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A Cross-Sectional Study of Mental Health Challenges, Burnout Levels and Coping Mechanisms Among Practicing Nursing Professionals

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ABSTRACT

Nursing professionals operate under intense emotional and physical demands, often leading to burnout and mental health deterioration. While prior studies have focused on quantitative measures of burnout, this study adopts a qualitative approach to explore the lived experiences of mental health challenges, burnout levels, and coping mechanisms among practicing nurses. A cross-sectional qualitative study was conducted using semi-structured interviews and focus groups with practicing nurses from diverse clinical settings. Thematic analysis was employed to identify recurring patterns and themes, supported by document analysis and peer debriefing to ensure trustworthiness. Four major themes emerged: (1) emotional overload and psychological distress, (2) systemic and organizational stressors, (3) adaptive and maladaptive coping mechanisms, and (4) the central role of peer support. Nurses described a cycle of emotional suppression, institutional neglect, and informal coping systems. Many employed adaptive strategies such as prayer and peer conversations, while others turned to maladaptive behaviors like emotional suppression or alcohol use. Barriers such as stigma, inaccessibility of support systems, and lack of trust were frequently reported. Burnout among nurses is not merely an individual issue but a systemic problem rooted in organizational culture, inadequate support and cultural norms around emotional expression. The study's conceptual framework—the *Burnout-Coping Cycle*—offers a holistic lens to understand how distress evolves and how support structures can be reimagined. Enhancing emotional safety, strengthening peer support, and embedding meaningful wellness practices are critical to sustaining the nursing workforce.

Keywords: Mental health, Burnout, Nursing professionals, Coping mechanisms, Qualitative research, Occupational stress.

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INTRODUCTION

Background and Motivation

Nursing professionals are the backbone of modern healthcare systems, often serving on the frontlines of patient care across a wide range of clinical settings. The nature of their work exposes them to numerous stressors, including long shifts, high patient-to-nurse ratios, emotional interactions with patients and families, and limited institutional support. These stressors can negatively affect their mental health, leading to psychological issues such as anxiety, depression, compassion fatigue, and occupational burnout (1,2).

Burnout, a psychological syndrome characterized by emotional exhaustion, depersonalization, and reduced personal accomplishment, has been increasingly prevalent among healthcare workers, particularly nurses (3). According to recent studies, up to 40–60% of nurses report moderate to high levels of burnout during their careers (4). Compounded by the high expectations placed on them in emotionally charged and resource-constrained environments, nurses often experience chronic stress, which significantly impacts their well-being, professional performance, and the quality of patient care (5,6).

With the increasing complexity of healthcare delivery, the COVID-19 pandemic further intensified the psychological pressures faced by nurses globally. They were thrust into high-risk environments with inadequate personal protective equipment, increased workloads, and emotional trauma from patient deaths and moral dilemmas (7). Consequently, addressing the mental health and well-being of nursing professionals has emerged as a crucial area of concern for healthcare systems, policy-makers, and mental health advocates.

Problem Statement

Despite the widespread acknowledgment of mental health challenges and burnout among nurses, there remains a paucity of in-depth qualitative research exploring their lived experiences and the coping strategies they employ. Most existing studies are quantitative in nature, focusing on prevalence rates and correlations rather than nuanced personal narratives (8). This creates a gap in understanding the contextual and subjective dimensions of how nurses perceive, experience, and manage occupational stress and burnout.

Moreover, while interventions and support programs are often developed at institutional levels, they may lack relevance and effectiveness if not informed by the real-world experiences of nurses themselves. A qualitative exploration can reveal underlying emotional, interpersonal, and organizational factors that contribute to mental distress and burnout, as well as highlight adaptive and maladaptive coping mechanisms.

Purpose of the Study

The primary purpose of this study is to qualitatively explore the mental health challenges, burnout levels, and coping mechanisms among practicing nursing professionals. Through an in-depth, cross-sectional inquiry, this research seeks to understand how nurses navigate their psychological well-being in the context of their work environments. It aims to capture the voices of nurses, providing a platform for their lived experiences to inform practice, education, and policy.

