CROSS-CULTURAL MANAGEMENT JOURNAL

Burnout in Mental Healthcare Systems: A Multidimensional Perspective

Hanukayev, Elizabeth [1] (Russia)
Manolică, Adriana [1] (Romania)

Abstract: Burnout among mental health nursing staff represents a critical and under examined challenge with far-reaching implications for both healthcare personnel and patient outcomes. This article undertakes a systematic review of the organizational, environmental, and personal determinants of burnout within psychiatric nursing contexts, situating the analysis within established occupational health frameworks and current empirical literature. Drawing on Maslach's conceptualization of burnout, the Conservation of Resources model, and generational workforce theory, the article examines how structural deficits—including chronic understaffing, inadequate professional autonomy, high emotional labor demands, and misaligned organizational culture—interact with individual vulnerability factors to produce and perpetuate burnout. Special attention is given to the distinct pressures inherent in acute inpatient psychiatric settings, where staff are routinely exposed to patient aggression, complex ethical dilemmas, and unpredictable clinical demands. The article further explores generational differences in work values and coping styles among Generation Y and Z nursing staff, and discusses evidence-based strategies for burnout prevention at the individual, team, and institutional levels. The discussion culminates in a set of policy-oriented recommendations aimed at fostering sustainable motivation, psychological resilience, and high-quality care delivery within mental health nursing workforces.

Keywords: Mental health nursing; organizational culture; occupational stress; Generation Y; Generation Z; resilience

JEL Classification: I12; I18; J28; M54

Citation: Hanukayev, E., & Manolică, A. (2026). Burnout in mental healthcare systems: A multidimensional perspective. *Cross-Cultural Management Journal, 28*(2), 133–140.
https://doi.org/10.70147/c28133140
Received: 16 June 2026
Revised: 9 July 2026
Accepted: 12 July 2026
Published: 20 July 2026

[1] *Alexandru Ioan Cuza University of Iasi, Faculty of Economics and Business Administration*

INTRODUCTION

This paper addresses occupational burnout, which is a pervasive and costly phenomenon across human services professions, yet its manifestation within mental health nursing is particularly acute. Empirical evidence consistently demonstrates that psychiatric nursing staff report higher rates of burnout compared to their counterparts in other clinical specializations (Megošsáková et al., 2024; Woo et al., 2020). This disparity is attributable to a confluence of factors unique to the mental health care environment, namely, exposure to patients in acute psychological distress, elevated risk of verbal and physical aggression, morally complex clinical decision-making, and a systemic shortage of qualified personnel. Despite the growing recognition of this problem in both national and international healthcare discourse, targeted, evidence-based prevention frameworks for mental health nursing burnout remain insufficiently developed and inconsistently implemented.

The consequences of unchecked burnout extend well beyond the individual nurse. Research indicates that burned-out healthcare workers exhibit diminished empathy, increased rates of medication errors, higher absenteeism, and elevated intention to leave the profession—all of which directly compromise patient safety and care quality (Li et al., 2024). In the context of already strained psychiatric services, the departure of experienced nurses precipitates a vicious cycle as staffing shortages intensify workload for remaining personnel, accelerating the very burnout that triggered attrition in the first place. This article approaches burnout not as an individual pathology but as a systemic and organizational phenomenon amenable to structural intervention. Drawing on personal clinical experience as a registered nurse in an acute inpatient psychiatric unit, combined with a review of peer-reviewed literature, the article aims to: (1) delineate the theoretical and empirical landscape of burnout in healthcare, with specific reference to psychiatric nursing; (2) identify and critically analyze the organizational and environmental determinants of burnout in mental health settings; (3) examine the role of generational factors in shaping staff vulnerability and resilience; and (4) propose evidence-informed recommendations for policy and practice. Ultimately, this work aspires to contribute to the development of a sustainable, humane, and effective mental health nursing workforce.

