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A Multiple Goals Perspective on Burnout Disclosure and Support among Attending Physicians

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A MULTIPLE GOALS PERSPECTIVE ON BURNOUT DISCLOSURE AND SUPPORT AMONG ATTENDING PHYSICIANS

DISSERTATION

A dissertation submitted in partial fulfillment of the
requirements for the degree of Doctor of Philosophy in the
College of Communication and Information
at the University of Kentucky

By
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ABSTRACT OF DISSERTATION

A MULTIPLE GOALS PERSPECTIVE ON BURNOUT DISCLOSURE AND SUPPORT AMONG ATTENDING PHYSICIANS

Burnout is a common experience among physicians and has been identified as a precursor to substance abuse and suicide ideation. When not addressed, burnout can have many negative personal, relational and professional consequences. Research about the burnout experience is limited due to the taboo nature of the topic. The present study used a multiple goals theoretical perspective to examine how physicians disclose burnout in order to access social support. Attending physicians from various specialties (N = 30) participated in one-on-one interviews and were asked to discuss their burnout experience, conversational goals during burnout disclosure, catalysts and barriers for disclosure, and provide details about how they evaluated supportive messages from others. Participants also completed a questionnaire in which they were asked to provide demographic information and details about their work experience. Interviews were transcribed and coded using qualitative descriptive analysis. Overall, the findings highlight conversational goals and dilemmas that were salient for participants when disclosing burnout and how they evaluated supportive responses from others. Specifically, results indicated participants' burnout experiences involved emotional exhaustion, depersonalization, loss of work fulfillment, feeling stuck or wanting to leave the field of medicine, and recognition of changes about themselves. Participants reported having multiple task and identity goals during disclosure and identified how these goals often led to conversational dilemmas. Participants described using several strategies for disclosing burnout, including not calling it burnout, sharing knowledge with other physicians, choosing appropriate confidants, sharing selective information, and not disclosing. Factors that made it easier for them to disclose included normalization of burnout, others disclosing burnout, shared professional experiences, perceived confidentiality, and their role as an attending. Participants also identified factors that made disclosure difficult, including stigma and fear of judgment, the perception that no one cares or that support is unavailable. Additionally, participants found responses more supportive when they included listening, support for professional changes, sympathy and compassion or reassurance. Less supportive responses included dismissal of feelings, canned responses, or inadequate professional support. Theoretically, the results provide evidence for the three categories commonly used to conceptualized burnout (i.e., emotional exhaustion, depersonalization, loss of work fulfillment), while also highlighting two sub-categories related to loss of work fulfillment (i.e., wanting to leave medicine but feeling stuck; recognizing changes about themselves). The results also provide evidence of how stigma influences conversational goals, highlighting an opportunity to further investigate potential connections between types of goals and evaluation of supportive responses. Practically, the findings provide insight for how physicians can effectively disclose burnout and how healthcare administrators and friends and family members of physicians can be more supportive when responding to burnout disclosure.

KEYWORDS: Burnout, Communication, Disclosure, Multiple Goals, Physicians, Support

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A MULTIPLE GOALS PERSPECTIVE ON BURNOUT DISCLOSURE AND SUPPORT AMONG ATTENDING PHYSICIANS

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For Andy, the most selfless person I know.

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Finally, I am thankful for Him, through which all of this has been possible.

"…whatever you do, do it all for the glory of God"

- 1 Corinthians 10:31

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Chapter One: Introduction

During formal education and training, health providers take an oath to "do no harm" (Hulkower, 2016, p. 43) for their patients; however, this statement does not always translate to taking care of their own health. Medical education and training historically has been known for its long hours, high expectations, and intense pressures, and working in this type of environment can negatively impact providers' mental and physical wellbeing (Cook et al., 2014). Consequently, burnout is a common experience among healthcare professionals, with particularly high rates occurring during medical school and residency training (Goldman et al., 2015). Burnout has been identified as a precursor to suicide ideation (Dyrbye et al., 2008), and perhaps not surprisingly, the suicide rate in the United States among practicing physicians is approximately double the rate of the general population (Zwack & Schweitzer, 2013).

The increased rates of physician burnout and suicide point to a need for additional research about ways to improve physicians' ability to identify early signs of burnout and encourage providers to seek support. There is overwhelming evidence that social support is linked to better mental health and that the success or failure of communicated social support influences coping, relationship satisfaction, and individual health and wellbeing (Goldsmith, 2004). However, although research clearly documents the need for social support for physicians, the topic of psychiatric issues among health providers is often viewed as taboo, and therefore, research about these experiences, including the potential impact of social support in this context, is limited (Bender et al., 2016).

This research project is designed to address physician mental health and burnout from a communication perspective to further scholarly understanding of how physicians

can communicate effectively to access the social support they need. The study uses a multiple goals perspective and the normative model of social support to explain how attending to conversational goals and identifying helpful conversational features during disclosure conversations may lead to more or less supportive conversations. In Chapter Two, I review literature relevant to physician burnout, disclosure, and social support. In Chapter Three, I outline the theoretical frameworks and research questions that guide this study. In Chapter Four, I summarize the results from a pilot study informing this dissertation research, and present the method used to conduct the present study. In Chapter Five, the results of this study are outlined and explained. Finally, in Chapter Six, I discuss the theoretical and practical implications of my findings, as well as the limitations of my study and opportunities for future research.

Chapter Two: Literature Review

Physician burnout is a unique experience with a number of negative consequences, and physicians who face burnout often find themselves in need of social support. When burnout occurs, a physician who discloses their experience to others can access many benefits, including social support, which can help them cope; however, there are significant barriers that may prevent physicians from disclosing their burnout and therefore preclude physicians from accessing the support they need. In this chapter, I review this dilemma by summarizing literature about physician burnout, social support, and disclosure.

Physician Burnout

Burnout is defined as emotional exhaustion, depersonalization, and loss of work fulfillment (Shanafelt et al., 2012). Emotional exhaustion, also known as "emotional overload" or "compassion fatigue" (Maslach, 1982), occurs when an individual does not feel they have the emotional resources necessary to care for others. The second component of burnout is depersonalization, which occurs when a person begins to emotionally detach themselves from others, leading to a negative attitude, disregard for others, and uncaring demeanor (Maslach, 1982). The third characteristic of burnout is reduced personal fulfillment. This is often related to achievement and occurs when an individual reflects on the ways he or she is changing and begins to feel inadequate in multiple areas of his or her life, including professionally.

Burnout is commonly experienced by individuals whose job requires them to help people all day long (e.g., physicians, nurses, police officers, 911 operators), as it is a response to everyday stress that comes from a sense of overload (e.g., information

overload, demand overload, emotional strain, life-and-death situations; Maslach, 1982). There is some evidence that burnout is commonly viewed as something that happens to "defective people" (Maslach, 1982, p. 9); however, the widespread nature of burnout and the diverse personalities and backgrounds of those who are affected by this phenomenon suggests it is not caused by individual characteristics, but instead by situational factors. Although there is research to support the normalcy of burnout, it is common for individuals to still interpret their own burnout experience as the result of a personal weakness (Maslach, 1982).

While each situation is unique, there are some factors, such as age, that can put individuals at an increased risk for experiencing burnout. For example, researchers have found that younger employees (i.e., individuals less than 55 years old) are 200% more at risk for experiencing burnout than older employees (i.e., individuals 55 years or older) (Dyrbye et al., 2017). This makes sense, as older workers often have more experience and stability in their job and may feel as though they have more control over contributing factors to burnout, such as scheduling and work conflicts. Female physicians are 30 to 60% more at risk for burnout than male physicians (Shanafelt et al., 2015). Additionally, physicians who are married often have a different view of their job (i.e., do not see it as a way to meet social needs) compared to those who are single, which can lead to less emotional strain at work and thus lower odds of experiencing burnout (Doan-Wiggins et al., 1995). Additionally, workers who are divorced are at greater risk for experiencing the high emotional exhaustion that comes with burnout, but not necessarily the depersonalization or reduced personal accomplishment that is likely to be experienced by individuals who are single (Maslach, 1982). Finally, having a family has been found to be

a potential source of support for individuals rather than an additional demand and has been linked to lower burnout rates (Taku, 2014).

Among physicians, specifically, burnout rates are high (approximately 54% of all physicians experience burnout; Shanafelt et al., 2012). Research suggests this high rate of burnout is a result of demanding job responsibilities, varying schedules, and high professional expectations. Brigham et al. (2018) identified four external causes of burnout among physicians: (a) socio-cultural factors (e.g., alignment of societal expectations and the clinician's role; stigma of mental illness), (b) regulatory factors (e.g., reimbursement structure, litigation risk, maintenance of licensure), (c) organizational factors (e.g., level of support for all team members; professional development), and (d) learning environment factors (e.g., autonomy, professional relationships and mentorship). Additional research supports this categorization. For example, excessive workloads have been linked to burnout and poor patient outcomes (Aiken et al., 2002), and time demands from electronic health record documentation requirements have also been found to contribute to physician burnout (Rassolian et al., 2017).

These four external factors commonly lead to burnout among physicians in training (i.e., medical students, residents, fellows) in particular. Physicians in training are more likely to ignore their own physical and emotional wellbeing, and these trainees often carry this pattern of ignoring their wellbeing into their career. A lack of focus on self-care makes it difficult for physicians to recognize and acknowledge burnout before it turns into a longer lasting condition (e.g., mental disorder). It has been reported that some behaviors exhibited by physicians during and after training are similar to those seen in

patients with post-traumatic stress disorder (Heru et al., 2009); however, many physicians in training view self-care as an unrealistic option (e.g., Dyrbye et al., 2015).

In addition to external influences, Brigham et al. (2018) also identified three causes of physician burnout that are unique to each individual, including: (a) health care role (e.g., administrative and clinical responsibilities; student/trainee responsibilities), (b) personal factors (e.g., family dynamics; financial stresses; social support), and (c) skills and abilities (e.g., personal achievements; interests). There is empirical evidence linking these internal factors to burnout in physicians. For example, unbalanced work-life integration (Dyrbye et al., 2013), limited personal time (Shanafelt et al., 2009), and physician satisfaction (Keeton et al., 2007) have been shown to heavily contribute to burnout. Other burnout predictors include accumulating debt (West et al., 2011), long working hours (Shirom et al., 2010), sleep disturbances (Goldberg et al., 1996), and work-home conflict (Dyrbye et al., 2011). Additionally, Shanafelt et al. (2016), found that physicians who spent less than 20% of their time on work activities they identified as "personally meaningful" were found to be 275% more likely to experience burnout.

The consequences of untreated burnout can be substantial. Specifically, burnout can contribute to deficits in important areas for daily functioning. Therefore, when a physician does not address their burnout, there can be negative personal, relational and professional consequences.

Personal Consequences

There is an irony to the phenomenon of physician burnout when it comes to its impact on health. As physicians work to improve the health of their patients, many inadvertently cause deterioration to their own physical and psychological health. Physical

exhaustion makes individuals more susceptible to illness, more likely to have poor nutrition habits (e.g., skipping meals), and experience lingering headaches (Maslach, 1982). Sleep hygiene is an important, yet sometimes ignored, part of physical health, and according to Maslach (1982), burnout can impede a person's ability to get proper rest, as they struggle with insomnia and nightmares or a job that interrupts their nighttime sleep.

Burnout also contributes to poor mental health among physicians and may lead to feelings of isolation and negative self-esteem, both of which are characteristics of depression (Maslach, 1982). When untreated, burnout can turn into or co-occur with mental illnesses such as depression (Bianchi et al., 2015; Eckleberry-Hunt et al., 2017) and lead physicians to become bitter, easily irritated, impatient, and angry (Maslach, 1982). Depression affects a person's emotions, thoughts, and actions (Mata et al., 2015) and when ignored, depression can lead to life-threatening consequences such as suicidal ideation (Piccinini et al., 2017) or addiction (Boyd, 2017).

In the United States, nearly 400 physicians commit suicide every year (Andrew & Brenner, 2018); a rate that is higher than the general U.S. population (Gold et al., 2013). This statistic is equivalent to two classes of medical school graduates dying by suicide each year (Myers, 2017) or one physician dying everyday by suicide. Suicidal ideation is not an issue limited to physicians still in training (i.e., medical students, residents), and in fact, research findings suggest that rates of suicide increase the most near the end of a physician's career (Petersen & Burnett, 2007). Therefore, although much of the research on physician burnout has focused on experiences among medical students (e.g., Shiralkar et al., 2013; Williams et al., 2015) and residents (e.g., Kealy et al., 2016; Lafreniere et al., 2016), it is also important to understand how burnout impacts physicians post-residency,

or once training has been completed. A common misconception among physicians is that once training is completed, there will be more control over clinical decisions and they will be less likely to experience burnout (Eckleberry-Hunt et al., 2017); however, this is not often the case, and physicians find ways to cope with their new reality.