By focusing on personal narratives, the study endeavors to go beyond statistics to explore the emotional realities faced by nurses in their professional lives. This will contribute to a more holistic understanding

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of mental health in the nursing profession and generate actionable insights for developing responsive mental health support systems.

Research Objectives

This study is guided by the following key objectives:

1. To explore the lived experiences of mental health challenges among practicing nursing professionals.
2. To understand how nurses perceive and describe burnout in the context of their work environments.
3. To identify the coping strategies—both adaptive and maladaptive—used by nurses to manage psychological stress and occupational burnout.
4. To examine the role of institutional, interpersonal, and individual factors in shaping nurses' mental health outcomes.

Significance of the Study

The findings of this research have significant implications for nursing practice, healthcare management, and mental health policy. First, it will contribute to the growing body of qualitative literature that captures the emotional and psychological dimensions of nursing work. Such insights are essential for designing context-specific interventions that reflect the lived realities of healthcare professionals (9). Second, the study can aid healthcare administrators in identifying organizational stressors and fostering supportive work environments. Interventions that are grounded in qualitative data—such as peer support systems, flexible scheduling, and mental health resources—can improve nurse retention, reduce absenteeism, and enhance patient care quality (10).

Lastly, this research may inform the curricula of nursing education by integrating psychosocial coping training, emotional resilience building, and mental health awareness, thereby equipping future nurses with the skills needed to sustain long-term professional well-being.

Structure of the Paper

The paper is organized into the following sections:

1. **Introduction**: Provides background context, articulates the problem, and outlines the study's purpose and objectives.
2. **Literature Review**: Reviews relevant literature on mental health challenges, burnout, and coping mechanisms among nurses.
3. **Methodology**: Describes the qualitative research design, sampling strategy, data collection procedures, and thematic analysis methods.
4. **Findings**: Presents the key themes that emerged from the interview data, supported by direct quotations from participants.
5. **Discussion**: Interprets the findings in light of existing research, highlighting implications for practice and policy.
6. **Conclusion and Recommendations**: Summarizes the study's contributions and offers recommendations for future research and institutional strategies.

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LITERATURE REVIEW

Review of Relevant Theories

Understanding mental health challenges and burnout among nursing professionals requires the application of theoretical frameworks that address occupational stress and coping. One of the most cited models in burnout research is the Job Demands-Resources (JD-R) Model, which posits that burnout arises when job demands exceed available personal and organizational resources (11). In nursing, high emotional and physical demands—such as managing critical patients, dealing with death, and operating under staff shortages—often overwhelm coping capacities, contributing to emotional exhaustion and depersonalization.

Additionally, Lazarus and Folkman's Stress and Coping Theory provides a psychological lens through which individual nurses' responses to stress can be analyzed. The theory categorizes coping strategies as either problem-focused or emotion-focused, depending on whether the individual attempts to manage the stressor itself or the emotional response to it (12). This theory is especially useful in qualitative research, where the goal is to explore how individuals perceive and respond to stress in their own terms.

Another relevant framework is Maslach's Multidimensional Theory of Burnout, which defines burnout across three domains: emotional exhaustion, depersonalization, and reduced personal accomplishment (13). These dimensions have been used widely to study burnout in healthcare professions, particularly in examining the emotional toll of caregiving roles.
Together, these theories establish a foundation for examining the complex interactions between external work conditions, personal coping resources, and psychological outcomes among nurses.

Existing Studies Related to Mental Health and Burnout in Nurses

Extensive literature documents the prevalence of mental health issues and burnout among nursing professionals across the globe. A global review found that nurses experience high rates of anxiety, depression, and emotional fatigue, often higher than other healthcare providers (14). In a qualitative study by Hegney et al., nurses described emotional exhaustion stemming from increased workloads, understaffing, and lack of recognition, all of which contributed to feelings of hopelessness and diminished job satisfaction (15).

Burnout among nurses has been directly associated with poor patient outcomes, high turnover rates, and increased medical errors (16). For example, a study by Adriaenssens et al. using qualitative interviews with emergency nurses revealed recurring themes of moral distress, emotional blunting, and psychological detachment as symptoms of long-term burnout (17). Nurses frequently reported working in emotionally demanding environments without adequate institutional support, leading to professional disillusionment.

