parmensis*, *89*(7-S), 60–69. https://doi.org/10.23750/abm.v89i7-S.7830

Henderson, R., & Rheault, W. (2004). Appraising and incorporating qualitative research in evidence-based practice. *Journal of Physical Therapy Education*, *18*(3), 35–40. https://doi.org/10.1097/00001416-200410000-00005

Hiyoshi-Taniguchi, K., Becker, C. B., & Kinoshita, A. (2018). What behavioral and psychological symptoms of dementia affect caregiver burnout? *Clinical Gerontologist*, *41*(3), 249–254. https://doi.org/10.1080/07317115.2017.1398797

Hofmann, A. (n.d.). Living life to its fullest: Occupational therapy in skilled nursing facilities. American Occupational Therapy Association. https://www.aota.org/about-occupational-therapy/professionals/pa/articles/skilled-nursing-facilities.aspx

Kandelman, N., Mazars, T., & Levy, A. (2018). Risk factors for burnout among caregivers working in nursing homes. *Journal of Clinical Nursing*, *27*(1–2), e147–e153. https://doi.org/10.1111/jocn.13891

Kiger, M. E., & Varpio, L. (2020). Thematic analysis of qualitative data: AMEE Guide No. 131. *Medical Teacher*, *42*(8), 846–854. https://doi.org/10.1080/0142159x.2020.1755030

Kohn, R., Brown, M., Hasson, C., Sheeran, T., Stanton, L., Nanda, A., & Bayer, T. (2021). COVID-19 and long-term care healthcare worker mental health in Rhode Island. *The American Journal of Geriatric Psychiatry*, *29*(4), S101–S102. https://doi.org/10.1016/j.jagp.2021.01.097

Korstjens, I., & Moser, A. (2017). Series: Practical guidance to qualitative research. Part 4: Trustworthiness and publishing. *European Journal of General Practice*, *24*(1), 120–124. https://doi.org/10.1080/13814788.2017.1375092

Leonardi, M., Pagani, M., Giovannetti, A. M., Raggi, A., & Sattin, D. (2013). Burnout in healthcare professionals working with patients with disorders of consciousness. *Work*, *45*(3), 349–356. https://doi.org/10.3233/WOR-121539

Malterud, K., Siersma, V. D., & Guassora, A. D. (2016). Sample size in qualitative interview studies. *Qualitative Health Research*, *26*(13), 1753–1760. https://doi.org/10.1177/1049732315617444

Mayo Clinic Staff. (2021). *Know the signs of job burnout*. Mayo Clinic. https://www.mayoclinic.org/healthy-lifestyle/adult-health/in-depth/burnout/art-20046642

Medscape National Physician Burnout & Suicide Report 2020. Available from: https://www.medscape.com/slideshow/2020-lifestyle-burnout-6012460

Merriam, S. B. (2002). Basic interpretive qualitative research. In S. B. Merriam (Ed.), *Qualitative research in practice: Examples for discussion and analysis* (pp. 37–39). Jossey-Bass.

Palinkas, L. A., Horwitz, S. M., Green, C. A., Wisdom, J. P., Duan, N., & Hoagwood, K. (2015). Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. *Administration and Policy in Mental Health*, *42*(5), 533–544. https://doi.org/10.1007/s10488-013-0528-y

Patton, M. (1990). Qualitative evaluation and research methods (pp. 169–186). Sage.

Prasad, K., McLoughlin, C., Stillman, M., Poplau, S., Goelz, E., Taylor, S., Nankivil, N., Brown, R., Linzer, M., Cappelucci, K., Barbouche, M., & Sinsky, C. A. (2021). Prevalence and correlates of stress and burnout among US healthcare workers during the COVID-19 pandemic: A national cross-sectional survey study. *EClinicalMedicine*, 35, 100879. https://doi.org/10.1016/j.eclinm.2021.100879

Selye, H. (1975). Confusion and controversy in the stress field. *Journal of Human Stress*, *1*(2), 37–44. https://doi.org/10.1080/0097840x.1975.9940406

Shin, J., McCarthy, M., Schmidt, C., Zellner, J., Ellerman, K., & Britton, M. (2022). Prevalence and predictors of burnout among occupational therapy practitioners in the United States. *The American Journal of Occupational Therapy*, *76*(4). https://doi.org/10.5014/ajot.2022.048108

Smythe, A., Jenkins, C., Galant-Miecznikowska, M., Dyer, J., Downs, M., Bentham, P., & Oyebode, J. (2020). A qualitative study exploring nursing home nurses' experiences of training in person-centered dementia care on burnout. *Nurse Education in Practice*, *44*. https://doi.org/10.1016/j.nepr.2020.102745

Tammany, J. E., O'Connell, J. K., Allen, B. S., & Brismée, J. M. (2019). Are productivity goals in rehabilitation practice associated with unethical behaviors? *Archives of Rehabilitation Research and Clinical Translation*, *1*(1–2), 100002. https://doi.org/10.1016/j.arrct.2019.100002

White, E. M., Wetle, T. F., Reddy, A., & Baier, R. R. (2021). Front-line nursing home staff experiences during the COVID-19 pandemic. *Journal of the American Medical Directors Association*, *22*(1), 199–203. https://doi.org/10.1016/j.jamda.2020.11.022

Yıldızhan, E., Ören, N., Erdoğan, A., & Bal, F. (2019). The burden of care and burnout in individuals caring for patients with Alzheimer's disease. *Community Mental Health Journal*, *55*(2), 304–310. https://doi.org/10.1007/s10597-018-0276-2