One way physicians may cope with burnout is addiction, which can include substance misuse. Although rates of substance use among physicians (approximately 8 to 15%) are similar to the general population (Baldisseri, 2007), physicians are more likely than non-physicians to use illicit drugs and alcohol for recreational purposes and prescription drugs such as opiates and benzodiazepines for self-treatment (Boyd, 2017). Furthermore, a physician's specialty may contribute to the substance used (Hughes et al., 1999; Rose et al., 2017). For example, emergency physicians have been found to be most likely to use illicit drugs (e.g., marijuana, heroin), while anesthesiologists are more likely than other physicians to use opiates (e.g., Norco, Percocet), and psychiatrists are more likely to use benzodiazepines (e.g., Xanax) than physicians in other specialties (Boyd, 2017). Additionally, multiple studies (e.g., Rosta, 2008; Rosta & Aasland, 2005) have found that surgeons are more likely to engage in problematic use of alcohol than non-surgeons.

Relational Consequences

Burnout can also negatively impact a physician's close relationships. When a person is emotionally drained, those closest to them (e.g., friends, family) can be affected. For physicians, burnout has been reported as being both the result of *and* a predictor of poor relational functioning (Eckleberry-Hunt et al., 2017). When physicians experience burnout, they are more likely to have relational issues at work (e.g., with co-

workers and patients) and outside of work (e.g., with spouses and friends) (Rosenstein, 2017). Physicians may shift the way they communicate with others as a mechanism for coping with burnout, and this shift can cause issues in their relationships. For example, at work, physicians may unintentionally begin expressing a dislike for patients, complain more, and use less eye contact with co-workers (Rosenstein, 2017). Outside of work, they may refuse to talk about work and suggest that it is to protect their loved ones; however, it may instead be their way of emotionally detaching themselves from the negative experience of work.

Long hours and inconsistent schedules can cause disruptions to physicians' relationships outside of work. For example, physicians' schedules may not allow them to attend extracurricular activities, or when they can, being "on call" may disrupt the time they can spend with family and friends. Finally, when physicians are emotionally exhausted and do not feel they have the emotional resources necessary to maintain close relationships, they may begin engaging in inappropriate relational communication, such as treating family members as they would a patient or co-worker (Maslach & Jackson, 1979).

Professional Consequences

Finally, there are many ways burnout negatively impacts physicians at work. For example, burnout has been associated with negative patient outcomes such as lower patient satisfaction (Shanafelt et al., 2009), reduced health outcomes, increased healthcare costs (Bodenheimer & Sinsky, 2014), and lower compliance with physician care plans (Ariely & Lanier, 2015). Additionally, burnout can lead to negative physician outcomes such as decreased quality of care (Shanafelt & Noseworthy, 2017), increased medical

errors (Shanafelt et al., 2010; Wears & Wu, 2002), decreased productivity (Shanafelt et al., 2016) and increased turnover (Ariely & Lanier, 2015; Misra-Hebert et al., 2004; Shanafelt et al., 2016; Shanafelt & Noseworthy, 2017).

When burnout leads to lower quality of care, it does not necessarily mean that physicians are doing a *bad* job at work, but instead that they simply begin to do *less* (e.g., avoiding tasks, spending less time with patients; Sheppe & Stevenson, 1963). Often this is because physicians have become dissatisfied with their work and may begin taking risks more easily, with potential for a lapse in professional judgment (Shanafelt et al., 2010). For example, physicians who are experiencing burnout may begin approaching their work in a robotic fashion, responding to each patient as fitting into a category or labeled with a specific problem rather than treating each patient with a tailored approach (Goppelt, 1978).

In short, burnout is a common experience among physicians that negatively impacts their physical and mental health, ability to maintain close relationships, and performance at work. Physicians typically view the consequences of burnout as a "weakness" which prevents them from disclosing their burnout.

Disclosure

To gain support from others, physicians must first disclose personal information about their burnout experience (Greene et al., 2003). The process of disclosing health information can be difficult, as it often differs from sharing other types of information by requiring individuals to reveal raw feelings and vulnerabilities related to their experience (Charmaz, 1999; Derlega et al., 2004). Disclosing health information can lead to feelings

of discomfort and disconnectedness (Rawlins, 1983) and influence a physician's decision to share or withhold information.

Although disclosing personal information can be beneficial, there are many reasons physicians may decide not to share their burnout experiences with others. First, by disclosing burnout, physicians reveal they are having difficulty with their work, putting them at risk for stigmatization. Stigma, or "an undesired differentness" (Goffman, 1963/2009, p.5) can be a barrier for disclosure, as stigma influences how individuals perceive and communicate about topics (i.e., burnout). Although physicians are aware of how burnout negatively impacts them, they are also aware that the negative impact may be viewed as a "weakness". In the United States, being healthy is considered "normal," and having an illness is considered a deviance (Hayden, 1993). For physicians, concerns about burnout are compounded by expectations to remain highly dedicated to the profession, avoid exposing any potential weaknesses, and exhibit emotional strength – all while providing the best care for patients. These pressures related to burnout are combined with the perceived stigma or "an undesired differentness" from what is expected or anticipated (Goffman, 1963/2009, p. 5) and can discourage providers from revealing information that might be seen by others as exposing a personal weakness.

Research findings consistently link perceived stigma and willingness to disclose health-related topics (Greene, 2015), and often the more stigma that is associated with a topic, the less a person is willing to disclose (Greene, 2000). This connection between stigma and disclosure has been found in research about health topics such as HIV (Derlega et al., 2004), lung cancer (Caughlin et al., 2011), breast cancer (Donovan-Kicken & Caughlin, 2010), miscarriage (Bute & Brann, 2015), obesity (Brown et al.,

2007), anorexia (Chang & Bazarova, 2016) and erectile dysfunction (Rowland et al., 2005). There is also evidence of the link between stigma and disclosure in research about mental illness, covering topics such as depression (Barney et al., 2006), perinatal depression (Moore et al., 2016), and bipolar disorder (Hawke et al., 2013).

For physicians experiencing mental illness or burnout, perceived stigma appears to have a similar influence, as it impacts physicians' willingness to share. For example, nearly half of the female physicians in one study met criteria for a mental health disorder but did not seek help due to fears that sharing may negatively impact their career (Gold et al., 2016). In another study, medical students at six different schools reported they were experiencing burnout and depression, yet only one-third of the students indicated they would seek out help, citing perceived stigma and negative judgment from others as reasons for concealing their mental health status (Dyrbye et al., 2015).

Another reason a physician may avoid disclosure is out of fear of rejection (Derlega et al., 1998). An uncomfortable self-disclosure (i.e., burnout) may lead to minimal responses and cause others to deflect the conversation (Coupland et al., 1991). This can result in feelings of shame (Matthews & Harrington, 2000), lower self-esteem (Braithwaite, 1991), rejection (Cole et al., 1997), and labeling (Karp, 2017). A negative response experience may also prevent future disclosure (Caughlin et al., 2008). For physicians, simply the possibility of a negative response may be enough to prevent them from sharing.

Finally, physicians may avoid disclosure because sharing personal health information can include a loss of control (Charmaz, 1999; Cozby, 1973) and be a source of uncertainty (Goldsmith, 2015). The degree to which a person discloses personal

information is often informed by their view of communication as a resource (i.e., support) or as a source of uncertainty (Collins & Miller, 1994). If an individual believes sharing their health experience will help them meet personal needs (e.g., support, catharsis, self-clarification; Greene et al., 2006), they are more likely to share than if communication is viewed as a way to introduce more uncertainty into the relationship. Therefore, if a physician needs support but is unable to communicate their needs with others, he or she may choose to withhold information as a way to avoid more uncertainty, regardless of his or her intimacy level or past experiences with the other person.

Despite the potential risks of sharing, there are reasons physicians may ultimately decide to share their burnout experience with others. Disclosing personal information can lead to both relational and personal benefits. First, disclosure can lead to relational growth, as trust builds between the person sharing and others who are receiving the information (Derlega et al., 1998) by increasing intimacy (Greene et al., 2006). Disclosure can also be a way for individuals to ask for support or share information in a relationship (Derlega et al., 2008).

In addition to relational benefits, physicians may decide to share their burnout experiences for individual benefits. For example, the act of disclosing personal information can be cathartic (Derlega et al., 2008), has been shown to decrease stress (Frattaroli, 2006; Rüsch et al., 2014) and can be a way to access social support (Grice et al., 2018). Disclosure also allows individuals to process emotions (Ignatius & Kokkonen, 2007) and improve overall well-being (Chaudoir & Fisher, 2010). Finally, when a disclosure experience is positive, the event can give individuals the confidence that is necessary to reduce fears and encourage future disclosure (Chaudoir & Fisher, 2010).

While physicians often acknowledge a desire to disclose details about their burnout experience, they also understand the risks of sharing and commonly report that they do not know how to communicate about the topic, so they do not. Physicians are acutely aware that the benefits of disclosing burnout may not always outweigh the costs (Greene et al., 2003) and therefore can face the dilemma of wanting to share and also to avoid potential risks. Some physicians manage this situation by disclosing their experiences in anonymously published articles rather than face-to-face with another individual (e.g., Anonymous, 2018).

The lack of disclosure about burnout by physicians is problematic given that seeking out support through disclosure is the primary way for individuals to meet interpersonal needs such as inclusion, control, and affection (Derlega, 1984; Schutz, 1958). By withholding information about their burnout experience, physicians may be unintentionally adding stress to an already negative situation. However, it is important to recognize that the process of sharing is often not easy and can be complicated and unpredictable (Greene, 2015). To gain support from others, physicians must share at least some personal information about their burnout experiences (Greene, et al., 2003), which can make them vulnerable (Greene, 2015; Slade et al., 2007) and requires significant effort to make informed decisions about when, how, and what to share (Derlega & Grzelak, 1979; Donovan-Kicken et al., 2012). Therefore, when physicians choose to expose their burnout experiences, it is likely after thoughtful planning and consideration.

Disclosure Quality

Although disclosing burnout can be helpful for physicians, research confirms it is not enough to simply disclose, and instead, *how* disclosure takes place is just as

important. In other words, more communication does not always translate to better communication, and therefore, the quality of communication makes a difference in conversational outcomes (Scott & Caughlin, 2014). Previous work in this area has focused on a variety of stigmatized health disclosure topics such as HIV (e.g., Caughlin et al., 2008; Caughlin, 2010; Derlega et al., 1993; Greene & Faulkner, 2002), heart conditions (e.g., Checton & Greene, 2012), cancer (e.g., Venetis et al., 2013), infertility (e.g., Steuber & Solomon, 2011), and depression (e.g., Scott et al., 2013).

Situational factors of a disclosure event can influence whether the interaction is effective (i.e., helpful) or ineffective (i.e., unhelpful) (Altman & Taylor, 1973; Charmaz, 1991; Greene et al., 2003). For example, the topic shared may be stigmatized and this may impact how a person shares the information as well as how others respond. Situational factors outside of the interaction (e.g., culture, personality differences) may contribute to the quality of a disclosure, and other influences may be more closely related to the interaction such as perceived recipient availability, location, flow of conversation, relationship quality, and anticipated response (Greene et al., 2006).

Conversational features (e.g., message sophistication and self-presentation) also impact the quality of disclosure interactions. While the actual message from the person disclosing can influence reactions from others (Caughlin et al., 2008), there are specific message features that are most helpful. First, message sophistication is the extent to which a response message attends to relevant conversational goals (O'Keefe, 1988) and may vary during disclosure conversations (Scott et al., 2013). Researchers suggest responses to illness disclosure are evaluated as more supportive when they are more sophisticated (O'Keefe, 1988) as opposed to responses that are less sophisticated (Scott et

al., 2013). Additionally, the most helpful (i.e., supportive) responses are those that avoid the use of threats, insults, blame, or criticism (Caughlin et al., 2008).

Another important conversational feature is self-presentation, or the way a person presents their own coping during disclosure (Scott et al., 2013; Silver et al., 1990). When individuals sharing health information appear to be successfully coping with the situation, they are more likely to be met with responses that are less sophisticated (Scott et al., 2013). In these instances, the person responding feels less distressed (Silver et al., 1990) and does not feel as much of a need to provide comfort to the person disclosing (Scott et al., 2013). Conversely, if the person sharing appears to have difficulty coping, they are more likely to be met with a better, or more sophisticated, response (Scott et al., 2013). Taken together, these findings suggest that more or less helpful responses to disclosure are the result of what information is shared, the extent to which conversational goals are attended to, and how coping is presented during the interaction.

