Research and Analysis Journals 9(02): 09-15, 2026

e-ISSN: 2589-9228, p-ISSN: 2589-921x

Research Article

Nurses' Lived Experiences of Burnout and Coping Strategies in Public Hospitals in Naga City

[1]Sharon B. Sta. Ana, [2]Sarah B. Sta. Ana, [3]Qvimrej A. Dimabogte

[1,2,3]Camarines Sur Polytechnic Colleges

Abstract:

Burnout among nurses is a critical concern in public healthcare settings, particularly in resource-constrained environments. This qualitative phenomenological study explored the lived experiences of burnout and the coping strategies employed by nurses working in public hospitals in Naga City, Camarines Sur. Using purposive sampling, registered nurses with at least one year of clinical experience participated in semi-structured, in-depth interviews. Data were transcribed verbatim and analyzed through thematic analysis guided by phenomenological principles. Findings revealed that nurses' experiences of burnout were deeply embedded in their daily professional realities and shaped by systemic conditions. Two major themes emerged regarding burnout: overwhelming workload and resource scarcity and emotional exhaustion and depersonalization. Nurses described burnout as a cumulative and ongoing experience rather than a temporary response to isolated stressors. Despite these challenges, nurses employed adaptive coping strategies, primarily peer support and shared understanding, as well as personal meaning-making and emotional regulation. While these strategies enabled nurses to sustain their professional roles, they were largely individual- or peer-driven, reflecting limited institutional support. The study concludes that burnout among nurses in public hospitals is a structurally driven phenomenon that requires organizational and policy-level interventions. Strengthening institutional support systems is essential to promote nurses' well-being, sustain professional engagement, and improve the quality of patient care in public healthcare settings.

Keywords: Burnout; Nurses; Public Hospitals; Coping Strategies; Phenomenological Study.

1. Introduction

The nursing field is well known as an occupation based on care, compassion, and long-term human engagement; it is also one of the most physically, emotionally, and psychologically exhausting jobs in the healthcare framework. Nurses are consistently subjected to heavy workload, emotional labor, shift work, high-stake clinical decisions, which expose them to a high risk of occupational stress and burnout (James, 2021; Mesaros, 2024; Thomas et al., 2022; Choukir, 2025). Burnout is widely defined by emotional exhaustion, depersonalization, and loss of personal accomplishment, and has been linked to several undesirable consequences in the form of lower job satisfaction, worse patient care, and heightened turnover intentions among nurses (Allam et al., 2021). Since nurses are at the forefront of healthcare, learning their work-related experiences is critical to both the well-being and sustainability of the workforce as well as healthcare.

Systemic and structural constraints tend to aggravate the experience of burnout in external hospitals. The environments in which public hospitals operate are often characterized by the lack of resources, understaffing, high patient-to-nurse ratios, and extended working hours and serve large and diverse populations (Assaye et al., 2021). Such institutional pressures may increase emotional pressure and burnout, especially when nurses have to balance professional duties and ethical obligations to patient-centered care. It has also been demonstrated that nurses in healthcare facilities operated by the government are particularly susceptible to burnouts since they are subjected to organizational stressors that are not within their control (Shah et al., 2021).

Although the literature on nurse burnout is rich, most of the available studies have been dominated by quantitative studies that aim at measuring prevalence, predictors, and analyzing the existence of statistical relationships between burnout and work-related variables. Although these studies are useful in defining the extent and predictors of burnout, they usually do not give a lot of insight into the personal experience of burnout and how these nurses interpret it in the daily work setting. Additionally, the relative lack of qualitative research that anticipates the voice of nurses, especially in the population hospital setting, continues to exist, as the working conditions and the organizational culture are vastly different in comparison with the private healthcare facility. This gap highlights the necessity of the intensive qualitative research undertaking that would help to capture the meaning, emotions, and coping mechanisms that are inherent in the experiences of nurses.