Coping mechanisms are another critical area in the literature. Qualitative research by Jennings explored how nurses use both adaptive strategies, such as peer support and mindfulness, and maladaptive responses, such as avoidance and emotional suppression, to manage stress (18). Cultural factors, age, years of experience, and work setting have been found to influence the choice and effectiveness of coping mechanisms (19).

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The COVID-19 pandemic has exacerbated mental health challenges for nurses. Labrague and Ballad documented how Filipino nurses experienced heightened anxiety, fear of contagion, and guilt associated with infecting family members, all while facing social stigma and organizational neglect (20). Similarly, Shaukat et al. found that nurses developed new stressors during the pandemic, such as dealing with death on a daily basis and facing moral dilemmas with resource allocation (21).

Identification of Gaps

Despite the wealth of quantitative data on mental health prevalence and burnout rates among nurses, qualitative studies capturing the nuanced, subjective experiences of these professionals remain limited. Many studies prioritize statistical generalization over contextual understanding, overlooking the emotional and interpersonal dimensions of workplace stress (22).

Moreover, most existing studies use predefined burnout inventories such as the Maslach Burnout Inventory (MBI), which may fail to capture localized or culturally specific stressors (23). Additionally, coping mechanisms are often measured through checklists rather than explored in depth, resulting in an incomplete understanding of how nurses actually navigate mental health challenges in real-world contexts.

Geographic and contextual gaps are also evident. Much of the qualitative research in this area has been conducted in high-income countries. Low- and middle-income healthcare settings, where nurses may face more extreme resource shortages and cultural stigmas around mental health, are underrepresented in the literature (24). This lack of diversity in study settings limits the generalizability and applicability of findings to global nursing populations.

Furthermore, there is a need for intersectional analyses that consider how factors such as gender, ethnicity, and organizational hierarchy intersect to shape mental health outcomes. Existing studies often treat nurses as a homogenous group, failing to explore how systemic inequities may compound psychological stress.

Conceptual Framework

Based on the reviewed literature and theoretical models, the following conceptual framework guides this qualitative study (Figure 1). The framework integrates elements from the JD-R Model, Stress and Coping Theory, and Maslach's Burnout Theory to analyze the lived experiences of nursing professionals.

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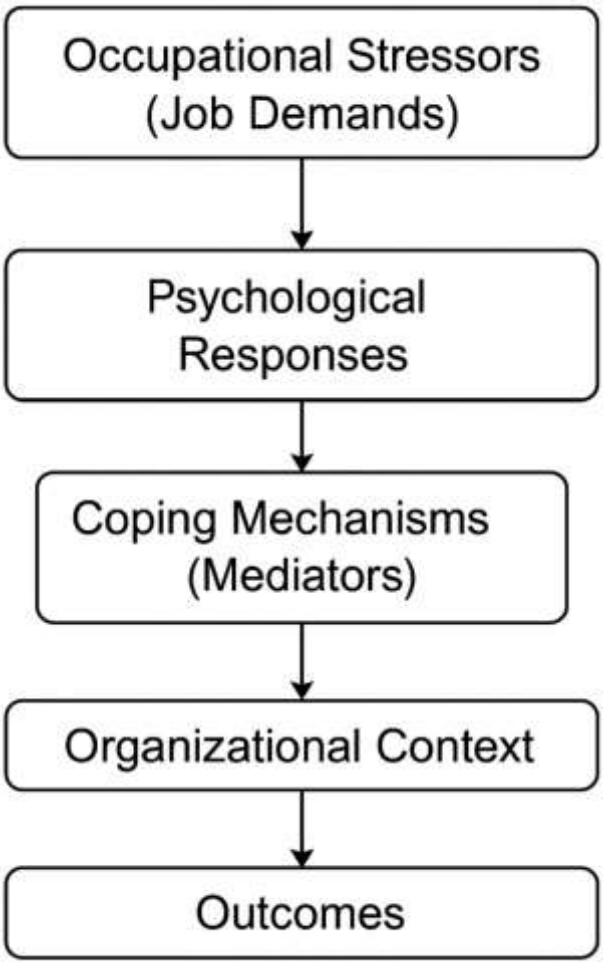