In short, there are many reasons physicians may ultimately decide to share or withhold their burnout experiences. The potential risks and benefits associated with disclosure present a dilemma for physicians, often causing them to use various strategies – including anonymous disclosure and withholding information – to manage the situation. To better support physicians sharing burnout, there is a need to further understand how situational and conversational features influence disclosure and lead to more or less supportive responses in this particular context.

Social Support

Social support is commonly identified as the things people say or do for another person and is often referred to as *enacted* or *received support* (Goldsmith, 2004). This

definition of support refers to the performance of communicative behaviors and is studied by highlighting the properties of a supportive conversation (Goldsmith, 2004) and linking social relationships to well-being (Umberson & Montez, 2010). Researchers in this area have identified three broad types of support. First, emotional support aims to buffer stress by showing care for another person through concern and empathy (e.g., listening, legitimizing; Burleson, 1984). The second type, informational support, involves the transmission of information from one person to another with a goal of reducing stress (e.g., advice, suggestions). Finally, tangible support is a way for one person to physically help another person by offering goods or services.

Physicians experiencing burnout can benefit from each type of support. First, emotional support can act as a buffer for stress (Burleson, 1984) and even the simple act of asking how a physician is feeling or how they are handling a specific situation can be helpful (Loos, 2018). Other forms of emotional support have been identified by physicians as being helpful, including the use of humor to reduce emotional strain (Maslach, 1982). Empathy, or the ability to understand how another person is feeling (Maslach, 1982), is central to providing effective emotional support, as it can be easier to share personal feelings with someone who seems to understand the situation. Therefore, therapeutic interventions are one way to facilitate emotional support by encouraging empathy and sharing during stressful experiences (Guille et al., 2015).

For physicians, there is evidence that Balint groups can serve a similar purpose (Benson & Magraith, 2005). A Balint group is comprised of 6 to 10 physicians who meet regularly with a facilitator to reflect on and discuss clinical experiences (Benson & Magraith, 2005), with a goal of providing a safe and confidential environment (Roberts,

2012). Although Balint groups were initially created for family practitioners, the groups have also been used to support physicians in other specialties. Participation in Balint groups can lead to many positive outcomes. For example, palliative care physicians have reported that by participating in Balint groups they were able to reduce emotional exhaustion and depersonalization while simultaneously increasing their perceived social support (Popa-Velea et al., 2019). Balint group participants have reported other benefits, including an increase in competence and satisfaction at work (Kjeldmand & Holmström, 2008) and increased coping ability and patient-centeredness (Kjeldmand et al., 2004). In short, Balint groups can be a helpful way to provide emotional support for physicians by facilitating emotional comparison and providing a space for peer-to-peer communication (Maslach, 1982).

Physicians experiencing burnout can also benefit from informational support. First, receiving recognition from co-workers and supervisors can be one way to provide support to physicians and has been linked to lower burnout rates (Maslach, 1982). Additionally, when physicians receive information about their patients, this can also be viewed as support. For example, some physicians have reported that learning information about the patients they care for and receiving positive feedback directly from patients can be helpful (Loos, 2018). Finally, informational support in the form of lessons shared among physicians about past experiences can be helpful (e.g., Loos, 2018) and lead to mentoring, which is one way to positively influence the work of physicians (Hoff & Scott, 2016).

The last type of social support, tangible support, is well documented as a way to improve physician well-being. For example, sharing work duties can reduce burnout rates

(Wright & Katz, 2018), including tasks such as helping physicians with patients who are emotionally draining or preparing supplies for procedures (Loos, 2018). There is also evidence that time away from work is another way to provide support. Taking a break or slowing down can be especially helpful for physicians who work in especially difficult situations (e.g., death, trauma). Time away may include allowing physicians to shift between emotionally difficult cases and tasks that are not as demanding (Maslach, 1982), replacing traditional work time with continued medical education (e.g., workshops, training) or granting physicians traditional vacation time (Maslach, 1982).

Support Quality

Social support does not always involve an observable communicative act (i.e., enacted support), and instead can be the result of an individual's perception of the support that is available to them. Therefore, supportive communication has also been studied as *perceived support*, or the property of an individual's cognition about the world rather than the supportive acts that are explicitly communicated (i.e., enacted support; Helgeson, 1993). Perceived support reflects a stable view of the social world and personalities, whereas enacted support fluctuates with changes occurring in a relationship (Sarason et al., 1990).

Research about perceived support has not always differentiated between support types or the various facets of supportive behaviors, and this lack of consistency has led to mixed results about its effects on well-being (Goldsmith, 2004). For example, perceived support has been cited as a better predictor of important health outcomes (e.g., well-being; adjustment to stressors) than enacted support (Helgeson, 1993), and some findings suggest that enacted support (rather than perceived support) actually leads to more stress

rather than less (e.g., Cohen & Hoberman, 1983). Moreover, some research suggests enacted support is a buffer for stress, while other evidence shows enacted support having no effect at all (Goldsmith, 2004). The mixed findings have led researchers to further investigate enacted support by examining how other factors that are involved in communication processes may influence the evaluation of supportive behaviors and subsequently impact health outcomes (Goldsmith, 2004).

The effectiveness of support (i.e., how conversations are evaluated by those who receive the support) is unique to each person and situation. Therefore, the study of support has shifted to focus on the *quality* of support (as opposed to quantity markers, such as amount or frequency) to uncover why some supportive attempts succeed while others fail, where quality can be defined as "the extent to which an utterance is adaptive to multiple desired outcomes (i.e., goals)" (Goldsmith & Fitch, 1997). Support quality is especially important to study given that there are many complexities that exist during conversations about difficult topics (e.g., illness; stressful life events) and may impact outcomes related to well-being (Goldsmith, 2004; Goldsmith et al., 2006).

In general, enacted support is effective to the extent that it is adapted to fit a particular situation and addresses the purpose of coping. In other words, the effectiveness of support is related to how well individuals attend to conversational goals during an interaction (Scott et al., 2011). Goldsmith (2004) has identified specific behaviors that are commonly identified as helpful to individuals who are coping with various illnesses (e.g., cancer, depression, multiple sclerosis) and life stressors (e.g., unemployment, disabled parents, divorce). Some of these behaviors include an opportunity to talk or vent, reassurance, honesty, empathy, and respect for autonomy. Similarly, there are also

behaviors that have been identified as being ineffective (i.e., unhelpful) such as a lack of communication, questioning the severity of a situation, little concern, criticism, blame, control, and unwanted discussion of a problem (Goldsmith, 2004).

In short, the effectiveness of enacted support hinges on the interpretation and evaluation of what is said, how it is said, and the meanings that are attributed to messages (Goldsmith, 2004). Therefore, it is not only important to understand what behaviors are helpful or unhelpful but also to consider how message features and communication processes influence the evaluation of supportive behaviors.

Chapter Three: Theoretical Frameworks

The decisions physicians make about if or how they talk about burnout not only has implications for their own lives, but also for the lives of their co-workers, patients, family, and friends. Although some research exists about the topic of burnout, more work is needed to better understand what makes conversations about burnout experiences more or less effective. In this chapter, two frameworks are discussed. First, a multiple goals theoretical perspective is shared, followed by an explanation of the normative model of social support. Both of these frameworks are then applied to the context of discussions about burnout.

Multiple Goals Theoretical Perspective

The multiple goals perspective is one way to conceptualize communication in terms of goal conflicts and to evaluate the quality of conversations. Multiple goals theories assume that all individuals have conversational goals during interpersonal interactions (Caughlin, 2010). Goals are "desired end states" (Caughlin, 2010; p. 826) and are concerned with "what people want to accomplish in a situation" (Burleson et al., 2006; p.42). Therefore, goals are central to the discussion of burnout, as they influence how individuals communicate with others and how those interactions are evaluated.

There are many possible goals in a conversation; however, three broad types of goals are relevant across various social situations, including instrumental, identity, and relational goals (Clark & Delia, 1979; Scott & Caughlin, 2012). *Instrumental goals* refer to the main task that a person is hoping to accomplish during a conversation (Caughlin, 2010). For example, instrumental goals may include making requests (Brown & Levinson, 1987; Wilson, 2002), giving or receiving information (Brashers et al., 2002), or

providing comfort (Burleson, 2009; Goldsmith, 2004; Vangelisti, 2009). Instrumental goals are highly contextual, as they are most often concerned with social appropriateness in any given situation (Price & Bouffard, 1974).

Identity goals are the second type of goal and are concerned with both self-presentation and the protection of impressions made by others during an interaction (Caughlin, 2010; Goffman, 1959). Individuals often pursue this type of goal by featuring different parts of their identity (e.g., appearing demanding or kind). Identity goals stem from a desire to limit disapproval or embarrassment during an interaction, and therefore, individuals with these goals often avoid discussing difficult topics (Caughlin & Vangelisti, 2009).

Finally, *relational goals* are goals that are pursued by individuals to affirm or undermine a relationship, and communication is used to help an individual achieve the relationship they desire (Caughlin, 2010). For instance, a person who wants to have relational harmony may avoid bringing up sensitive topics in conversation. Individuals may also have other relational goals such as relational growth (Mongeau et al., 2007) or relational maintenance (Canary & Dainton, 2003; Ramirez, 2008).

Many goals are relevant to disclosure of physician burnout. Physicians may use disclosure as a way to achieve instrumental goals such as sharing information about their burnout experience for cathartic emotional expression, seeking support from others, giving advice about burnout, or persuading others to seek help (Beach et al., 2004; McDaniel et al., 2007). Disclosure may also be a way to pursue identity goals such as appearing authentic, courageous, or professionally competent when sharing their burnout experiences (Malterud & Hollnagel, 2005). Finally, it's evident from past research that

disclosure is important to relationships and can be used to achieve relational goals (e.g., Caughlin, 2010; Derlega et al., 1993; Greene et al., 2006). For physicians, disclosure may be used to build trust in a relationship or to expose a weak support system.

The multiple goals perspective makes three broad assumptions about communication. First, all interactions are assumed to be purposeful. However, when conversational goals are pursued, individuals are not always aware or mindful of these goals (Caughlin, 2010). The second assumption of the multiple goals perspective is that goals are commonly pursued simultaneously and, as a result, communication is used to serve multiple purposes (Caughlin, 2010). Given that many goals may be present in a conversation at the same time, it can be helpful to distinguish between primary goals and secondary goals in a conversation (Dillard et al., 1989).

Primary goals are most central to a conversation and partially define the interaction (Dillard et al., 1989), whereas secondary goals shape and constrain how individuals pursue their primary goals (Caughlin, 2010). For example, a physician may have a primary goal of sharing information about their burnout experience while simultaneously pursuing secondary goals such as appearing professionally competent or committed to their relationship with the other person. The final assumption of the multiple goals perspective is that goals may conflict and lead to conversational dilemmas such as when the pursuit of one goal limits or prevents an individual from pursuing another goal (Caughlin, 2010). For example, a physician sharing burnout may want to ask for emotional support (i.e., primary goal), without being viewed by others as an emotional burden (i.e., secondary goal; Goldsmith & Fitch, 1997). When there is a low probability that goals will conflict, (e.g., chatting in the break room), there is little

variation in how these goals are pursued (Caughlin, 2010). However, in more complex situations (e.g., disclosing burnout; providing support to a physician), there can be more variation in how goals are pursued. This is because goals become more meaningful in complex situations. In these instances, goals are more unique and there are more inconsistencies between goals, making them more difficult to achieve than in less complex situations (Delia et al., 1982). In short, when goals conflict and lead to conversational dilemmas, messages that are well-intentioned do not always have a favorable outcome (Goldsmith et al., 2006).

Multiple goals theory has three broad implications for studying communication. First, goals shape communication and message production (O'Keefe, 1988). Individuals may have similar or exactly the same goals during an interaction; however, the messages they communicate may not be alike. The second implication is that goals are useful in evaluating the sophistication of messages. Sophistication refers to how relevant a message is for any given situation, and therefore, some goals are more relevant in conversation than others, even if they are not recognized as such (O'Keefe, 1988). When messages do not align with the context of an interaction, individuals can be evaluated by others as incompetent (Caughlin, 2010). This has led to the study of communication quality, or the extent to which an individual manages goals in a specific context (Caughlin, 2010). Finally, goals-related research highlights that beliefs about goals shape the meaning of communication. In other words, goals not only explain the *production* of messages, but also influence how individuals *interpret* the meaning of messages during social interactions (Berger, 2002; Wilson, 2007). Therefore, the more physicians can remain sensitive to the multiple goals of their disclosure, the more likely they are to be

effective in accessing the support they need while minimizing the risks of disclosure and achieving other relevant goals.