LITERATURE REVIEW

Conceptualizing burnout: Theoretical foundations

The concept of burnout first entered the scholarly lexicon through the work of Herbert Freudenberger (1974) and was subsequently formalized by Christina Maslach and Susan Jackson, whose Maslach Burnout Inventory (MBI) became the gold standard instrument for burnout assessment across professional contexts. Maslach and Leiter (2022) define burnout as a psychological syndrome comprising three core dimensions: emotional exhaustion, depersonalization (or cynicism), and a diminished sense of personal accomplishment. This tripartite model has been extensively validated and remains the dominant framework for understanding burnout across healthcare, education, and social services.

Complementing the MBI framework, Shirom and Melamed (2006) propose the Shirom-Melamed Burnout Measure (SMBM), which conceptualizes burnout as a state of energy depletion manifested across three domains: physical fatigue, emotional exhaustion, and cognitive weariness. Physical fatigue encompasses the subjective sense of depleted bodily resources and an inability to recover through rest. Emotional exhaustion refers to a reduced capacity for affective engagement—a progressive emotional numbness that renders the nurse unable to respond empathetically to patients' distress. Cognitive weariness involves difficulties in concentration, sustained attention, and complex decision-making, which reflect capacities that are indispensable in clinical nursing practice.

The Conservation of Resources (COR) theory, advanced by Hobfoll (1989), offers a complementary etiological account. COR theory posits that stress, and ultimately burnout, arises when individuals perceive actual or threatened losses of personally valued resources, including time, energy, professional recognition, and a sense of mastery. Chronic resource depletion without adequate replenishment leads to a loss spiral in which diminishing resources impair the individual's capacity to manage further demands, generating escalating vulnerability. This theoretical lens is particularly germane to the mental health nursing context, where emotional and cognitive resources are continuously drawn upon in high-stakes clinical encounters with limited organizational support for renewal.

A critically important and often overlooked dimension of burnout etiology concerns the paradox of dedication, namely, those individuals most susceptible to burnout are frequently those who entered their profession with the strongest intrinsic

motivation, the deepest commitment to patient welfare, and the highest personal standards (Shanafelt et al., 2025). The idealistic nurse who invests enormous personal energy in patient care is, paradoxically, at greater risk of profound disillusionment when organizational realities fail to align with professional ideals. Hobfoll (1989) argues that burnout carries an ironic and tragic quality: it selectively targets an organization's most conscientious employees.

Burnout in Nursing: Epidemiology and Trends

The epidemiological evidence on nursing burnout is striking in both scale and consistency. A landmark 1999 study found that 43% of nursing staff reported high levels of emotional exhaustion, and a subsequent 2007 investigation documented burnout prevalence rates of approximately 36% among hospital and long-term care nurses in Israel (Lee & Cha, 2023). International comparisons reveal substantial variability as European studies report burnout prevalence among mental health nurses ranging from 30% to 44%; figures from Greece reach as high as 78%, while U.S. studies report approximately 34% (Lee & Cha, 2023). These figures must be interpreted cautiously given heterogeneity in measurement instruments, sample characteristics, and burnout definitions, but they collectively underscore burnout as a major, cross-national workforce crisis.

The Israeli healthcare system context adds further analytical dimension. Over recent decades, Israel has undergone rapid healthcare restructuring aimed at service optimization. Rising life expectancy has driven sharp increases in the prevalence of chronic and co-morbid conditions, technological transformation has imposed new administrative and digital competency demands on clinical staff, and periodic restructuring has intensified workload while often failing to expand staffing proportionally (Ministry of Health, 2016). These systemic pressures are superimposed on a profession already characterized by inherently high emotional labor demands—a combination that positions Israel's mental health nursing workforce as particularly vulnerable.