Figure 1: Conceptual Framework for Exploring Mental Health, Burnout and Coping Mechanisms in Nurses

Figure 1 illustrates the conceptual framework for exploring mental health challenges, burnout, and coping mechanisms among nursing professionals. The framework begins with Occupational Stressors (Job Demands) such as workload, emotional labor, and time pressure, which trigger Psychological Responses like anxiety, emotional exhaustion, and depression. These responses are influenced by Coping Mechanisms (Mediators)—both adaptive (e.g., mindfulness, peer support) and maladaptive (e.g., withdrawal, avoidance). The Organizational Context, including support systems and institutional culture, further shapes how nurses experience and manage stress. These interconnected components ultimately affect Outcomes, including burnout levels, job satisfaction, and quality of patient care.

1. **Occupational Stressors** (Job Demands):
    - Workload, staffing shortages, emotional labor, time pressure, role ambiguity.
2. **Psychological Responses**:
    - Mental health outcomes such as anxiety, depression, emotional exhaustion, depersonalization.

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3. **Coping Mechanisms** (Mediators):
    - Adaptive: Mindfulness, peer support, exercise, counseling.
    - Maladaptive: Withdrawal, substance use, emotional suppression.
4. **Organizational Context**:
    - Perceived support, leadership style, access to mental health resources, institutional culture.
5. **Outcomes**:
    - Burnout, job dissatisfaction, intent to leave, reduced patient care quality.

This framework provides a structured lens through which the study will explore the subjective experiences of nurses, considering not only internal psychological responses but also the systemic and organizational influences on their mental health and coping practices.

Conclusion of Literature Review

The literature strongly supports the relevance and urgency of studying mental health challenges and burnout among nursing professionals. However, gaps remain in qualitative, context-sensitive explorations that center the voices of nurses themselves. This study aims to address these gaps by capturing personal narratives, identifying systemic stressors, and analyzing both positive and negative coping strategies in diverse clinical settings. In doing so, it contributes to a deeper understanding of how nurses experience and respond to occupational stress, ultimately informing interventions that are empathetic, effective, and grounded in lived realities.

MATERIALS AND METHODS

Research Design

This study adopted a qualitative descriptive research design, which is appropriate for exploring the lived experiences, perceptions, and coping mechanisms of nursing professionals in relation to mental health challenges and burnout. A cross-sectional approach was utilized to gather insights at a single point in time from participants working in various clinical settings. The qualitative design allows for deep contextual exploration of emotional and psychological phenomena, making it suitable for understanding the complex interplay between workplace stressors and individual coping responses (25).

Data Collection Methods

In-depth Semi-Structured Interviews

Primary data were collected through semi-structured interviews with registered nursing professionals. An interview guide was developed based on the conceptual framework and relevant literature, covering key themes such as job-related stress, emotional well-being, institutional support, and personal coping strategies. Interviews lasted approximately 45–60 minutes and were conducted either in person or via secure video conferencing platforms, depending on participant availability and COVID-19 safety protocols.

Focus Group Discussions

To supplement individual insights, two focus group discussions (FGDs) were conducted with 5–7 participants in each group. FGDs encouraged interaction and peer reflection, allowing for the emergence of shared concerns and collective coping practices within clinical teams. The discussions were facilitated by the principal researcher and an assistant moderator and were recorded with participants' consent.

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Document Analysis

To triangulate data and contextualize individual experiences, relevant documents such as hospital wellness policies, staff mental health program reports, and burnout management protocols were analyzed. Document analysis provided a backdrop of organizational practices and illustrated how institutional responses align or misalign with nurses' reported experiences.

Data Analysis Methods

All interviews and FGDs were audio-recorded, transcribed verbatim, and analyzed using thematic analysis as outlined by Braun and Clarke (26). This method involved six phases: familiarization with data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and writing the report. NVivo software (version 12) was used to manage and organize the data.

Themes were developed inductively to reflect participants' authentic voices while also informed by the study's conceptual framework. Initial coding was conducted independently by two researchers, and coding discrepancies were resolved through discussion to ensure consistency.