Normative Model of Social Support

The normative model of social support, which is a theory that is part of the broader multiple goals perspective, suggests some features of supportive conversations are more helpful than others. Social support is reframed as a communicative (rather than mechanical) process (Goldsmith & Fitch, 1997), and the theory allows scholars to move beyond reporting the frequency of generic support types (e.g., informational, tangible, emotional) and address why some messages are evaluated as more supportive than others (Goldsmith, 2015).

Although multiple goals theory suggests communication is high quality to the extent that it achieves the goals being pursued, interactions are complex, and it can be difficult for individuals to accomplish multiple goals during an interaction. When goal conflicts exist, conversational dilemmas can limit a person's ability to pursue multiple goals successfully. Therefore, Goldsmith (2004) suggests that the quality of communication is the extent to which an individual can successfully manage these dilemmas, and the normative perspective highlights why some messages are evaluated as more helpful than others, making it a useful framework to use when identifying what makes supportive conversations more or less effective (Scott et al., 2011).

A normative approach to the study of support during burnout disclosure places emphasis on the evaluation of behavior as a way to explain what makes for more effective and appropriate communication (Goldsmith, 2001). The more physicians can

identify what features are most helpful during supportive conversations, the more likely they are to be effective in both seeking and receiving support during burnout.

Research Questions

Based on the reviewed literature and the theoretical frameworks guiding this dissertation, I presented the following research questions. First, to gather a first-hand description of the burnout experience, I asked:

RQ1: How do physicians describe their burnout experience?

To more fully examine goals during burnout disclosure, the second research question asked about the types of goals that are most salient for physicians in these situations:

RQ2: What goals do physicians have when disclosing burnout?

The third and fourth research questions addressed the topic of goal management during burnout disclosure:

RQ3: How do multiple goals create dilemmas for physicians disclosing burnout?

RQ4: What strategies do physicians use to disclose burnout?

The fifth research question asked about what features influence the disclosure event:

RQ5: What makes it easier or more difficult for physicians to disclose burnout?

Finally, the sixth research question addressed how physicians evaluate supportive messages:

RQ6: When physicians disclose burnout, what responses do they perceive to be more or less supportive?

Chapter Four: Pilot Study

This chapter outlines a pilot study about the topics of burnout and communication among healthcare providers that helped inform this dissertation. First, research questions are presented and are followed by methodological details and a summary of findings. I then discuss specific ways that the findings of this study informed my dissertation.

Research Questions

Limited research exists to uncover how stigma impacts the disclosure of burnout among healthcare professionals and the ability to access social support. Although some research suggests therapeutic interventions can be helpful in some situations (Guille et al., 2015), there remains a need to understand what makes providers more or less likely to disclose burnout with others and how sharing or withholding information about burnout impacts access to social support. Thus, the following research questions were proposed:

RQ1: What barriers exist for healthcare providers when sharing burnout?

RQ2: How does disclosure (or nondisclosure) impact access to social support?

Participants

At the time of this study, all participants were employed as healthcare providers working in the surgery department at a university teaching hospital with a Level I Trauma Center. This type of facility is capable of providing all levels of care from prevention to rehabilitation. The sample included a total of 10 surgery providers, with 4 identifying as female and 6 as male. Participants self-identified as advanced practitioners (i.e., nurse practitioner/physician assistant; n= 4), resident physicians (n= 3), and attending physicians (i.e., individuals finished with medical school and residency/fellowship training; n=3). Participants in this study ranged in age from 28 to 48 years old and 7 were

married, while 3 had never been married. The providers' experience working in the medical field (including both graduate education and clinical training) varied, ranging from 5 years to more than 10 years.

Procedure

After receiving approval from the Institutional Review Board, participants were recruited using publicly available emails for in-depth face-to-face interviews (See Appendix A). Surgery providers interested in participating in the study were encouraged to contact the researcher to schedule an interview. All interviews followed a semi-structured interview guide (See Appendix B), which did not change substantially during the interviewing process. Probing and follow-up questions were included to clarify understanding and validate the interviewer's interpretations of participant responses.

At the beginning of each interview session, participants read and signed an informed consent document (See Appendix C). Next, participants completed a brief demographic survey (See Appendix D), providing information such as their age, marital status, and work experience. Finally, participants engaged in an in-depth face-to-face interview with the researcher. The semi-structured interview protocol included questions about asking for help with burnout (e.g., "Can you think of an example of a time when you or someone you know had an easy time asking for help with mental health/burnout? Can you think of a time when you or someone you know had a hard time asking for help with burnout?"), social support (e.g., "Can you think of a time when someone was trying to support you with mental health/burnout issues and you thought it was particularly helpful? What about a time when this support was unhelpful?"), and disclosure decisions (e.g., "Is your mental health something you prefer to keep private? "What makes it easier

or more difficult to talk about your mental health and burnout?"). Interviews lasted between 47 and 72 minutes, were audio recorded, and transcribed verbatim. Each participant received a $25 gift card for participating in the research.

Analysis

Qualitative descriptive analysis (Sandelowski, 2000) was used to analyze the transcribed interview data and provide a low-inference, yet comprehensive summary of participant experiences. For data analysis, two coders (two doctoral students trained in communication research) were recruited to assist with the study. During a brief training, all three coders reviewed the definition of burnout (Shanafelt et al., 2012) and other relevant medical vocabulary (e.g., attending, rounds) to ensure consistency.

The analysis process proceeded in three phases. First, all coders reviewed the transcripts on their own and used open coding (Strauss & Corbin, 1998) to identify key themes related to disclosure and support. Next, coders met as a team to discuss and refine the initial key themes before independently reviewing the transcripts again. During the second review of transcripts, coders used the refined thematic scheme to code and identify illustrative quotations for each theme. Finally, all three coders met to discuss and reach consensus in identifying the final themes and the interrelationships among them. During the final meeting, all coders also selected participant quotations used in the results. All participant names were changed to pseudonyms.

Results

Participants in this study discussed their own mental health and experience with burnout. In doing so, participants identified what barriers exist when sharing these experiences (RQ1) and explained how their choice to disclose or conceal this information

impacted their ability to access social support (RQ2). In this chapter, I outline the findings from this study.

Disclosure Barriers

Although many of the participants in this study acknowledged having a desire to share their burnout experiences with others, they also discussed how barriers such as stigma, professional judgment, and requirements of their jobs prevent them from doing so.

Stigma. Participants who did not disclose their burnout with others said doing so was a way to avoid being viewed or labeled negatively by others. For example, Carrie described how these potential labels kept her from disclosing: “Oh no. Never. No. I don't want to be called a crazy person or like have people lower their voices when they talk about if I'm anxious or have depression. So then I'm like I won't say anything.” Elliot shared similar feelings and feared the potential judgment of others, and suggested these labels may be related to past negative experiences providers have had with patients: “We take care of so many psychiatrically unstable people that I think there's a dissociation like that's bad; not being that way is good and so as soon as you swing that way, it feels bad.”

In addition to being labeled, many providers said burnout and mental illness are viewed as weaknesses by others in the medical field. Alex said that although providers recognize how their work negatively impacts their mental state, there continues to be a stigma associated with publicly acknowledging it:

> Everybody acknowledges that we have a hard job, and we take care of things that are hard to cope with, but acknowledging mental health of what it is something

we can struggle with, something we're vulnerable to. Is almost like it's out of weakness.

George shared this view and said individuals specifically working in surgery are not only labeled when they are disclosing mental health issues, but are sometimes also treated differently: “Surgery can sometimes attract a mean spirited type of person, and some people are bullies. I mean, they just are. When they see someone they perceive as weak, they pick on them a lot.” She then went on to suggest the perception of weakness may come from needing help from others: “I think it, to me, would be more of a weakness if you let it get you down so much that you're not functioning and then we have to intervene.”

Professional Judgment and Job Requirements. In addition to stigma, participants in the pilot study also said disclosing burnout can lead to judgment from others about their ability to perform at work. For example, Carrie said disclosing burnout would communicate to others that success was not the ultimate goal: “I think some health care providers will recognize it. There are ones that don't want to share, because they actually want to succeed.” John added to this, saying that surgery, in particular, is a specialty that links personal struggles (i.e., burnout) with professional achievement: “There is always going to be a perception of performance ability when that comes out. I don't know if I can say it for other specialties, but for surgeons, you've got to be the tough guy.”

In addition to judgment from others, participants discussed how expectations from others at work can be a barrier for disclosing burnout. For example, John explained that there is an expectation in the field of surgery for providers to avoid showing emotion: “I

think surgeons are, as you may be discovering, usually fairly stoic." Elliot echoed this by saying, "Physicians still very much have that stigmata of you have to be stoic."

Providers in this study also shared how the intensity of their work can make it difficult to disclose personal information. Working long hours and a fast-paced environment were cited by some providers as barriers, making conversations about burnout and mental health feel unrealistic. Shawn said: "We're not randomly going to sit around and be like how are you feeling today because we got too much shit to do." Alex added that, after a busy day of surgery procedures, providers are not interested in discussing personal topics:

> It's like the surgical culture, so I guess for anyone that's not in there with surgery, long hours, we're up early like 4:00 or 5:00 a.m. And then usually if it's a busy operating day, we're operating all day, so then once we're done it could be like 6:00, 7:00 or 8:00 p.m. So, then after you're done with that, no one wants to stay after work and be like, "Let's talk about feelings, or how are you doing? That was a really tough day. How are you feeling?"

Amanda said there is also a cultural expectation to stay on task and avoid thinking about personal issues:

> You just don't really discuss it because you're too busy to think really about the mental health of yourself or the people around you…We work at a level that all we really know is work and that's that time crunch. We don't talk about personal things. We internalize the struggles of the day and take them home, and hopefully home is dealing with it.

Finally, Elliot compared how the expectations of her job differ from others working outside of medicine: “I have a friend who struggles with depression and anxiety and she'll take days off because she needs to go see her psychiatrist at the last minute. You could never do that in this job.” To summarize, providers acknowledged that in medicine, and specifically in surgery, there is an expectation to work long hours, internalize difficult experiences, and keep personal information concealed. Stigma surrounding the topic of burnout and mental health can be barriers for physicians who are struggling and may want to disclose their experience.

Disclosure Dilemma. Most participants in this study were forthcoming about the fact that providers experience burnout as well as mental health issues and need support. Carrie even went so far as to compare their need for support to patients: “I think few admit they may need [support]. I think more probably do need it. With trauma, they probably need it more than sometimes even the patients.”

Some providers recalled specific instances when they recognized a need for support. For example, Matt said: “Every day I woke up and I was just like I hate going to work.” Jessica also described a difficult time when she needed support:

> I mean I was straight up suicidal. I mean there is no question. I was at a just very dark place. My life was like wake up, go to work, come home, cry, wake up, go to work. That's like a vicious cycle, because you're just feeding on your own negative emotions.

Meghan added by explaining the need for support can impact patient care:

> I never had suicide ideations, I never had homicide ideations. I was just, I didn't really care that the sun rose yesterday. I can sit here all day and just not do

anything. You can't pour from an empty cup. You can't take care of people who are critically ill and their families needs if you're not well yourself.

Despite the need for support, providers in this study said they have experienced a dilemma of wanting to disclose information to others while also recognizing the potential risks of doing so. Elliot said disclosure comes with trade-offs: “I guess in the competitive environment, there's that tension of if I'm vulnerable what if then somebody tries to take advantage of me emotionally, like push me around?” Other participants were more concerned about implications to their professional life. When asked about disclosing her burnout with others while she was a resident, Amanda (who is now an attending physician) said she feared job loss:

> Oh hell no. I think it's probably a little bit different, because at the faculty level, we have so much personal power with our own lives and essentially autonomy. Let's say if I was really struggling, or I was really unhappy, I can walk away from here immediately and go work in the next county over. As a resident you can't. You lose your spot in residency.

Finally, the job title or level of experience was mentioned by participants as contributing to their willingness to disclose burnout. Attending physicians were mentioned most often by participants as individuals known for not discussing personal matters such as burnout. Jessica said that, although she had discussed non-work topics with attendings in the past, the topic of burnout has never come up: “I've never had that conversation. I've never even heard an attending bring this up. It's mostly work related. I've certainly had not-work related conversations with attendings, but they're more superficial kind of conversations.”

Although many participants said it would be rare for them to disclose burnout with an attending physician, some providers felt they would be more willing to disclose their own personal struggles if others were forthcoming with this type of personal information. Matt said:

> It'd be easier if someone I respected and was a role model did it. If they admitted in a way that was very matter of fact like, "Yeah, I had depression or I had anxiety and I got therapy for it and I'm better," or, "I'm not and I'm still going through it." I have not seen that. I am not saying that this has not happened to them. It's just that I have no idea. I think it would help. If I was having problems and I heard that, it could help make me like, motivate me to go talk to somebody. Because then it's like someone I admire needed help, so it's not like I'm a horrible screw up, you know.