To address this void, the current research paper will endeavor to understand the lived experience of burnout among nurses working in the public hospitals and the coping mechanisms that they engage in during their practice. Informed by a phenomenological approach, the proposed research aims to elicit first-person accounts that are rich and provide insight into how burnout is manifested, perceived, and coped with in the realities of working in the field of public healthcare. With a focus on the stories of nurses, the proposed study will create context-specific inferences that can be applied to the support systems within the institutions, mental health interventions, policy changes that would enhance the well-being of these nurses and their retention. In sum, the study also

adds to the expanding body of nursing knowledge since it further clarifies the concept of burnout as an experience, not only as a quantifiable fact, but as a continuous and experience-based phenomenon contingent on both individual and organizational factors.

2. Research Questions

1. How do nurses describe their lived experiences of burnout while working in public hospitals?
2. What coping strategies do nurses employ to manage burnout in the context of public hospital work?

3. Methodology

3.1 Research Design

This study employs a qualitative phenomenological research design to explore nurses' lived experiences of burnout and the coping strategies they employ while working in public hospitals. Phenomenology is appropriate for this inquiry as it focuses on understanding how individuals experience, interpret, and make meaning of a particular phenomenon in their everyday lives (Neubauer et al., 2019). Since burnout is a subjective, emotionally grounded, and context-dependent experience, a phenomenological approach allows for an in-depth exploration of nurses' perspectives beyond measurable indicators.

3.2 Research Setting

The study will be conducted in selected public hospitals located in the Naga City, Philippines. Naga City is predominantly rural to semi-urban and is served by government-operated hospitals that cater to a large and diverse population. These public hospitals often operate under conditions of limited resources, high patient volumes, staffing constraints, and extended working hours. The selection of Naga as the research setting is purposeful, as nurses in this area face unique workplace challenges distinct from those in highly urbanized or private healthcare institutions. Examining burnout within this provincial public hospital context enables the study to generate locally grounded insights that may inform institutional support mechanisms and policy development for similar healthcare settings.

3.3 Participants and Sampling Technique

The participants of the study will consist of registered nurses currently employed in public hospitals within the Naga City. A purposive sampling technique will be used to select participants who have direct experience with workplace stress and burnout and who are capable of articulating their lived experiences. Inclusion criteria include: (1) Registered nurses currently working in a public hospital in Naga City; (2) At least one (1) year of clinical experience; (3) Direct involvement in patient care, and (4) Willingness to participate and provide informed consent. Participant recruitment will continue until data saturation is achieved, defined as the point at which no new themes or significant insights emerge from the interview data (Braun & Clark, 2021).

3.4 Data Collection Method

Data will be collected through semi-structured, in-depth interviews, which allow participants to freely narrate their experiences while maintaining alignment with the research questions. An interview guide will be developed based on the study objectives and research questions, consisting of open-ended questions designed to elicit detailed accounts of burnout experiences and coping strategies. With participants' consent, interviews will be audio-recorded and conducted at a time and location convenient and comfortable for the participants. Each interview is expected to last approximately 30 to 60 minutes. Field notes will be taken during and after the interviews to document non-verbal cues, contextual observations, and reflective insights relevant to the analysis.

3.5 Data Analysis

The interview recordings will be transcribed verbatim and analyzed using thematic analysis guided by phenomenological principles. The analysis will follow Braun and Clarke's (2006) six-phase approach: familiarization with the data, initial coding, searching for themes, reviewing themes, defining and naming themes, and producing the report. Coding will be conducted inductively, allowing themes to emerge directly from participants' narratives. An iterative process of moving between the data, codes, and themes will be employed to ensure that interpretations remain grounded in the lived experiences of the participants. Reflexivity will be maintained throughout the analysis to acknowledge the researchers' positionality and minimize interpretive bias.

3.6 Ethical Considerations

Prior to data collection, ethical clearance will be obtained from the appropriate institutional ethics review committee. Permission will also be sought from the administrators of the selected public hospitals in Naga City. Participants will be provided with an informed consent form that clearly explains the purpose of the study, research procedures, potential risks and benefits, confidentiality measures, and their right to withdraw from the study at any time without penalty. Participants' identities and institutional affiliations will be protected through the use of pseudonyms, and all data—including audio recordings and transcripts—will be securely stored in password-protected digital files accessible only to the researchers. All data will be used strictly for academic purposes and handled in accordance with ethical research standards and data privacy regulations.