The behavioral and attitudinal consequences of nursing burnout are well-documented. Burned-out nurses demonstrate reduced emotional responsiveness to patient distress, diminished quality of clinical documentation, increased frequency of interpersonal conflicts with colleagues and patients, and a tendency toward depersonalization—treating patients as cases rather than individuals (Maslach & Leiter, 2022). Notably, burnout does not always manifest as overt disengagement; it may also present as presenteeism, namely, nurses physically present at work yet cognitively and emotionally unavailable, a phenomenon that may be even more insidious from a patient safety standpoint than outright absenteeism.

Organizational Determinants of Burnout

Empirical consensus converges on organizational factors as the primary determinants of burnout, outweighing individual dispositional characteristics in explanatory power (Li et al., 2024). The healthcare organizational environment encompasses several potent burnout-generating mechanisms. Workload and understaffing constitute the most consistently implicated structural factor. High nurse-to-patient ratios demand rapid cycling between tasks, reduce opportunities for meaningful patient contact, and force difficult triage decisions that conflict with professional values. When staff absences compound already tight staffing levels, remaining nurses face compounding workload demands that rapidly erode their resource reserves. International evidence suggests that each additional patient per nurse is associated with a 23% increase in the odds of burnout (Li et al., 2024).

Erosion of professional autonomy represents a second critical mechanism. Autonomy, operationalized as the nurse's capacity to exercise independent clinical judgment, participate meaningfully in unit governance, and make decisions consonant with professional standards, is a powerful protective factor against burnout (Prapanjaroensin et al., 2017). Conversely, hierarchical organizational cultures in which nurses' clinical expertise is systematically subordinated to administrative directives or physician prerogative generate profound role frustration and erode the sense of professional meaning that sustains long-term engagement.

Role ambiguity and interprofessional conflict constitute related organizational stressors. Mental health nursing occupies a complex position at the interface of custodial care, therapeutic engagement, pharmacological management, and crisis intervention. When role boundaries are unclear, when nursing contributions are undervalued by multidisciplinary teams, or when collaboration between nurses and psychiatrists is poor, staff experience chronic frustration that amplifies burnout risk. A culture of blame in the event of adverse outcomes, rather than systems-oriented analysis, further undermines psychological safety and professional confidence.

Work-life imbalance is an additional and frequently underappreciated contributor. The operational demands of inpatient psychiatric nursing, including evening, night, and weekend shifts, mandatory

overtime to cover absent colleagues, and on-call obligations, encroach chronically on family and personal recovery time. Family commitments, social connection, and adequate sleep are themselves critical resources; their systematic erosion intensifies vulnerability to burnout. Nurses who sacrifice five or more shifts per week to compensate for staffing deficits are effectively funding their institution's staffing crisis with their own wellbeing.

Burnout-Specific Factors in Acute Psychiatric Settings

While the determinants described above apply broadly across healthcare, acute psychiatric nursing presents a set of challenges that are categorically distinct. Patients admitted to acute inpatient units are frequently in severe psychological crisis; they may be acutely psychotic, agitated, suicidal, or displaying behaviors that constitute a genuine physical threat to staff and other patients. Woo et al. (2020), in a systematic review and meta-analysis, document that the chronic exposure to potential violence, the responsibility of maintaining ward safety, and the emotional labor of sustaining a therapeutic alliance with profoundly distressed individuals place mental health nurses in a uniquely taxing occupational position.

Moral distress is a particularly significant and underexamined dimension of burnout in psychiatric settings. Moral distress arises when nurses are constrained from acting in accordance with their ethical convictions, for example, when resource limitations prevent the delivery of care they know patients require, when institutional policies conflict with patient-centered values, or when they are required to implement coercive interventions (such as restraint or involuntary treatment) without adequate ethical support and debriefing (Labrague, 2023). Over time, repeated exposure to morally distressing situations without resolution corrodes the nurse's sense of professional integrity and meaningfulness.

Compassion fatigue, a construct related to but distinct from burnout, also warrants attention in this context. While burnout develops gradually through chronic resource depletion, compassion fatigue can arise acutely as a response to vicarious trauma: the emotional toll of sustained empathic engagement with individuals experiencing profound suffering (Ge et al., 2023). In psychiatric nursing, where therapeutic relationship is itself the primary clinical instrument, the capacity for empathy is simultaneously the nurse's core professional resource and their greatest point of vulnerability.