To summarize, participants in this pilot study said they had experienced burnout and recognized providers need support. However, despite the potential benefits that could come from sharing, the providers in this study said that barriers such as fear of labeling and judgment often prevented them from disclosing burnout. They described this as a dilemma of wanting to disclose while also attempting to minimize potentially negative consequences. However, most of the time, the providers in this study ultimately decided not to share.

There are two primary ways the pilot study helped inform my design of the current study. First, the participants in the pilot study were all advanced healthcare professionals, but not all were physicians. Many of the participants indicated they had never heard an attending physician discuss burnout and were not sure if attendings would

be willing to do so. This highlighted an opportunity to expand this research further by including only attending physicians in the present study. Next, the initial questions included in the pilot interview guide asked participants to share information about their own mental health. After the first few interviews, it became clear based on responses that the topic of burnout was taboo and oftentimes, participants responded to questions by talking about their patients (rather than their own), only to briefly talk about their own mental health when follow up questions were asked. The following interviews included more questions about burnout as a way to start the conversation about their personal emotional and mental health. Participants were more receptive to these types of questions, indicating the potential for further research about disclosure and burnout.

Chapter Five: Current Study

Research about the topic of burnout among healthcare providers often includes nurses, medical students, and resident physicians. Although this is a start in the right direction, these studies do not examine how other medical professionals, such as attending physicians, may be impacted by burnout. To better understand how this group of physicians experience burnout and how communication can be most effective in these instances, this study utilized a variety of data collection and analysis techniques. This chapter includes a detailed outline of the methods used for this dissertation project. First, the participant sample and recruitment strategies are described, followed by the procedures used, including a questionnaire and interview protocol. Finally, data analysis and results are discussed.

Participants

All participants in this study were attending physicians working in the United States and self-identified as having experienced burnout. At the time of the study, participants reported working in a variety of clinical settings, including at a community hospital (n = 5), teaching hospital (n = 9), community and teaching hospital (n = 6), teaching hospital and office-based single specialty (n = 4) or another combination of clinical settings (n = 6). Participants were employed as an attending physician in one of the following specialties: family medicine (n = 3), internal medicine (n = 5), emergency medicine (n = 13), obstetrics and gynecology (n = 2), or surgery (n = 2). Five participants reported working in another specialty (e.g., nephrology). The specialty areas participants were working in at the time of the study did not always match the residency training they had completed. Participants reported completing the following residency

programs: internal medicine (*n* = 10), emergency medicine (*n* = 7), family medicine (*n* = 5), general surgery (*n* = 5), obstetrics and gynecology (*n* = 1), and anesthesiology (*n* = 1). One physician did not report a residency program.

Physicians in this study reported completing an average of 11.97 total years of medical training (i.e., medical school, residency, fellowship; *SD* = 6.24*;* range 4-26 years). On average, participants worked as an attending physician for 16.02 years (*SD* = 9.74*;* range 3 - 42 years). The training required (i.e., number of years, procedures, examinations) for attending physicians in family medicine is comparable to that of emergency medicine, and therefore, participants working in these areas often share similar experiences. Additionally, physicians working in family medicine, emergency medicine, OBGYN, internal medicine, and surgery have repeatedly reported having high burnout rates, making this a particularly important topic for this specific group of physicians (Kane, 2019).

The sample (*N* = 30) included 21 (70%) males and 9 (30%) females, with 29 married and 1 widowed. The mean age of participants was 48.04 years old (*SD* = 10.10, range 35-69 years) and participants identified as White/Caucasian (*n* = 18), Asian/Asian American (*n* = 9), Black/African American (*n* = 1), and Latino/a or Hispanic (*n* = 1). One participant did not report their age or ethnicity. At the time of the study, most participants were employed in Kentucky (*n* = 23), while others worked in North Carolina, Indiana, Michigan, Virginia, and West Virginia.

Procedure

Once this study was approved by the Institutional Review Board (IRB), participants were recruited through purposive sampling to identify attending physicians

that were knowledgeable and had experience with burnout (Creswell & Clark, 2017). I shared information about the study via email with program directors and attending physicians in the target specialties at three hospitals using publicly available email addresses (see Appendix A). Recruitment information was also shared on my personal Facebook page. In addition, snowball sampling was used to encourage participants to share information about the study with others in their social network who were eligible and interested in participating (Tracy, 2013).

All materials used for recruitment included a description of the purpose of the study (i.e., to understand how physicians talk about burnout experiences), details of participation (i.e., completion of questionnaire and interview), and the incentive for participation (i.e., $25 Starbucks gift card). Recruitment materials also included my contact information (i.e., email address) and individuals interested were encouraged to contact me to participate or learn more about this research. When participants contacted me, I reviewed the purpose of the study, expectations of participation, and the incentive for participation.

Given the research questions guiding this study asked participants about their interpretations of experiences with burnout disclosure and social support, in-depth interviews were used as the primary method for data collection (Fontana & Frey, 2005; Weiss, 1994). In-depth interviews are well suited to understand individual experiences (Lindlof & Taylor, 2011) such as those related to burnout, support, and disclosure. For topics that can be sensitive (i.e., burnout), in-depth one-on-one interviews are often used by researchers (Liamputtong, 2007) to gather rich and meaningful data while also

allowing participants to feel comfortable discussing potentially difficult topics with a stranger (Knox & Burkard, 2009).

After agreeing to participate in my study, individuals were asked their preference of participating in either an in-person or phone interview. In-person interviews can allow researchers to use nonverbal cues to ask better probing questions and clarify information (Fontana & Frey, 2005), while phone interviews can make participants feel more relaxed when disclosing sensitive information (Hopper, 1992). Therefore, both modes of interviewing were appropriate for this study.

If participants preferred an in-person interview, they were asked to select a convenient location they felt comfortable having a private conversation (e.g., private campus location, off campus) with the researcher. Allowing participants to choose a location can make participants feel more comfortable (Blackstone, 2012). If participants preferred a phone interview and granted permission to be contacted, participants provided their phone number to the researcher. Otherwise, I provided a phone number for them to call for the interview. Once the mode of communication was determined, we scheduled a day and time for the interview. Half of the participants elected to meet for face-to-face interviews (n = 15; 50%), while the remaining participants scheduled phone interviews (n = 15; 50%).

Participation in my study involved three steps. First, prior to any interview, each participant was asked to read and sign an IRB-approved informed consent document (see Appendix B). Next, participants met with me at the predetermined location or on the phone to engage in an in-depth, one-on-one interview. I conducted all interviews between December 4, 2019 and April 30, 2020, and each interview lasted an average of 37

minutes (ranging from 14 minutes to 62 minutes). During each interview, participants were asked questions (See Appendix C) about their experience with burnout (e.g., "Can you please share with me your personal experience with burnout? To what extent do you think burnout impacts physicians in general?"), disclosure of burnout (e.g., "What makes it easier or more difficult to talk about burnout? Can you think of an example of a time you specifically chose not to share your need for support? Do you think you are more or less likely to talk about burnout now that you are an attending physician? Why?"), conversational goals (e.g., "What goals do you have when talking about burnout related to what you hope to achieve in the conversation? Can you think of an instance when one goal might be in conflict with another goal while disclosing burnout? What are ways you might handle this situation?"), social support (e.g., "Have you experienced support related to burnout? Do you feel there are advantages or disadvantages to getting this type of support? Can you think of a time when someone was trying to give you support related to burnout and you thought it was particularly helpful or unhelpful?"). The interview ended with two final questions ("If you wanted to provide support or help another attending physician who was experiencing burnout, what would you tell them? What advice would you have for any physicians going through burnout?").

When in-person interviews were completed, participants were asked to complete a demographic survey through Qualtrics using an iPad provided by the researcher. At the end of a phone interview, each participant was sent a link to the same demographic survey to complete as the final step of participation in the study. Once the survey was completed, participants received a $25 Starbucks gift card. The brief questionnaire (see Appendix D) asked participants to provide demographic information (e.g., gender, age,

race, marital status) and additional information about their work experience (e.g., state of employment, total years medical training, years as an attending physician, residency program, current specialty and work setting). I tracked participation in the survey by matching interview dates with survey dates, sending reminders via email if needed. Participants were not asked to share their names in Qualtrics to protect anonymity. All participants successfully completed the demographic questionnaire. After the first 5 interviews were conducted, I reviewed the initial transcripts to make sure the interview guide was capturing the intended information. No substantial changes were made to the protocol and I proceeded with the rest of the interviews.

Analysis

Following each interview, I created a brief memo to document my thoughts, reflect and help with data analysis and validity checking. According to Glaser (1978), memos help researchers retain ideas that may otherwise be forgotten. Memo writing is an effective way for the researcher to maintain productivity (Charmaz, 2006) and allows the researcher to document interpretations, generate possible links between themes, and record any instances they may have been influenced by the conversation during the interview (Saldaña, 2009). Each memo in my study ranged from a paragraph to a half page in length.

Similar to the pilot study in this chapter, I conducted an iterative content analysis of the transcribed interview data using qualitative descriptive analysis (Sandelowski, 2000). Qualitative descriptive analysis is an inductive, low-inference method designed to gather information about a phenomenon in the everyday terms used by those who experience the phenomenon (Morgan, 1993). There are two things that separate this

analysis technique from other types of analysis: codes are generated from the data rather than applying a pre-existing set of codes to the data, and the collection and analysis of data mutually shape each other (Sandelowski, 2000). Given that the goal of this study was to develop a comprehensive summary of the physician burnout experience, disclosure decisions, and evaluation of support, this technique was appropriate.

The initial step in the analysis phase was to create a team of coders. Two coders (both graduate students trained in communication research; different coders from the pilot study) were recruited by the researcher to help with data analysis. Each coder was compensated with $10 per hour for their assistance, with all meetings between coders occurring virtually using video conferencing. Prior to viewing any transcripts, coders met with the researcher for a brief training. During the training meeting, both coders were provided with Shanafelt et al.'s (2012) definition of burnout, characterized by emotional exhaustion, depersonalization and loss of work fulfillment. Other relevant medical vocabulary (e.g., attending, rounds) used by participants was also shared with coders for understanding. Next, I provided coders with a brief overview of the multiple goals framework to equip them with the knowledge necessary to identify the difference between task, identity, and relational goals. Finally, I shared with coders a few guidelines to follow, asking them to stay focused and only code information relevant to this study (e.g., examples of burnout description, goals, helpful and unhelpful support) and to keep memos to capture their thoughts and reactions during the coding process. An Excel spreadsheet was used as a template for coding among all three participants, with a separate spreadsheet used for each research question.

Data analysis then proceeded in three phases. First, all coders read all transcripts on their own and used open coding to identify emergent themes and begin comparing them for similarities and differences (Strauss & Corbin, 1998). Our identification of burnout descriptions were guided by Shanafelt et al. 's (2012) definition of burnout. During the first phase, we all reviewed the same five transcripts at a time to ensure consistency in our coding and for time management purposes. We then documented our initial findings in separate Excel files and when the first five transcripts were completed, we each added our file to a shared folder by an agreed upon deadline. We then continued coding the next five transcripts, with the entire process lasting approximately six weeks until all transcripts were finished.

When all transcripts had been reviewed by all coders individually, we met to discuss initial key themes, collectively refine them into axial codes, and develop a codebook (See Appendix E). Axial coding allowed us to organize and begin to draw connections between codes (Corbin & Strauss, 1990) and as the primary researcher, I was responsible for creating and maintaining the codebook (MacQueen et al., 2008). Emergent themes were examined in the context in which physician's discussed them and categorized as burnout descriptions, goals, disclosure strategies, dilemmas, catalysts, barriers, and evaluation of responses. There were several similarities among our salient themes, no new issues were identified and we began to recognize repetition in the data, suggesting theoretical saturation of our data and indicating that any further data collection would be redundant (Glaser & Strauss, 1967; Hennink, Kaiser, & Marconi, 2016). After engaging in a detailed discussion, we reached consensus about the consistency of the

emergent themes and developed a joint list of refined themes to use in the second round of coding.

Next, all coders reviewed the 30 transcripts independently again, using the refined thematic scheme to identify axial codes and also to identify illustrative quotations for each theme. During the final phase of analysis, all three coders met to discuss our findings and reach consensus about the final themes and participant quotations to be presented in the results. A colleague well-versed in health communication research tested our refined themes against the transcripts to provide an external assessment of their validity (Denzin, 1970). All participant names were changed to pseudonyms.