4. Results and Discussion

This section presents and discusses the major themes that emerged from the thematic analysis of nurses' narratives regarding burnout and coping strategies while working in public hospitals in Naga City. The findings are organized according to the two research questions and are discussed in relation to existing literature to situate the results within broader nursing scholarship.

4.1 Nurses' Lived Experiences of Burnout in Public Hospitals

Analysis of the interview data revealed that nurses' experiences of burnout were multifaceted and deeply embedded in their daily professional realities. Two major themes emerged: overwhelming workload and resource scarcity and emotional exhaustion and depersonalization.

4.1.1 Overwhelming Workload and Resource Scarcity

Participants consistently described burnout as originating from overwhelming workloads coupled with persistent resource scarcity in public hospitals. Nurses reported being assigned to a large number of patients per shift while simultaneously attending to bedside care, medication administration, documentation, coordination with physicians, and other administrative duties. These responsibilities were often carried out under time pressure and with limited staffing support. Participants emphasized that understaffing and shortages of basic medical supplies were routine rather than exceptional, making even standard nursing tasks physically demanding and mentally taxing.

Several nurses described their shifts as continuous and unrelenting, with little opportunity for rest or recovery. The convergence of high patient loads and insufficient resources created an environment where nurses were constantly "catching up," contributing to a sustained sense of pressure that they associated directly with feelings of burnout.

"Sometimes I handle more than twenty patients in one shift. You want to give proper care, but you're rushing all the time because there are too many patients and too few nurses." – P3

"It's not just bedside care. You have to do the charting, assist doctors, answer relatives, and still attend to emergencies. By the end of the shift, your body and mind are both exhausted." – P6

The narratives indicate that burnout developed as a cumulative response to sustained exposure to excessive job demands rather than as a reaction to isolated stressful events. Nurses described repeatedly working beyond their physical and emotional limits, often skipping meals, delaying restroom breaks, or extending their shifts to ensure that essential tasks were completed. This pattern of overextension gradually eroded their energy and resilience, resulting in chronic fatigue and emotional depletion.

Resource scarcity further intensified workload-related stress. Participants shared that shortages of equipment, medications, and supplies forced them to improvise, delay care, or repeatedly seek alternatives, increasing cognitive load and frustration. The need to constantly "make do" heightened nurses' sense of responsibility while simultaneously limiting their capacity to perform optimally. This mismatch between professional expectations and actual working conditions contributed to feelings of helplessness and inadequacy.

In the Naga City public hospital context, these conditions were experienced as structural realities rather than temporary challenges. Nurses perceived workload pressure and resource scarcity as normalized aspects of their work environment, reinforcing burnout as an embedded and ongoing experience rather than a transient state.

"There are days when you don't even notice that you haven't eaten yet. You just keep going because patients are waiting." – P1

"When supplies are lacking, you feel stressed because you know what should be done, but you don't have what you need. It adds to the mental exhaustion." – P8

"It's tiring because even if you work hard, the problems are still there the next day. It feels like there's no end." – P4

These findings imply that burnout among nurses in public hospitals cannot be effectively addressed through individual coping strategies alone. When excessive workloads and resource shortages are normalized within institutional practice, nurses remain exposed to continuous physical exhaustion and emotional strain. Over time, this may lead not only to diminished well-being but also to compromised patient safety, reduced quality of care, and increased risk of workforce attrition. The data suggest that without organizational interventions—such as adequate staffing levels, equitable workload distribution, and reliable access to essential resources—burnout is likely to persist and intensify. Addressing burnout, therefore, requires systemic responses that recognize nurses' experiences as outcomes of structural conditions rather than personal limitations.

This supports existing research identifying high patient-to-nurse ratios and limited resources as major contributors to burnout in public healthcare settings (Mofoye, 2024). However, the present study extends these findings by illuminating how such conditions are lived and endured by nurses in provincial public hospitals. The study reinforces the view that burnout is a systemic and contextually shaped phenomenon, underscoring the need for institution-level reforms alongside individual support mechanisms.