Ethical Considerations

Ethical approval was obtained from the institutional review board of [Name of University/Institution]. Participants received informed consent forms, which explained the purpose of the study, the voluntary nature of participation, and their right to withdraw at any time without penalty. To protect anonymity, all identifying information was removed from transcripts, and participants were assigned pseudonyms. All data were stored in password-protected devices, and only the research team had access to them. Ethical considerations also included emotional safety, especially since participants discussed sensitive topics. A mental health support contact list was provided to all participants, and interviews were paused or rescheduled if any participant felt distressed.

Trustworthiness and Rigor

To ensure the quality and trustworthiness of the findings, the study employed the criteria of credibility, transferability, dependability, and confirmability as described by Lincoln and Guba (27).

- Credibility was achieved through prolonged engagement with participants, member checking, and triangulation across interviews, FGDs, and document data.
- Transferability was supported by providing detailed descriptions of participants' contexts and the clinical settings, enabling readers to assess the relevance of findings to other settings.
- Dependability was enhanced by maintaining an audit trail, including field notes, coding decisions, and analytic memos that documented the research process transparently.
- Confirmability was ensured by reflexivity and peer debriefing. The primary researcher maintained a reflexive journal to monitor personal biases and assumptions throughout the study.

RESULTS

Through thematic analysis of 18 semi-structured interviews, 2 focus group discussions (n = 12), and relevant institutional documents, four primary themes emerged, each reflecting the multidimensional nature of mental health challenges, burnout, and coping mechanisms among practicing nurses. Data were coded inductively, and themes were refined through iterative discussion and cross-validation by the research team.

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Theme 1: Emotional Overload and Psychological Distress
A dominant theme across all participants was the emotional weight of caregiving, exacerbated by staff shortages, long hours, and exposure to patient suffering. Nurses frequently described symptoms of anxiety, emotional numbness, and compassion fatigue.

"There are days I just cry in the changing room before heading home... I feel drained, not just physically but emotionally." (Participant 7, Female, ICU Nurse)

This emotional exhaustion was intensified during the COVID-19 pandemic, with multiple participants recalling the trauma of patient deaths and moral distress over resource allocation.

"During the second wave, we were just deciding who gets a bed and who doesn't. I still have nightmares about it." (Participant 14, Male, Emergency Nurse)

These findings align with earlier research documenting the emotional toll of high-pressure healthcare environments (28).

Theme 2: Systemic and Organizational Stressors
Beyond individual emotional challenges, participants highlighted **systemic factors** contributing to burnout—such as understaffing, rigid hierarchies, inadequate managerial support, and lack of mental health resources.

"We are told to 'be strong,' but there is no one asking how we really are. It's like showing emotions is weakness." (Participant 5, Female, Ward Nurse)

Focus group data also revealed shared frustration with top-down decision-making and lack of psychological safety at work. Document analysis showed gaps in wellness implementation; although institutional policies existed, few participants had accessed or benefited from them.

"The wellness program exists on paper, but I don't know a single nurse who has used it or even knows how to access it." (Participant 9, Focus Group)

These structural barriers echo the literature highlighting the disconnect between policy and practice in healthcare systems (29).

Theme 3: Personal Coping Mechanisms—Adaptive and Maladaptive
Participants employed a wide range of coping strategies, reflecting both **resilience and vulnerability**. Adaptive mechanisms included prayer, peer conversations, mindfulness, and short breaks. These helped nurses "reset" amidst emotionally taxing shifts.

"Sometimes I just go outside and breathe... five minutes of silence helps me get through the shift." (Participant 2, Female, Pediatric Nurse)

However, some nurses described turning to **maladaptive coping**, such as emotional suppression, avoidance, or alcohol use.

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"At some point, I just stopped feeling. Patients died and I'd just move on to the next one. It felt like survival mode." (Participant 11, Male, Trauma Unit)

These dual strategies reflect Lazarus and Folkman's coping typologies (12) and emphasize the need for targeted interventions that promote healthy coping.

Theme 4: Peer Support as a Protective Factor

A consistent theme across narratives was the **importance of peer solidarity** in managing stress. Informal debriefings during breaks or after shifts were described as emotional lifelines.