Researcher Reflexivity

Due to the nature of qualitative research, it can be difficult to completely avoid personal biases in a project (Tong et al., 2007) and according to Cohen and Crabtree (2006), reflexivity is an important part of qualitative research, as it allows the researcher to understand how previous experiences, assumptions, and knowledge may impact knowledge construction throughout the research process. Therefore, it was important for me to engage in reflexivity throughout this entire project.

Researcher positionality, which influences reflexivity, helps researchers consider how their approach to research may have affected a specific study (Holmes, 2014). The present study was completed through a phenomenological lens, using an interpretivist worldview. Drawing from these perspectives, I have assumed that a phenomenon may have multiple interpretations rather than a single truth (Hammersley, 2013). Therefore, this study is only one way to interpret burnout and related conversations.

During data collection, I made sure to use memos to capture ways my identity, credentials, gender, and experience may influence participants' responses as well as my understanding of the topic of burnout (Mills et al., 2005). All coders (including myself) also kept memos during the analysis phase of this dissertation to reflect on our own personal interests and assumptions while reviewing transcripts.

Reflexivity is as much about recognizing how the researcher impacts the study as it is about acknowledging how the researcher's relationship and interactions with the participants may influence participants' responses and the researchers' understanding of the phenomenon being studied (Mills et al., 2005). As such, I would be remiss not to acknowledge my own connection to the group of participants in this study. The topic of physician burnout is especially important to me as I am married to an emergency room physician. Although I am not a physician myself, I am familiar with details about their education, training, and work experience in a way that others may not be. Therefore, it was crucial for me during the interview process to not let participants know this information, as I did not want my background or experience to influence their responses. Finally, working with my specific team of coders on this project was important, as neither of the other coders had personal experience with physician burnout and both had limited knowledge about the medical education and training process as well as physician lifestyles and work experience. Having their perspectives helped contribute to producing findings that were more balanced and less biased than they may have been if I was the only coder.

Chapter Six: Results

Burnout can be a complex experience for physicians. Participants in this study described their own experiences with burnout and provided examples of emotional exhaustion, depersonalization, loss of work fulfillment, a desire to leave the field medicine, and unanticipated changes they noticed about themselves (RQ1). Participants identified various goals they have while discussing burnout with others (RQ2), highlighting how these goals can sometimes create dilemmas (RQ3). They discussed multiple strategies they have used to disclose burnout to others (RQ4), and then explained what they perceive makes it easier or more difficult to disclose burnout to others (RQ5) and what types of responses from others seem to be more or less supportive (RQ6). In this chapter, I outline the findings from this study in response to the six research questions, using data from the interviews as illustrative examples.

RQ1: The Burnout Experience

The first research question asked how physicians describe their burnout experiences. The experiences described by participants fit into at least one of the following categories: emotional exhaustion, depersonalization, and loss of work fulfillment. In addition, two additional sub-categories were identified: feeling stuck or having a desire to leave the field of medicine and recognizing changes about themselves.

Emotional Exhaustion

When describing burnout, participants often discussed feeling emotionally exhausted. They said they were left without the energy they felt was necessary to properly care for themselves or others. The phrase “emotionally exhausted” was not

always used verbatim; however, similar phrases were used to describe this part of the experience (e.g., “numb,” “emotionally busted”). For example, Cory said:

> You feel like you've given all that you can, and people still want more, and you just don't have any left to give. This compassion fatigue. We talk about all the time in emergency medicine where it's just hard to keep giving.

Terry shared how feeling “empty” impacted his life outside of work:

> I just remember thinking, “I have nothing left. There's nothing left in me.” That's what I kept thinking. And kind of feeling trapped because I made a really good living doing what I did, and I didn't think that I could support my family the way I always had if I walked away from it. But just feeling trapped and had zero emotional drive to do the work or to do much of anything else.

When describing burnout, Lee recognized a deficit in his ability to be emotionally present and said he relied on his medical knowledge and skills to help him perform at work: “I know that my knowledge and abilities can get me through to do the job correctly, but it's not with the same care or emotion that I would normally like to have.”

In some instances, participants shared what they believed contributed to their emotional exhaustion. For example, Jamie said unintended negative patient outcomes contributed to his burnout:

> I feel that the burnout that I feel is not avoidable. Taking call and having complications and mortalities are unavoidable consequences of this. So that’s what I feel like. Maybe it’s not right, but that’s what I get the most emotionally exhausted from or numb from.

Adrian, an obstetrician, also said his lack of emotion was the result of a series of negative patient outcomes:

> There was, like, three deliveries in a row that were just really horrible. One where the baby did fine, the second one the baby died, and then there's a third one where a baby had a congenital malformation of the nose and mouth that I ended up doing a C-section on, and that baby died as well. It took an emotional toll on me, and then all the physical demands with my [spouse]’s school and at home and a lot of long hours and everything just really—that's when everything was crashing all at the same time.

Pat discussed how his work hours contributed to his burnout and negatively impacted the way he interacted with others:

> At times when I'm working heavy hours for several months in a row, it just gets where I don't even like to be around myself let alone anybody else...I get so irritable that people can't stand to be around me. I find myself snapping, and I know it's me, not them. Just because I'm so tired. Emotionally busted.

Rather than describing one specific instance that led to his burnout, Chris suggested his burnout occurred after multiple difficult experiences. He said, "Burnout is not just one experience. So, it's that cumulative effect of experiences in the workplace that, you get to a threshold point where you feel like you're just going to fall off the cliff."

Nearly all of the physicians in this study described the emotional toll they experienced during burnout. Some participants described specific situations they believed contributed to their burnout, whereas others said they believed emotional exhaustion was the result of multiple factors. Almost all physicians in this sample described the interconnectedness between physical and emotional exhaustion, suggesting they occur at the same time. Despite this, most participants felt they were expected (by others and themselves) to continue working, performing, and accomplishing as much as possible professionally, regardless of how exhausted they became.

Depersonalization

The second category participants identified when describing their burnout was depersonalization. One example physicians described were instances when they recognized a detachment from their patients and found themselves viewing patients as symptoms rather than as individuals with personal stories, experiences, and loved ones. Peyton explained how she felt when this happened:

> When I walk in a room, and it's a diagnosis, it's not a patient, that's the worst. That's as far as it gets for me. That's real bad…In your mind, you disconnect from it, and instead of seeing the person behind it, instead of seeing Mrs. Jones, the lovely lady who has granddaughters that she needs to get back to, you see the elderly woman with heart failure that needs diuretics. And I think for people who don't understand burnout, that becomes the job. It's just the next door. It's just the next disease. It's just the next—and dangerous for everybody involved.

Casey described a similar experience: "When I was obtaining a history, I'm just less patient with waiting for them to give me the right answer that I'm waiting for essentially." Similarly, some physicians, like Alex, shared how experiencing depersonalization in his professional life as an ER physician has impacted his ability to empathize and express emotions outside of work. He shared:

> I think it gets hard to manage what you do in the ER and what happens in real life. So it's just hard. You try to separate the two as much as you can, but it's really hard to do, because it does carry over. And when something happens, with family or friends, you almost find that same disconnect sort of settle in. It's a protective kind of reflex that we have. So when you hear about something, you say, "Well, maybe it was just meant to be; this is life." So you just learn to not grieve. You learn to not talk about it because we don't talk about it…And then the one time you do kind of sit down and really think about what just happened, and the impact that's happening, you just don't even know how to handle it.

In sum, although participants provided various specific examples of depersonalization, almost all the examples involved situations when they felt disconnected from others. Some physicians said they did not feel emotionally connected to their patients and did not feel like they provided the same level of care as they would have liked. Others described how depersonalization transferred into their personal lives, leaving them feeling emotionally disconnected in personal situations with family or friends.

Loss of Work Fulfillment

The third way participants described their burnout was by explaining how it affected their ability to enjoy work. Sometimes, seemingly out of nowhere, some physicians realized they were not satisfied anymore. This happened to Terry one day while getting ready for work:

> It hit me completely out of the blue while I was getting dressed. I was combing my hair, getting ready to hit the road because I traveled an hour away as an emergency physician, and I had to be there at seven. I just looked in the mirror and it just hit me, I don't want to do this anymore. It hit that fast. So, [burnout] started that way. I tried to work my way through it, because I couldn't believe that it actually happened to me. I used to really love what I did, and I never saw it coming.

Elliot shared that, despite knowing how much she had previously enjoyed working as a physician, she no longer felt the same satisfaction. She recalled: “I was losing my mind. I wasn’t sleeping well. I would love medicine. I always have. And I was hating going to work.” Sawyer echoed this feeling: “I've always been quite a driven kind of person. At that time, I kind of hated myself, because I knew I was not at all doing what I should. At that time, my heart was not in my work.”

To illustrate how the experience of burnout can create feelings of unfulfillment at work, some participants used analogies to describe their experience. Mickey said:

> The analogy I use: you get home, you’re with your kids, with your [spouse], glass of wine, enjoying television shows and a little candle in your heart lights. Get a good night sleep. And you wake up in the morning and someone just blows it out.

Todd shared:

> Imagine spending the next 30 years going to work and hating what you do. You hate it every day that you get up to go do it. It’s just like essentially waking up every morning and there’s somebody there to punch you in the face. Eventually get tired of waking up. That’s exactly what it’s like.

Among the physicians who described feeling a loss of work fulfillment, it was common for them to compare how unsatisfied they felt with their job during burnout and

their level of satisfaction they thought they *should* feel with their job, highlighting a disconnect between the two. As a result of this comparison, some physicians expressed feelings of guilt or shame for not being more satisfied at work.

Wanting to Leave Medicine but Feeling Stuck

Participants described their burnout experience by saying they wanted to leave medicine, but felt they were "stuck" working as a physician. Shawn said:

> I'm like, "Okay, well, this is for the birds. I've done this for 10 years now. Now when does it slow down? When do I start enjoying this job instead of getting hit with all this death and disease and everything?"

Kerri shared a similar experience:

> When I think about burnout, I think when you get to the point where you start thinking about, "Why did I do medicine, what can I do?" I told my [spouse] recently, it's been crazy, so you get these feelings like maybe I'm going to quit medicine, we can sell our house and let's just do something drastic and go do anything else.

Mickey dreamt about working outside of the medical field:

> I have a dream. Leave medicine and open a thrift shop. I don't thrift. I don't want to be in the sun with skin cancer. I'm going to sit inside and sell lip balm and sunscreen and see the ocean.

Despite wanting to leave medicine, participants did not see leaving as a realistic option. For example, Charlie said:

> You get caught in what essentially is golden handcuffs. Most of us go to work, whether you want to live and get paid your salary, you live up to that salary, and it's hard to walk away…I think probably nowadays it's easier for younger people to talk about stuff than people in my age group, which is basically stuck.

Alex pointed to his many responsibilities and what he perceived as a limited skillset as reasons why he could not leave:

> If I tell you about burnout and I tell you all the things that are leading to it, then the question should be, well what do we do to fix that? And there's nothing I can

> do. I'm hopeless because I have student loans, I've got life, goals, loans, mortgage, kids, family and ER is the only way I know how to make ends meet.

When describing burnout, some physicians said they wanted to leave medicine and do something unrelated to medicine for work. However, regardless of how strong these feelings were, participants said did not feel that they could actually leave and felt stuck working as a physician. They felt this way because they perceived themselves to have a limited skillset, overwhelming medical school debt, and a lack of ability to pay their Chriss any other way.

Changes to Self

Participants often said they recognized their burnout when they began noticing changes in the way they behaved. For instance, Peyton reflected on an interaction she had while burned out and said her actions did not match the person she thought she was: "It was like, 'Oh my. What is wrong with me? This is not me. This is not who I am. I don't talk to people that way.' And that was really profound for me." Other participants shared examples of interactions with their spouses and said these conversations made them realize they were changing, which highlighted how their burnout was affecting others. For example, Elliot said:

> I just wasn't myself. Like, my [spouse] and I weren't getting along, and that's just really not like us…It was like my threshold, like, my patience, was gone. Like, things that normally wouldn't bother me or the things that are slightly annoying, they were a big deal.

Parker shared that he was not only noticing changes in his actions and his personal relationships, he was also noticing changes to his performance at work. He said:

> I wasn't the happy-go-lucky guy I used to be. My [spouse] noticed that I didn't seem to be happy. I wasn't performing what I thought to my level on everything I was doing. It sort of touched everything in my life, actually.

To summarize, participants did not always use their thoughts and feelings to identify burnout. Instead, they said they realized they were experiencing burnout when they noticed changes in the ways they interacted with others. Often, these changes lead them to reflect on discrepancies between their current and past behaviors, and it was the differences between the two that lead them to recognize their experience as burnout.