Generational Dimensions: Generation Y and Z in Mental Health Nursing

Contemporary mental health nursing workforces are increasingly composed of Generation Y (born 1981–1996) and Generation Z (born 1997 onward) nurses. These cohorts' orientations toward work, authority, and professional meaning differ in important ways from preceding generations. Generation Y nurses are characterized by high expectations for organizational transparency, participative leadership, rapid professional development, and work-life balance (Shanafelt et al., 2025). They are comfortable with technology, value collaborative workplace cultures, and are likely to exit organizations that fail to meet these expectations, a pattern with significant implications for mental health services that struggle to retain junior staff.

Generation Z, entering the workforce in increasing numbers, amplifies many of these characteristics while additionally demonstrating heightened awareness of mental health and psychological wellbeing, both in clinical and personal terms. This generation's familiarity with digital tools and preference for rapid feedback and meaningful task variety may conflict with the sometimes hierarchical, protocol-driven, and emotionally taxing realities of inpatient psychiatric nursing. Understanding and engaging with these generational characteristics is not merely a matter of managerial accommodation; it is a strategic imperative for healthcare organizations seeking to attract, develop, and retain the nursing workforce of the future (Hampton et al., 2024; Rutledge et al., 2024).

A Sociological Perspective of Burnout in Mental Health Nursing

From a sociological perspective, burnout among mental health nurses cannot be fully understood as an individual psychological condition. Rather, it must be viewed in the broader social, cultural, and structural forces that shape healthcare work. Sociologist Arlie Hochschild's foundational concept of emotional labor, namely, the management of feelings as a required component of paid work, offers a particularly illuminating lens for psychiatric nursing, where sustained empathic engagement with acutely distressed patients constitutes the very substance of the professional role (Hochschild, 1983). In Hochschild's framework, workers who engage in "surface acting", i.e., displaying emotions they do not genuinely feel, are at substantially greater risk of burnout than those who engage in "deep acting", when authentically cultivating the required emotional state. Evidently, psychiatric nurses are routinely required to manage their emotional presentations across long shifts under conditions of severe interpersonal demand, and the

cumulative cost of this emotional performance, rendered invisible within most organizational accounting systems, constitutes a structural driver of burnout that purely psychological frameworks tend to understate.

Furthermore, from a sociological perspective, burnout in mental health nursing is also shaped by macro-level processes of healthcare restructuring driven by neoliberal policy logics. Since the 1980s, the progressive marketization of public health systems, characterized by cost-containment imperatives, efficiency metrics, privatization, and the erosion of public expenditure, has intensified workloads while simultaneously reducing the organizational resources available to support frontline clinical staff (Abramovitz & Zelnick, as cited in Piot, 2021). Within this framework, burnout emerges not merely as an occupational hazard but as a predictable consequence of structural disinvestment in the human infrastructure of care: nurses are asked to absorb escalating patient acuity, staffing deficits, and administrative burdens that are, in effect, the individual-level costs of systemic underfunding. The sociological insight here is critical: framing burnout as a problem of individual resilience or coping capacity, as much mainstream clinical discourse continues to do, functions ideologically to obscure the structural origins of the problem and to individualize responsibility for what are fundamentally collective failures of policy and governance (Varpio et al., 2018, as cited in Stulikova & Dawson, 2023).