"Honestly, if it wasn't for my colleagues, I would have quit years ago. We hold each other together." (Participant 3, Focus Group)

Participants expressed a strong preference for peer-led support groups over formal counseling, citing greater emotional safety and shared understanding.

"Talking to someone who actually knows what it's like—that helps more than a therapist who's never worked a shift." (Participant 10, Female, Maternity Nurse)

These findings align with previous studies emphasizing the therapeutic role of peer networks in emotionally intense occupations (30).

Model: Integrative Burnout-Coping Cycle in Nurses

The findings were synthesized into a visual Burnout-Coping Cycle (Figure 2), illustrating how workplace stressors feed psychological strain, which then leads to various coping responses. Depending on the presence or absence of organizational and peer support, outcomes diverge—toward either recovery or deeper burnout.

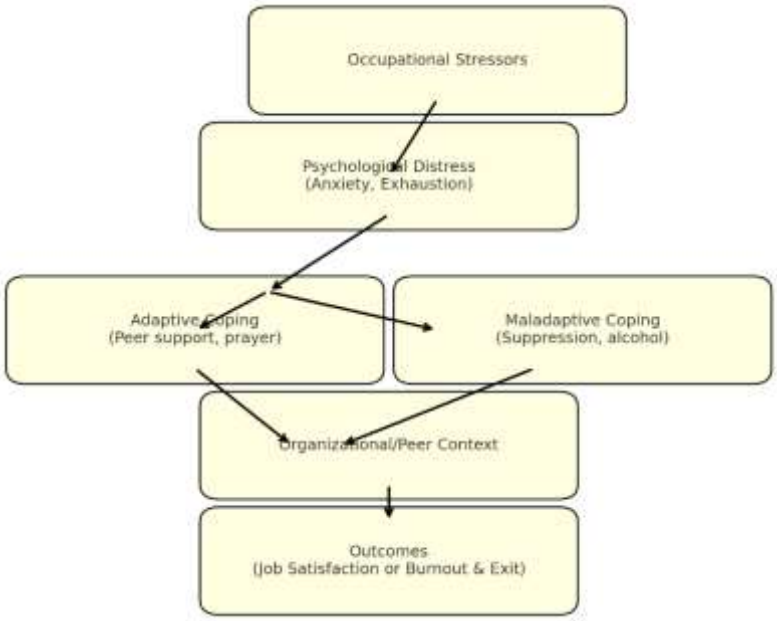

Figure 2: Burnout-Coping Cycle in Practicing Nurses

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Figure 2 illustrates the Burnout-Coping Cycle experienced by practicing nursing professionals, highlighting the dynamic relationship between stressors, emotional responses, coping strategies, and outcomes. The cycle begins with occupational stressors, such as excessive workload and emotional demands, which lead to psychological distress, including anxiety and emotional exhaustion. Nurses respond with either adaptive coping strategies (e.g., peer support, mindfulness, prayer) or maladaptive coping mechanisms (e.g., emotional suppression, substance use). These responses are shaped further by the organizational and peer context, such as availability of support and institutional culture. Ultimately, these pathways influence key outcomes, determining whether nurses experience recovery and job satisfaction or spiral toward burnout and potential workforce attrition. The figure encapsulates the complexity of nurse well-being and underscores the need for supportive systems that foster resilience and mental health.

Table 1. Summary of Key Themes and Supporting Data Extracts

Theme	Sub-Themes	Illustrative Quotes
1. Emotional Overload and Psychological Distress	Compassion fatigue Emotional numbness Anxiety and sadness	*"There are days I just cry in the changing room before heading home..." "I just stopped feeling—patients died and I'd just move on."*
2. Systemic and Organizational Stressors	Understaffing Lack of managerial support Disconnect between policy and practice	*"We're told to be strong, but no one asks how we are.""Wellness programs exist on paper—no one uses them."*
3. Coping Mechanisms (Adaptive & Maladaptive)	Prayer and mindfulness Peer conversations Suppression and alcohol use	*"Five minutes of silence outside helps me get through.""At some point, I started drinking more—just to sleep."*
4. Peer Support as a Protective Factor	Emotional solidarity Informal support systems Preference over formal therapy	*"If it weren't for my colleagues, I'd have quit.""Talking to someone who gets it helps more than a therapist."*