RQ2: Conversational Goals

The second research question aimed to address what participants hoped to achieve (i.e., goals) during conversations about burnout. Participants described having two types of goals: task and identity. Task goals included instances when participants discussed a task they wanted to accomplish while talking about burnout (i.e., share knowledge, vent, seek advice). Identity goals addressed how participants wanted to present themselves to others (i.e., normalize experience, seek validation) or how they hoped to be perceived by others (i.e., avoid being seen as weak or incompetent) during a conversation. Relational goals were not explicitly identified by participants in this study. Overall, task goals were most salient for participants in this study. Perhaps this is because physicians have a particular identity that can be more task-focused than relationally-focused.

Task Goals

Participants in this study reported three types of task goals they hoped to accomplish during conversations about burnout: share knowledge, vent, and seek advice from others.

Share Knowledge. Participants said talking about burnout was one way they could share information with others. For example, when asked what she hoped to achieve in these conversations, Peyton stated:

> Sharing knowledge. That's always the point. The more we share knowledge, the more we talk about it, the more people understand what it is, and why it happens, and how to make it better, and how to not let it get you into the black hole that you can't crawl out of. So, that's always the goal.

Terry explained how important he thinks it is to share knowledge with younger physicians:

> My goal was just—I've always been one of those weird people that tries to mentor people, even if they're not asking to be mentored—because the goal is to make lives better for people that are following behind you.

Parker also expressed a desire to share his knowledge with younger physicians who may not yet be aware of potential consequences of their decisions. He said:

> To say, "do as I say, not as I do" kind of thing. To recognize that "Hey, I've done this, I've experienced that, I've been depersonalized, and be careful." I can see that they're on that path. Making sure if it's really worth it, the decisions they're making. We have some docs that want to work 23 days, 24 days a month, and that's great for paying off debt and accumulate some cash. But, boy, it comes with an awful cost.

Vent. Another task goal described by participants was the desire to vent. Casey said: "Sometimes it's just about venting, like, 'Can you believe this is happening to me?'". Mickey explained that "sometimes it's just about venting, like, 'Can you believe this is happening to me?'". Other participants described potential benefits of venting. For instance, Avery said: "It sometimes helps relieve the stress a little bit, just being able to voice it". Taylor shared: "I think the benefit is just, you know, you vent, basically. I think it's a stress relief." Many of the physicians who identified venting as one of their goals expressed they found its therapeutic benefits appealing.

Seek Advice. The third task goal identified by participants was to seek advice from others. The type of advice physicians sought out varied. When Lee shared his burnout with his spouse, he recalled wanting sympathy for what he was going through

while also seeking advice from her about interactions he had at work that he felt contributed to his burnout. He said:

> I'm looking for sympathy and for her to tell me that I did the right thing, but at the same time, I kind of am also looking for her to say, "You know, you should have thought about that. You should have been able to put aside that other person that you didn't want to satisfy or let them feel like they were right and you were wrong."

When participants were talking to other physicians, they were commonly looking for advice specifically related to work. For example, Kerri said she would ask others about specific medical decisions she made by saying: "Would you have done anything different? Hey, do you think I should do anything different?". Casey described the specific kind of advice she finds helpful when talking to physicians who have more experience than she does:

> If I'm talking to one of the physicians that has been around for a while, I expect that they probably have had some burnout and maybe advice on how they've gotten through it…more about shared experiences and how someone else improved, or what they did to get over—not get over it, but ways to improve to be able to handle the workload.

In sum, physicians in this study used disclosure as a way to accomplish various tasks. Some disclosed burnout to share information and help less experienced physicians. Others wanted to personally benefit from their own disclosure, and to do so, disclosed burnout to vent or to seek advice from others. Regardless of the reason, it was clear the physicians had specific task goals they hoped to accomplish when disclosing their burnout.

Identity Goals

The second type of goal participants identified were identity goals. These goals addressed how physicians wanted to present themselves to others or how they hoped to

be perceived when talking about burnout. For the participants in this study, these goals were often related to concealing information and ultimately led some physicians to avoid disclosing their burnout. Participants discussed four types of identity goals: normalize the burnout experience; seek validation; avoid being seen as weak or incompetent, and be seen as a friend.

Normalize the Burnout Experience. Many participants in this study wanted to help others understand they are not alone in experiencing burnout and that it is common due to the stressors that come with being a physician. Cory shared:

> What I'm hoping to accomplish is to have people understand that having days where you're depressed, having days you're anxious, having days where you feel inadequate, feeling like crap because you had a bad outcome and got sued, that doesn't make you one of them. It makes you one of us...we need to normalize the conversation around the everyday stresses of what we do.

Avery said his goal is: "to let people know that even somebody like me has and experiences [burnout] and it's okay."

Participants suggested that normalizing the burnout experience is one way to help physicians understand that being burned out does not mean there is something wrong with them. Peyton said: "I go back to the word normalization. [Burnout] is something that happens to people. It's not an intrinsic problem with yourself." To Blake, normalizing the burnout experience is advantageous for doctors of multiple generations:

> I think the biggest advantage is normalization of the more doctors who share their experience, especially when I talk with older physicians and physicians who have been in practice longer and they say, "Yeah. I've been there. I know exactly what you're talking about" and kind of hearing their story makes it seem less like a unique experience.

The physicians in this study hoped that by talking about burnout, others would better understand the experience and not feel alone if they encountered it.

Seek Validation. The second identity goal described by participants was the desire to seek validation from others about their feelings and decisions related to burnout. Some participants, like Charlie, shared how helpful it could be when others validated his experience: “It's just validation of what I did or how horrible my day was and in return they'll tell me how horrible their day was.” Kim described a similar goal when talking to her close friend: “I will talk to her about [burnout]. And it's kind of more along the lines of just seeking validation, maybe, like, ‘Yeah girl, that sucks.’”

In addition to seeking validation for their feelings, participants also said they hoped others would validate their medical decisions. For example, Jamie used Twitter as an outlet and explained how, without sharing identifying patient information, he discussed difficult patient outcomes with other physicians in his field as a way to seek out validation. He said:

> So if I post a case [in a Twitter support group] and say “One of my patients died,” I'm leaving it open, because we all will say “Maybe next time you could have done this” but I want to throw it out there to see if anybody says that, and if they don't, that makes me feel better.

Blake also discussed burnout to seek validation for decisions he made at work: “I guess where I was pretty vulnerable and basically kind of seeking that affirmation of, ‘Yeah. No. You made a good decision’ or, ‘You made the only decision that you had available.’” These examples illustrate the desire participants had to check in with other physicians during the burnout experience and seek out validation for their feelings and medical decisions.

Attempt to Control Others’ Perceptions. The third identity goal shared by participants was a desire to control the perceptions of others. Sometimes this goal meant avoiding disclosure of burnout. Jamie explained how important it was for him to control

the way others perceived him: “I wouldn’t talk about it if it wasn’t kept confidential by someone who understands what I’m going through so that I can control the perception of myself…I mean, perception is everything.” Lee said he would not want to share his burnout with physicians in training out of fear they might view him differently: “I'd probably avoid [sharing burnout experiences with residents or medical students]...I guess I don't know if I want them to see me that way.”

More specifically, physicians in this study said they wanted to be cautious in their disclosure of burnout in order to avoid being labeled by others as weak, incompetent, or as a complainer. Some participants repeatedly stated burnout is often viewed as weakness, and this was a label they wanted to avoid. Terry said, “Maybe in my own mind, I still think it's a weakness, at least on my part, that I couldn't get past that.” Similarly, Chris shared: “I think that I've probably been guilty of times when I just didn't want to open up my weakness or demonstrate vulnerability.” Shawn explained how she tries to control others’ perceptions of her when talking about burnout to avoid being labeled as weak:

> The biggest thing you’ve got to worry about is weakness, too. Will people think of you different if you sit here and then that you’re feeling weak or not feeling yourself, if you have questions about yourself? Are they going to look at you different? Are they going to treat you different?

Some participants said they wanted to avoid being perceived by others as incompetent. Parker shared that, in general, physicians are high achievers and, therefore, they try to avoid any label that may suggest otherwise. He explained, “Physicians are, as a group, mostly Type A people. They've been high achievers their whole life, and they don't want to admit that they bit off more than they can chew.” Peyton wanted to avoid

others perceiving her as incompetent, stating that when that happens, it can feel like a character flaw. She said:

> It feels so personal. It feels like there's something wrong with me. Why can't I just stop thinking about this? Or why can't I just do better next time? And then it's embarrassing to talk about. It feels like something is wrong with you.

Some participants said talking about burnout can be seen by others as complaining, and therefore, their goal was to avoid being labeled as a complainer. For Taylor, the desire to control others' perceptions made disclosing his burnout more difficult. He explained:

> What makes it more difficult to talk about burnout I think is really maybe the frustration that probably nobody really cares is the feeling sometimes when you say it or that, that you are concerned that, that people get a negative picture of you...a complainer or something.

Alex said he was aware how nurses may view him if he were to talk about burnout, and therefore, his goal was often to avoid being perceived as a complainer:

> Talking to a nurse, I also have to be conscious of the fact that the nurses look at me, and thinking, "I'm in the same ER as you, working the same number of hours, but you're making four times as much as me." So I can't be bitching that much about life when their life is not even much better.

Finally, Kerri described the responsibility she feels to control how others perceive not just her, but all doctors: "If you were talking about burnout in the lay world, it would make it sound like you don't care…You don't want to cause a negative impression about surgeons or doctors in general."

Physicians in this study hoped to control how others viewed them to avoid being seen as weak, incompetent or as someone who complains. At work, some physicians avoided sharing with trainees to control how medical students and residents viewed

attending physicians. Outside of work, participants said they tried to limit sharing to protect the positive impression others had of them or of doctors in general.

Be Seen as a Friend. The fourth identity goal discussed by participants was a desire for other medical professionals to view them as both a co-worker *and* a friend. When Robin was asked to describe how he wished to be perceived by peers while talking about burnout, he said, "a helpful friend and advocate." Shawn said she wanted be seen by others as "someone that's been there, and that had the experience, kind of like, 'We can get through this together.'" Blake hoped sharing about his burnout could help eliminate professional titles and hierarchy when talking about burnout. He said, "I try and present myself as a friend and colleague. You know? Even though I'm an attending, they're in medicine; you're still a colleague."

In summary, physicians wanted to disclose their burnout to help themselves and others feel less alone in the experience. They said burnout made them feel inadequate in many ways, and therefore, when disclosing their burnout, they aimed to help others recognize it as a common experience while also seeking validation. By doing so, they hoped to control how others perceived them at work and outside of work.

RQ3: Multiple Goal Dilemmas

The third research question aimed to identify what dilemmas participants experience when their conversational goals conflict. Two primary dilemmas emerged from the interviews. First, physicians expressed that they wanted to disclose their burnout to others, but did not want to appear to others as weak. The second dilemma physicians experienced was a desire to share their burnout while also wanting to avoid adding more work or emotional weight for others.

Wanting to Disclose Without Being Labeled

As the findings related to RQ2 illustrate, physicians in this study were aware that burnout is perceived as associated with being weak. Therefore, some participants believed that disclosing their experience could reflect negatively on their character and cause others to label them. Consequently, some participants described experiencing the dilemma of wanting to share without being perceived by others as weak. Casey said: "I definitely try to talk about it, or maybe I have to talk about it because I'm such a vocal person. But I don't want to seem weak." Drew also dealt with this dilemma and explained how his role as the provider and support person in his family contributed to hesitation about sharing with his spouse. He said:

> I think when I was trying to share these kinds of things with my [spouse], I was at the same time wanting help but on the other hand I was really trying to hold back because I was supposed to be the supporter of our family and not be weak at all.

Other participants said they knew sharing about burnout could be beneficial, but felt others might judge them. For example, Alex feared sharing would lead others to label him as unhappy with his job:

> Well, I think because you look at the person you're talking to, and what is the goal you're trying to do? One is you want to get something off your chest, right? So that's super important, and helps release kind of the tension that you're carrying inside of you. But then too, what impact would that have on the person you're talking to…When I'm talking to administration I have to be careful, because I don't want to convey anything that I'm the unhappy, pissed off doc, because then they label that to you.

According to Charlie, working in the medical field adds a unique stigma to burnout, and this contributed to his fear of being labeled "crazy" by others:

> I definitely think that when the job gets too demanding, you feel like you're alone, something bad happens, feel betrayed. I think it's good to have support to go talk to somebody or some guidance or some reassurance. Just somebody near to listen to…The problem with that though, as a medical professional, in the back of your

> mind, when you start going down that road, you probably wonder, "Well, if someone found out that I'm having to talk to somebody, then you're going to have the stigma. Well he's crazy."