A sociological analysis also draws attention to the gendered dimensions of burnout in nursing. Nursing remains a predominantly female profession, and the emotional labor that lies at its core has historically been socially constructed as an extension of women's "natural" caring dispositions — a framing that renders this labor culturally invisible and economically undervalued (Hochschild, 1983; Wharton, 2009). This gendered devaluation has direct organizational consequences: because emotional care work is not recognized as skilled labor in the same register as technical or biomedical competencies, it receives insufficient institutional support, recognition, and remuneration. The social ecology of burnout framework, recently proposed by de Lisser et al. (2024), extends this analysis by situating burnout within the relational and structural hierarchies of healthcare organizations, demonstrating that psychological safety, itself a socially produced condition dependent on power relations, institutional culture, and leadership behavior, is among the most powerful determinants of whether nurses can sustain engagement without suffering burnout. Hierarchical organizational structures, in this framework, function not merely as administrative arrangements but as social mechanisms that either protect or erode the professional identities and psychological resources of nursing staff.

Finally, sociology's attention to role strain — the stress generated when the multiple, and often contradictory, demands of a social role cannot be simultaneously fulfilled — offers a theoretically precise account of the burnout experienced by mental health nurses navigating competing obligations to patients, institutions, professional codes, and personal wellbeing (Goode, 1960). In psychiatric inpatient contexts, role strain is amplified by the inherently boundary-crossing nature of the therapeutic relationship, the morally ambiguous demands of coercive treatment, and the normative expectation that nurses will absorb interpersonal aggression without organizational sanction or debrief. The sociological perspective thus complements psychological and organizational frameworks by insisting that burnout is ultimately a social phenomenon: it is produced at the intersection of individual workers and the social structures — professional norms, institutional hierarchies, labor markets, and policy regimes — within which their work is embedded. Any prevention strategy that does not engage with these structural dimensions is, by definition, incomplete (de Lisser et al., 2024; Stulikova & Dawson, 2023).

DISCUSSION

The synthesis of literature review presented in this article points to a conclusion that is simultaneously well-established and insufficiently operationalized: burnout in mental health nursing is not an inevitable consequence of working in a demanding field, but a preventable organizational outcome amenable to targeted intervention. The literature consistently situates the primary levers of burnout prevention at the systemic and organizational level, not at the level of individual nurse resilience, mindfulness, or coping capacity alone. While individual-level supports are valuable adjuncts, interventions that leave structural drivers unaddressed are palliative at best and implicitly victim-blaming at worst.

The clinical experience underlying this article reinforces this evidence-based perspective. In acute inpatient psychiatric contexts, the day-to-day reality of nursing involves not merely technical care delivery but sustained, emotionally intensive human engagement with patients whose needs are complex, often unpredictable, and sometimes threatening. When staffing levels are inadequate, when clinical leadership is disengaged, when professional autonomy is curtailed, and when opportunities for

debriefing and reflective practice are absent, the cumulative toll on nurses' psychological resources is severe. These are structural failures, and they demand structural solutions.

At the same time, the review presented here complicate any simplistic narrative of burnout as purely job-induced misery. Nursing, even in its most demanding manifestations, is described by many practitioners as a source of profound meaning and satisfaction. The paradox of high burden and high satisfaction is not merely anecdotal; it is theoretically coherent within frameworks that emphasize the centrality of perceived meaning and personal efficacy in buffering occupational stress. Nurses who experience their work as meaningful, namely, who feel that they make a genuine difference to patients' lives, who are recognized for their expertise, and who participate actively in clinical decision-making, demonstrate substantially greater resilience in the face of objective workload demands (Rutledge et al., 2024). This finding has important implications: organizational interventions that attend to meaningfulness and professional recognition, not merely workload reduction, may yield disproportionate returns in terms of staff wellbeing and retention.

The generational dimension of the discussion opens additional avenues for organizational reflection. Mental health nursing institutions that persist in hierarchical, top-down management cultures, that fail to create genuine channels for staff participation in governance, that under-invest in career development pathways, and that treat wellbeing support as an optional extra, will find themselves increasingly unable to attract and retain Generation Y and Z nurses. The competitive labor market for nursing professionals, combined with these cohorts' heightened willingness to exit unsatisfying employment, represents both a threat and an opportunity: a threat to organizations that fail to adapt, and an opportunity for those that recognize that meeting the legitimate expectations of younger nurses is not merely about employee satisfaction but about building the workforce quality and continuity that excellent psychiatric care demands.