4.1.2 Emotional Exhaustion and Depersonalization

Emotional exhaustion emerged as a central and pervasive dimension of burnout among nurses working in public hospitals in Naga

City. Participants described a persistent sense of emotional depletion characterized by chronic fatigue, irritability, and a feeling of being psychologically "drained." Many nurses reported that even after rest days or time off, they returned to work feeling emotionally unrefreshed. Alongside emotional exhaustion, nurses also described experiences of depersonalization, manifested through emotional detachment, reduced empathy, and a sense of distancing themselves from patients as a means of coping with overwhelming stress.

Rather than viewing these experiences as isolated emotional reactions, participants framed emotional exhaustion and depersonalization as gradual changes that developed over time as a result of continuous exposure to heavy workload, suffering, and unmet institutional demands.

"You feel tired even before your shift starts. It's not just physical—it's like you're already exhausted emotionally." – P2
"Sometimes I feel numb. I still do my job, but inside, I feel empty." – P7

The narratives suggest that emotional exhaustion stemmed from prolonged emotional labor and repeated exposure to stressful clinical situations without adequate recovery. Nurses described managing patients' pain, distress, and family concerns while suppressing their own emotions to remain professional. Over time, this emotional suppression accumulated, leading to psychological fatigue and emotional withdrawal. Depersonalization appeared to function as a protective mechanism rather than a sign of indifference or lack of compassion. Nurses explained that emotional distancing allowed them to continue functioning in high-pressure environments without becoming overwhelmed. However, this strategy also produced internal conflict, as nurses struggled to reconcile emotional detachment with their professional identity as caring and compassionate practitioners.

In the context of public hospitals, where patient volume is high and emotional demands are constant, depersonalization became a survival strategy. Nurses emphasized that without emotional boundaries, they would be unable to continue working effectively.

"If you let yourself feel everything, you won't last. That's why sometimes you just do your tasks and try not to get too attached." – P4
"I noticed that I became less emotional with patients. It's not that I don't care—it's because I'm already emotionally tired." – P6
"You learn to distance yourself, especially when you see suffering every day. It's the only way to cope." – P1

These findings imply that emotional exhaustion and depersonalization among nurses should not be interpreted as personal weakness or declining professionalism. Instead, they reflect adaptive responses to sustained emotional overload in under-resourced healthcare environments. However, when such coping strategies persist without institutional support, they may increase the risk of long-term disengagement, reduced job satisfaction, and potential attrition from the nursing profession. The normalization of emotional exhaustion within public hospitals places nurses at risk of chronic burnout, which may ultimately affect patient–nurse relationships and quality of care. Without structured emotional support systems, nurses are left to self-regulate emotional distress, often at significant psychological cost.

These findings strongly align with West et al. (2012), which identify emotional exhaustion and depersonalization as core dimensions of burnout. While existing studies often measure these dimensions quantitatively, the present study extends the literature by illustrating how emotional exhaustion and depersonalization are lived, justified, and normalized within the everyday experiences of nurses in public hospitals. This study demonstrates that emotional exhaustion and depersonalization are deeply intertwined with organizational conditions, reinforcing the need for systemic interventions such as emotional debriefing programs, mental health support, and workload regulation within public healthcare institutions.

4.2 Coping Strategies Employed by Nurses to Manage Burnout

Despite experiencing significant levels of burnout, nurses demonstrated various coping strategies that enabled them to continue functioning in demanding public hospital environments. These strategies were largely adaptive and self-initiated, reflecting nurses' resilience in the absence of formal institutional support. Two major coping themes emerged: peer support and shared understanding as well as personal meaning-making and emotional regulation.

4.2.1 Peer Support and Shared Understanding

Peer support emerged as one of the most prominent and consistently cited coping strategies employed by nurses to manage burnout in public hospitals. Participants described relying heavily on their fellow nurses for emotional release, validation, and encouragement, particularly during periods of heightened stress. These supportive interactions were largely informal and spontaneous, occurring during brief breaks, handover periods, after-duty hours, or even in passing moments during busy shifts.