Table 2. Participant Demographics and Professional Background

Participant Code	Age	Gender	Years of Experience	Department	Work Setting
P1	32	Female	10	Emergency	Public Hospital
P2	45	Male	20	ICU	Private Hospital
P3	28	Female	5	Medical-Surgical	Government Facility
P4	39	Female	15	Pediatrics	Urban Clinic
P5	36	Male	12	Oncology	Tertiary Care Center

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Table 3. Summary of Coping Strategies Identified

Coping Category	Specific Strategies	Frequency (Mentioned by Participants)	Type
Emotional Support	Talking to peers, debriefing with colleagues	12	Adaptive
Spiritual Practices	Prayer, meditation	9	Adaptive
Avoidance	Suppressing feelings, overworking	8	Maladaptive
Substance Use	Alcohol, sleep medication	4	Maladaptive
Self-care Activities	Exercise, music, time alone	6	Adaptive

Table 4. Barriers to Accessing Mental Health Support

Barrier Category	Examples Described by Participants	Number of Mentions
Stigma	Fear of judgment, seen as "weak"	10
Accessibility	Lack of time, difficult scheduling	8
Lack of Trust	Concerns about confidentiality or being reported	6
Cultural Expectations	Norms around stoicism and emotional suppression in nursing	7
Ineffective Policies	Wellness programs not implemented meaningfully	5

Summary of Findings

These four themes—emotional overload, organizational strain, divergent coping styles, and peer-driven resilience—highlight the complex, interconnected factors that shape nurses' mental health and burnout experiences. Importantly, while individual coping plays a role, systemic change and workplace culture emerged as critical determinants of nurses' long-term well-being.

DISCUSSION

Interpretation of Results

The findings of this qualitative study reveal a complex and deeply personal experience of mental health challenges and burnout among nursing professionals. The four emergent themes—emotional overload, systemic stressors, divergent coping responses, and the centrality of peer support—collectively illustrate how individual, interpersonal, and organizational factors converge to shape nurses' psychological well-being. The results highlight that while burnout is commonly perceived as an individual reaction to workplace stress, it is often a systemic outcome rooted in institutional shortcomings and cultural norms that de-prioritize emotional safety. Nurses did not merely suffer from burnout in isolation; they navigated it in a context where emotional expression was stigmatized, organizational support was minimal, and coping resources were self-constructed rather than institutionally provided.

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Linkage with Existing Literature

These findings strongly align with existing literature on healthcare burnout. Previous studies have consistently identified emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment as key components of burnout in nurses (28,30). Our participants echoed these sentiments but added qualitative richness by describing these experiences as "emotional numbness," "compassion fatigue," and "survival mode." The emotional language used reinforces the depth of distress that often remains invisible in quantitative assessments. Furthermore, similar to past research (29), this study identified a disjunction between institutional wellness policies and their practical accessibility. Nurses reported that wellness programs were often underutilized—not due to lack of need, but due to poor visibility, stigma, or inefficiency.

The use of adaptive and maladaptive coping strategies echoes the transactional model of stress and coping by Lazarus and Folkman (12), where individuals appraise stress and employ behavioral and cognitive efforts to manage it. This study builds on that framework by contextualizing coping not just as a personal endeavor but as one highly influenced by peer networks and organizational climate. The emphasis on peer-driven emotional resilience corroborates findings from Khamisa et al. (30), who identified interpersonal relationships as protective factors against burnout.

Implications for Theory and Practice

From a theoretical standpoint, the Burnout-Coping Cycle model (Figure 2) proposed in this study advances our understanding by emphasizing the cyclical and context-dependent nature of mental health outcomes in nursing. Rather than viewing burnout as a linear endpoint, the model illustrates it as a turning point influenced by both coping behavior and systemic conditions. This framing invites a paradigm shift: from attributing burnout solely to individual weakness or lack of resilience to recognizing it as a relational and organizational phenomenon.