POLICY RECOMMENDATIONS

On the basis of the literature reviewed and observations, the following recommendations are advanced for healthcare institutions, nursing leadership, and policy makers:

• Staffing adequacy: Healthcare institutions must establish and enforce evidence-based minimum nurse-to-patient ratios in psychiatric settings, taking into account not merely census numbers but the acuity and behavioral complexity of admitted patients. Chronic understaffing should be recognized as a patient safety issue, not merely a budgetary constraint.

• Professional autonomy and shared governance: Nursing units should implement formal structures for shared governance that grant nurses meaningful participation in care protocols, scheduling decisions, and quality improvement initiatives. Investment in advanced practice nursing roles can expand professional scope and enhance satisfaction.

• Psychological support infrastructure: All inpatient psychiatric units should be provided with structured, regular clinical supervision and peer support groups facilitated by qualified mental health professionals. Debriefing after critical incidents, including patient aggression, unexpected deaths, and complex ethical situations, should be mandatory and destigmatized.

• Leadership development: Nurse Managers in mental health settings should receive specialized training in transformational leadership, staff wellbeing promotion, and generational workforce management. Evidence indicates that leadership style is one of the most powerful predictors of unit-level burnout rates.

• Wellbeing programs with systemic reach: While individual wellbeing programs (mindfulness training, resilience workshops) have a role, they must be embedded within—not substituted for—structural reforms. Organizations should conduct regular, anonymous burnout assessments using validated instruments and use results to guide targeted organizational change.

• Training in self-awareness and professional identity: Pre-service and continuing education curricula for mental health nurses should explicitly address the emotional demands of the role, the dynamics of compassion fatigue and moral distress, and strategies for sustainable professional engagement. Developing nurses' capacity for reflective practice and self-compassion is a clinical competency, not a luxury.

CONCLUSIONS

Burnout among mental health nursing staff emerges from this paper as a multidimensional phenomenon with roots in the intersection of individual vulnerability, professional context, and organizational systems. The literature reviewed in this paper makes clear that no single factor precipitates burnout; rather, it emerges from the sustained interaction of high emotional labor demands, inadequate organizational support, eroded professional autonomy, and the generational dynamics of a changing workforce. Its

consequences, both for individual nurses, for care quality, and for the viability of psychiatric services, are equally serious and extensively documented.

Yet the evidence also supports a fundamentally optimistic conclusion: burnout is preventable. Organizations that commit to adequate staffing, participative leadership, structured psychological support, and genuine attention to the professional development and meaning-making needs of their nursing staff can substantially reduce burnout prevalence and its associated costs. In this sense, investment in the wellbeing of mental health nurses is not a philanthropic gesture but a strategic, evidence-based imperative for healthcare quality.

This paper has argued that the most promising preventive approach combines structural organizational reform with investment in professional identity and self-efficacy. Nurses who are well-supported, professionally recognized, and equipped with robust self-awareness—who possess not only clinical competence but also the skills of self-regulation, reflective practice, and compassionate self-care—are substantially more resilient in the face of the inevitable stresses of psychiatric nursing. Developing this kind of nurse requires institutional commitment, evidence-based training, and a cultural shift in how healthcare organizations conceive of and invest in their human capital.

Future research should seek to address several gaps in the existing evidence base, namely, the relative efficacy of different organizational intervention models for burnout prevention in mental health settings; the specific burnout trajectories and protective factors associated with Generation Y and Z nurses over career time; the role of specific psychiatric subspecialties (e.g., forensic psychiatry, child and adolescent psychiatry, personality disorders) in shaping burnout risk; and the implementation science of scaling evidence-based prevention programs across diverse mental health systems. This article offers a contribution to the ongoing scholarly and policy conversation on these questions, in the hope of advancing sustainable, high-quality mental health nursing practice.

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