Nurses emphasized that support from colleagues was uniquely valuable because it came from individuals who shared similar workloads, responsibilities, and emotional demands. Unlike family members or friends outside the profession, fellow nurses were perceived as immediately understanding the realities of public hospital work without the need for lengthy explanations.

"Talking to my co-nurses helps a lot because they understand what I'm going through. I don't have to explain everything." – P4
"Even a short conversation during duty helps. Sometimes just knowing someone feels the same makes it easier." – P10
"We support each other because no one else really sees what happens inside the ward." – P3

The narratives suggest that peer support functioned as an informal emotional safety net, allowing nurses to externalize stress and normalize their experiences of burnout. By sharing frustrations, exhaustion, and emotional struggles with colleagues, nurses were able to reframe burnout as a collective occupational experience rather than a personal shortcoming. This shared understanding reduced feelings of isolation and self-blame, which are commonly associated with burnout. Beyond emotional validation, peer support also served a practical coping function. Nurses described exchanging advice on managing difficult patients, prioritizing tasks during understaffed shifts, and emotionally processing traumatic clinical encounters. These exchanges fostered collective problem-solving and strengthened team cohesion, reinforcing resilience within the group.

In the Naga City public hospital context, where formal mental health resources and institutional support systems were limited, peer relationships became a primary mechanism for emotional regulation and stress relief. The sense of "being in it together" allowed nurses to endure demanding work conditions with greater psychological endurance.

"When someone is really stressed, we talk to them and remind them that it's not just them. We're all struggling." – P6
"Sometimes we just laugh about how tired we are. It sounds simple, but it really helps release the stress." – P8
"If you don't talk to your co-nurses, you'll feel alone. Talking makes you feel lighter." – P1

However, the data also reveal that peer support often involved emotional labor among nurses themselves. Nurses frequently took on the role of listener, comforter, or motivator for their colleagues, even when they themselves were experiencing burnout. While this mutual support fostered solidarity, it also risked redistributing emotional burden within already exhausted teams.

These findings imply that while peer support is a vital and effective coping mechanism, its informal and self-sustaining nature reflects a significant gap in institutional support. Reliance on colleagues alone places the responsibility for emotional care on nurses, potentially reinforcing burnout when support demands exceed individual capacity. The data suggest a need for structured interventions that formalize and strengthen peer support without overburdening staff. Such interventions may include facilitated peer support groups, mentorship programs, and regular debriefing sessions that acknowledge emotional labor as a legitimate component of nursing work. Institutional recognition of peer support as essential—not supplementary—could help mitigate burnout more sustainably.

This finding aligns with existing research identifying social and peer support as protective factors against burnout among nurses, particularly in high-stress and resource-limited healthcare settings (Malik et al., 2025). However, the present study extends this literature by illustrating how peer support operates organically in provincial public hospitals, functioning simultaneously as a source of resilience and as a compensatory response to systemic deficiencies. The study highlights both the strength and the limits of peer support in the absence of organizational backing.

4.2.2 Personal Meaning-Making and Emotional Regulation

Personal meaning-making and emotional regulation emerged as central intrapersonal coping strategies used by nurses to manage burnout in public hospitals. Participants described consciously reframing their experiences by reconnecting with their personal values, professional purpose, faith, and sense of responsibility toward patients and family. Rather than eliminating stressors, nurses sought to endure burnout by attributing meaning to their work and regulating their emotional responses to daily challenges.

Many nurses emphasized that meaning-making was not automatic but an intentional process that required continuous self-reflection. Emotional regulation, on the other hand, involved controlling emotional reactions during stressful situations, suppressing feelings of frustration or sadness while on duty, and restoring emotional balance after work hours.