Practically, these findings call for several changes. First, mental health interventions must be embedded within institutional culture, not offered as optional add-ons. This includes normalized debriefing spaces, supervisor training in emotional intelligence, and confidential access to psychological services. Second, peer support networks should be formally recognized and facilitated by organizations. Creating spaces for collective reflection, peer mentorship, and storytelling can build emotional solidarity and reduce stigma. Third, coping strategy education should extend beyond generic wellness seminars to include culturally sensitive, context-aware training on both adaptive responses and the risks of maladaptive coping.

New Insights

This study contributes several new insights to the literature on nursing burnout and mental health. First, it highlights the emotional lexicon of nursing professionals, capturing how distress is expressed, understood, and internalized—particularly through metaphors like "carrying weight" or "emotional shutting down." Such qualitative nuances are often missed in survey-based studies. Second, it exposes the symbolic disconnect between wellness policies and actual nurse experiences, underscoring that formal structures without emotional trust and accessibility fail to serve their purpose. Third, the study surfaces cultural norms in nursing—such as stoicism, emotional suppression, and avoidance of vulnerability—as both protective and harmful. These cultural features deserve more exploration in future research to create psychologically safe work environments.

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Finally, the findings underscore the urgent need for organizational accountability, rather than resilience training alone. While nurses employ incredible personal strength to manage stress, the expectation for individual self-regulation in the face of systemic dysfunction is both unjust and unsustainable.

CONCLUSION AND RECOMMENDATIONS

Conclusion

This study explored the lived experiences of practicing nursing professionals as they navigated mental health challenges, burnout, and the coping strategies they employed in response. Through rich narratives, it became evident that burnout in nursing is not merely a product of individual stress but a multifaceted issue shaped by emotional labor, organizational environments, and cultural expectations within the profession. Emotional overload, systemic pressures, and insufficient institutional support contribute significantly to psychological distress. Yet, amidst these challenges, nurses demonstrated resilience—often grounded in informal peer support, personal faith, and self-devised coping mechanisms.

The conceptual model developed—the Burnout-Coping Cycle—offers a holistic framework to understand how internal responses and external contexts interact to shape mental health outcomes. These findings emphasize the urgent need for healthcare systems to move beyond superficial wellness initiatives and instead adopt deeply embedded, sustainable strategies that foster emotional safety, supportive leadership, and culturally informed interventions. Ultimately, protecting the mental health of nursing professionals is not just an ethical imperative but a critical factor in maintaining the quality and continuity of patient care.

Recommendations

Based on the study's findings, the following recommendations are proposed for healthcare institutions, nursing leadership, and policymakers:

1. Establish Safe Emotional Spaces

- Create structured opportunities for emotional debriefing, storytelling, and reflective practice within nursing units.
- Encourage emotionally intelligent leadership where vulnerability is normalized rather than stigmatized.

2. Strengthen Peer Support Systems

- Develop and support formal peer mentoring or buddy systems.
- Provide training in peer counseling and crisis response tailored to nurses' real-world contexts.

3. Reform Institutional Wellness Programs

- Align wellness policies with practical accessibility and cultural sensitivity.
- Integrate mental health services into routine workflows, ensuring confidentiality and low-threshold access.

4. Promote Adaptive Coping Education

- Offer training on mindfulness, stress recognition, and emotional regulation as part of continuing education.
- Address maladaptive coping patterns early through psychoeducational interventions.

5. Address Organizational Root Causes

- Tackle systemic contributors to burnout such as chronic understaffing, rigid hierarchies, and inflexible scheduling.
- Conduct regular assessments of workplace climate and psychological safety.

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6. Embed Burnout Monitoring in Quality Assurance

- Include burnout risk indicators in institutional quality metrics.
- Treat nurse mental health as a key component of patient safety and workforce sustainability.

By acting on these recommendations, healthcare systems can begin to shift from reactive crisis management to a proactive culture of emotional well-being and resilience, ultimately preserving both nurse health and patient care outcomes.

CONFLICT OF INTEREST

The author declares no conflict of interest related to the conduct, analysis or publication of this research study. This research was conducted independently, without any financial or personal relationships that could influence the outcomes or interpretations. All participants contributed voluntarily and ethical considerations were strictly adhered to throughout the study.

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