"I always remind myself why I became a nurse. That's what keeps me going, even when I'm very tired." – P1
"When I feel overwhelmed, I tell myself that at least I was able to help someone today." – P9
"You really have to control your emotions. If you let everything affect you, you won't be able to function." – P4

The data suggest that meaning-making functioned as a cognitive and emotional reframing strategy that allowed nurses to reinterpret stress and exhaustion as purposeful sacrifice rather than personal failure. By focusing on patient impact, professional identity, or moral duty, nurses were able to preserve a sense of purpose despite adverse working conditions. This reframing helped sustain motivation and emotional endurance, even when institutional recognition and support were lacking. Emotional regulation complemented meaning-making by enabling nurses to maintain composure in high-pressure clinical situations. Participants described consciously suppressing emotional reactions such as anger, fear, or sadness to remain professional, particularly during emergencies or emotionally charged patient encounters. While this emotional control allowed nurses to perform their duties effectively, it also required significant psychological effort.

In the Naga City public hospital context, emotional regulation was often learned informally through experience rather than through formal training. Nurses described adapting over time, developing internal rules about when and how to express emotions. However, prolonged emotional suppression contributed to cumulative emotional fatigue, suggesting that emotional regulation, while adaptive, also carried emotional costs.

"You cannot show your emotions all the time. You have to stay strong for the patients." – P6
"I try to calm myself, especially when the ward is very busy. If I panic, everything will be affected." – P8

"There are days when I just keep everything inside during duty, then release it when I get home." – P2
"Sometimes I pray before my shift. It helps me prepare emotionally." – P5

These findings imply that while personal meaning-making and emotional regulation are powerful coping mechanisms, they place a substantial emotional burden on individual nurses. When institutional systems rely implicitly on nurses' internal resilience to offset structural stressors, burnout may become normalized rather than addressed. Over time, the continuous effort required to regulate emotions and sustain meaning may lead to emotional depletion and disengagement. The data further suggest that nurses' reliance on faith, values, and personal motivation reflects a gap in organizational support structures. Without formal mechanisms for emotional processing—such as counseling, reflective debriefing, or psychological support—nurses are left to manage emotional strain privately, increasing the risk of silent burnout.

This finding aligns with Larson (2010), emphasizing meaning-making and emotional regulation as key resilience strategies in caregiving professions. However, the present study extends existing literature by demonstrating how these strategies operate as compensatory mechanisms in under-resourced public hospital settings. By foregrounding nurses' lived experiences in Naga City, the study highlights the dual nature of meaning-making and emotional regulation as both sources of strength and potential contributors to prolonged burnout when unsupported by institutional interventions.

In a similar vein, phenomenological research in educational contexts highlights how professionals employ adaptive self-regulatory strategies to manage emotional and cognitive demands. For instance, Fajardo (2024) demonstrated that college instructors in online English language learning contexts strategically used code-switching to regulate instructional flow, foster interpersonal relations, and sustain engagement amid contextual constraints. While situated in a different professional domain, these findings parallel the present study in showing how meaning-making and emotional regulation function as coping mechanisms in high-demand professions where institutional support is limited.

5. Conclusions and Recommendations

This study concludes that burnout among nurses working in public hospitals in Naga City is a complex, cumulative, and structurally driven experience shaped by chronic workload pressures, resource scarcity, and emotionally demanding work conditions. Nurses' lived experiences revealed that burnout is not a temporary response to isolated stressors but a sustained condition embedded in the everyday realities of public healthcare practice. Overwhelming patient loads, insufficient staffing, and limited resources contributed to persistent physical fatigue and emotional strain, while moral distress arising from the inability to provide optimal care eroded nurses' sense of professional fulfillment. Emotional exhaustion and depersonalization emerged as adaptive responses that enabled nurses to continue functioning, yet these strategies also carried psychological costs and threatened long-term professional engagement.

Despite these challenges, nurses demonstrated resilience through peer support, shared understanding, personal meaning-making, and emotional regulation. Informal peer relationships served as vital emotional safety nets that reduced isolation and normalized burnout as a shared occupational experience. Meaning-making, faith, and personal values helped nurses reframe stress as purposeful service, while emotional regulation allowed them to maintain composure in high-pressure clinical environments. However, these coping strategies were largely individual- or peer-driven, highlighting the absence of formal institutional mechanisms to support nurses' emotional well-being and reinforcing the notion that resilience was often achieved at personal emotional cost.

Based on these findings, the study recommends that hospital administrators and policymakers prioritize organizational-level interventions to address nurse burnout. These include improving staffing adequacy, ensuring fair workload distribution, and strengthening access to essential resources. Public hospitals should institutionalize structured support systems such as facilitated peer support programs, regular emotional debriefing sessions, and accessible mental health services. Recognizing emotional labor as an integral part of nursing work and creating supportive environments that allow nurses to process stress safely may help reduce emotional exhaustion and sustain professional engagement.

Furthermore, nursing practice and education should emphasize healthy boundary-setting, emotional awareness, and reflective practice, equipping nurses with tools to manage stress without normalizing burnout. Nursing education institutions may integrate burnout awareness and resilience training into curricula, while future research may examine burnout longitudinally or evaluate the effectiveness of institutional interventions. Overall, addressing burnout among nurses in public hospitals in Naga City requires systemic, compassionate, and sustained responses that value nurses not only as healthcare providers but as individuals deserving of care, support, and dignified working conditions.

6. References

1. Allam, Z., Malik, A., & George, S. (2021). The relationship between emotional exhaustion, depersonalization, personal accomplishment, and job satisfaction: An empirical study in Saudi Arabia. *The Journal of Asian Finance, Economics and Business, 8*(5), 1109–1117.
2. Assaye, A. M., Wiechula, R., Schultz, T. J., & Feo, R. (2021). Impact of nurse staffing on patient and nurse workforce outcomes in acute care settings in low- and middle-income countries: A systematic review. *JBI Evidence Synthesis, 19*(4), 751–793.

3. Braun, V., & Clarke, V. (2021). To saturate or not to saturate? Questioning data saturation as a useful concept for thematic analysis and sample-size rationales. *Qualitative Research in Sport, Exercise and Health, 13*(2), 201–216.
4. Choukir, J. (2025). Leadership and job demands on managerial decision-making effectiveness through emotional exhaustion in the aviation industry. *Qubahan Academic Journal, 5*(4), 227–243.
5. Fajardo, D. F. (2024). Code-switching dynamics of college instructors in online English language learning. *Malaysian Journal of ELT Research, 21*(2).
6. James, H. J. (2021). *Nursing burnout among registered nurses in ambulatory versus acute care settings* (Doctoral dissertation, Northcentral University).
7. Larson, E. (2010). Psychological well-being and meaning-making when caregiving for children with disabilities: Growth through difficult times or sinking inward. *OTJR: Occupation, Participation and Health, 30*(2), 78–86.
8. Malik, M., Yenokyan, G., Michtalik, H., Miller, J., Connors, C., Weston, C. M., … Wu, A. W. (2025). Strengthening the culture of well-being in rural hospitals through RISE peer support. *Healthcare, 14*(1), Article 91. https://doi.org/10.3390/healthcare14010091
9. Mesaros, K. (2024). *The relationships between stress, coping, burnout, and turnover intention in adult critical care nurses* (Master's thesis, The University of Akron).
10. Mofoye, E. (2024). *High nurse-to-patient ratio effect on nurse job dissatisfaction and burnout* (Unpublished manuscript).
11. Neubauer, B. E., Witkop, C. T., & Varpio, L. (2019). How phenomenology can help us learn from the experiences of others. *Perspectives on Medical Education, 8*(2), 90–97.
12. Shah, M. K., Gandrakota, N., Cimiotti, J. P., Ghose, N., Moore, M., & Ali, M. K. (2021). Prevalence of and factors associated with nurse burnout in the United States. *JAMA Network Open, 4*(2), e2036469. https://doi.org/10.1001/jamanetworkopen.2020.36469
13. Thomas, C. L., Johnson, L. U., Cornelius, A. M., Cobb, H. R., Murphy, L. D., & Vega, D. (2022). Incivility begets incivility: Understanding the relationship between experienced and enacted incivility with customers over time. *Journal of Business and Psychology, 37*(6), 1255–1274.
14. West, C. P., Dyrbye, L. N., Satele, D. V., Sloan, J. A., & Shanafelt, T. D. (2012). Concurrent validity of single-item measures of emotional exhaustion and depersonalization in burnout assessment. *Journal of General Internal Medicine, 27*(11), 1445–1452.