In sum, many physicians explained that there are potential benefits of disclosing their burnout with others and said that by disclosing, they wanted to relieve stress and find reassurance. However, despite their desire to share, many feared disclosing their burnout might lead others to view them as weak and label them in a negative way.

Wanting to Disclose Without Burdening Others

The second dilemma described by participants was the desire to disclose burnout while also being aware that doing so may burden others. There were two ways physicians felt disclosing burnout could burden others. First, disclosure could decrease their own workload and in turn, increase the workload for others. Second, sharing their burnout could add an emotional burden to others.

More Work. Many physicians in the sample felt responsible for taking care of their share of patients, even if doing so negatively affected their own health or well-being. They were aware that expressing burnout could lead to a decrease in their own workload and, consequently, add work for their colleagues. This created a dilemma. Avery explained:

> If I do need [support], I feel like I would probably voice it as like, "Hey, I'm burned out. You've got to give me some time." And if I do that, that means my colleagues would have to carry the load as well. And so that's also another negative.

Jamie said adding more work for someone else was similar to punishing them:

> Burnout would be associated with working too much. so if you are working too much, you complained about it and then you would work less. So if you work less, somebody else is going to work more. Then you're kind of punishing someone else.

Kerri discussed how adding work for her colleague would be reflective of the level of respect she has for him:

> I think of burnout as being like you need rest, you can't handle anymore, you've got to rest. You need time…If I say no [to accepting patients], where are they going to go? It's all going to go on my partners. One is already burned out and we're both getting killed, so I don't really, because I respect him as my partner.

For many participants, disclosing burnout was equated to asking for a decrease in workload, and therefore, they felt doing so would add more work for another physician, which created a conflict about wanting to share.

Emotional Weight. The second way physicians felt disclosing their burnout could burden others was by adding emotional weight. While burdening others with work was specific to the professional environment, fears about burdening others emotionally was most often discussed by participants as something they hoped to avoid when talking to their friends and family. Jordan said even though his spouse also worked in healthcare, he remained hesitant to share: "I have a supportive spouse but I know she's busy too, and she works in healthcare, so I try not to burden her." Similarly, Shawn's spouse worked as a police officer, and she expressed a desire to share her burnout with him, but she was also aware that doing so may add stress after he had his own difficult experiences at work. She said:

> I know my [spouse], when he comes home, and he's had a bad day, and he's been in a shoot down, or put in a sticky situation, or had to deal with the BS, or something, he doesn't want to hear about my bad day. He doesn't want to hear about my death, and my experiences, and everything. I don't want to put that burden on him, on top of his problems.

Although Lee felt supported by his [spouse] and said he would feel comfortable talking to her about burnout, he felt the topics involved in that type of conversation had the potential to make her sad or more aware of tragic events that could happen:

> Even when I talk to my [spouse], like, I can tell she's being supportive, but I mean, I'm talking about something that she doesn't really, it's not enjoyable to hear about. It's just adding...it's just making someone else sad. I'm just adding to someone else's thoughts about what can happen when you're driving or something, you know? I'm not really making her any better by telling her.

To summarize, participants acknowledged there are potential benefits of disclosing burnout; however, they also had hesitations about how disclosure might negatively impact others. At work, they feared that disclosing their burnout would give them time off and consequently add more work for another physician—something they were not willing to do, even if they desperately needed a break from work. Outside of work, they wanted to disclose their burnout with friends and family but feared that doing so could bring about unnecessary emotional weight for the other person. In both situations, the physicians in this study were aware of how their actions may impact others and often they were willing to put aside their own needs for the benefit of others.

RQ4: Disclosure Strategies

Physicians reported using a variety of strategies when disclosing burnout. There were five primary strategies used: not calling the experience "burnout"; sharing knowledge with other physicians; choosing appropriate confidants; sharing selective information; and limiting disclosure. Some participants described using only one strategy, whereas others shared instances when they used a combination of these strategies.

Not Calling it Burnout

The first strategy used to disclose burnout was relabeling the experience by not calling it "burnout." The term "burnout" was described by many participants as having a negative connotation and indicative of weakness, and therefore, some physicians said they used alternative words to describe their experience. Chris said he thought physicians

with more experience would not use the word burnout: “I think that especially among providers that have been doing it for 10 or so years, and I would say that it’s not manifested back, they don’t walk in and say, ‘I’m burned out.’” Robin explained how denying burnout can be one way to avoid the negative identity labels it is associated with: “Just like I said, ‘I don't have burnout.’ You might be saying, like, ‘Dude, you look burnt out.’ So I think not calling it by that term, it's a roundabout way.”

In an effort to avoid using the word “burnout,” some participants utilized other words to describe their experience. For example, Cory chose to describe himself as “crispy”: “I worked very hard and did a lot of stuff, and I found myself really having trouble keeping motivated at home and then eventually motivated at work…I was getting what I used to call ‘crispy.’” Pat shared a similar way of handling these situations, saying that he would tell others his actions were the result of “fatigue,” rather than burnout. He said: “With a coworker, when I get snappy or irritable, I'll step back and say, ‘This isn't me. This is just fatigue.’”

In sum, participants acknowledged trying to avoid using the term “burnout” when describing their experience with others. Although the experiences described by participants were often similar, the way each physician chose to label their own experience varied. Many physicians would use an alternative label to help separate their experience from their identity, attributing their actions to something other than themselves.

Share Knowledge with Other Physicians

The second strategy participants used to disclose burnout was seeking ways to share knowledge with other physicians. Kennedy, a seasoned physician, said having more

years of experience gives him the opportunity to share his knowledge with younger physicians: “I've got a lot of experience under my belt, so sometimes I can give examples of what I did that other younger folks may not have really thought about.” Blake also felt sharing knowledge was one way he could increase awareness about burnout with physicians who were still in training. He said: “We have residents and fellows in our program, and so I think I try to talk about burnout with them as with my partners just to try to help. Especially with the trainees. It’s somewhat to bring awareness to them and check in.”

Another reason some participants wanted to share knowledge about their burnout was to help other physicians realize they are not alone in the experience. Sometimes, this type of sharing occurred one-on-one between physicians. For instance, Elliot recognized that one of her colleagues was experiencing burnout and decided to share her own experience in hopes that it might help him. She recalled: “My colleague who I’m seeing burnout with, I told him my story and I’m like, ‘You got to do something about it’ because I can see him suffering, and I feel so much better now.” Other participants, like Mickey, chose to share knowledge about burnout with other physicians more formally and to a larger audience during an educational presentation:

> I gave a round to my fellowship on learning to fail. Failure medicine. I started by saying, “You probably never heard anyone that did that and certainly never heard anyone talk about their burnout in an open book”…I put myself out there. We’ve had these chronic failures, personal failures, training failures. I’m happy to talk about it because we all feel it.

He said his presentation was well received, and some physicians in the audience followed up with him to share their own experiences.

To summarize, finding ways to share knowledge is one way participants chose to disclose their burnout. Although the physicians in this study did not always want to share knowledge for the same reasons, many of them disclosed burnout as a way to find meaning in their own experience and to help other physicians.

Choose Appropriate Confidants

The third strategy participants used when disclosing burnout was choosing appropriate confidants. Kim explained: "You take it to the right person. You're selective with who you talk to those things about." Some participants chose to share with co-workers, but did so selectively. For example, Chris explained how he felt his role as an attending physician influenced how he selected confidants, stating he would not feel comfortable sharing his burnout with less experienced providers: "I would definitely not want to share it with a junior provider. I would want to go to somebody who was in a healthy situation." In this example, Chris did not perceive junior providers to be as "healthy" as senior providers, and, as a result, he did not feel comfortable sharing with them.

Some physicians were most comfortable sharing details about their burnout with their spouse. Casey's [spouse] is also a physician, and she said having the same job made it easier for her to talk to him about burnout:

> Outside of my colleagues, I wouldn't say it's very easy to talk about. It's also easy to talk about this, I'm married to a physician, so he knows what I'm going through. It's easier at home, I don't understand how people have nobody at home to talk about, like, if they're not married to a physician. I think it'd be very difficult for me to get by without having somebody at home to understand. I think that makes it easier for me personally.

Cory also felt most comfortable sharing with his [spouse]; however, after a resident in the program he supervised had committed suicide, he said there were parts of his experience she couldn't fully understand:

> Even to somebody I'd always felt understood, which is my [spouse], she always understands my work and forgives me for the harder ways. Even that, I felt like I was, I was isolated from her, because she did not really understand the guilt associated. She understood it cognitively, but I don't think she understood it viscerally.

In addition to spouses, participants discussed how they chose confidants outside of work. Alex said it is difficult for him to talk about burnout with individuals who do not work in the medical field, as he believes they may have a skewed perception about what doctors experience: "I mean, when you're complaining to someone outside of work, sometimes they don't know what the heck you're talking about… They think it's like a TV show and you're like, 'It's not at all like the TV show.'" Peyton also expressed difficulty sharing her burnout with individuals who do not work in healthcare. She recognized a prestige that is often associated with being a doctor and explained how disclosing her burnout could change how her family perceived her:

> There's probably a little piece of that in why I don't talk about it much at home. Because my parents are so proud, and there are other people in my extended family who have done great things. But I don't know. I'm seen as the one who made it.

For similar reasons, Peyton also avoided talking about burnout outside of work:

> I still don't talk a whole lot about [burnout] out of work…It's a downer to people who don't do this. And away from work, those people are my safe place. Those people are my "You're the most awesome person in the entire world" people, and I don't know. Sometimes you don't want to admit to them that you're not the most fabulous person in the whole world.

In this example, Peyton feared that sharing details of her burnout outside of work could jeopardize how others viewed her and, therefore, she chose not to share.

In summary, participants said they are selective and strategic when deciding with whom to share details about their burnout. Some physicians were more comfortable sharing at work with other physicians, whereas others said they preferred to share at home with their spouse. The majority of participants did not feel as comfortable sharing with friends and extended family.

Share Selective Information

In addition to being selective about *who* to share with, participants were also selective about *what* information they shared. Terry recalled a time when his level of burnout was the highest it had ever been and he became suicidal. During this time, he said he wanted to tell others he was struggling without going into much detail:

> I mentioned to my closest friends in my group that I was struggling with burnout, and that's all I told them. But I never said anything about the really troubling part of it, no. I didn't want anybody to know that, because in my heart of hearts, I really didn't think that I would do it. I just knew that that was a huge warning sign, that I'd better do something different.

Riley said sharing too many details about the burnout experience increased the risk of exposing parts of the experience (e.g., unhealthy coping strategies) that may not be viewed positively by others:

> If part of how you're dealing with your burnout is drinking a little more or doing something else, then you might be reluctant to talk about the burnout, because it might lead to revealing other things that you're doing that are maybe troubling.

To summarize, when physicians in this study shared burnout with others, they were careful about what information was disclosed. The choice to share specific information was strategic and influenced by a desire to conceal details to avoid concerning others about their well-being. Ultimately, many physicians decided to only

disclose that they were experiencing burnout, but did not explain what that meant or provide additional details.

Limited Disclosure

The final strategy physicians utilized was to limit disclose of their burnout. Participants cited various reasons for concealing. For instance, Cory often did not share with others, fearing they might find out he was receiving professional help: "I was one of the people that didn't ask for a lot of help. And when I did, I kept it quiet and I didn't tell a lot of people I was in therapy." Sawyer compared burnout to Post Traumatic Stress Disorder (PTSD) to explain why she felt the topic was often off limits for sharing: "I never shared it at all. Even towards the end, when people knew that I was planning to leave…It's not something people talk about, because I think it's something like PTSD for veterans that you just don't talk about." Charlie said that among other physicians in his age group, burnout is not a welcomed topic of discussion: "I would also say that my age group and probably a little bit older, we don't talk about this stuff at all. We just don't. I mean, you just suck it up and do it." Finally, Shawn described how her role as both a mother and a [spouse] influenced her decision to keep quiet:

> There's times when I come home, and I'm frustrated, and the kids have so much going on at home, whether it's schoolwork, or it's running to extracurricular activities that I choose just to push my feelings aside. And just when my family's needs come first, I push mine aside.

In sum, there were a variety of reasons why physicians chose to limit sharing details about their burnout experiences with others. Participants often did not share because they feared judgment, wanted to adhere to cultural norms, or they wanted to put others' needs before their own. Although most participants recognized the potential benefits of sharing about their burnout, some were still not willing to disclose.

RQ5: Disclosure Catalysts and Barriers

The fifth research question inquired about what makes it easier (i.e. catalysts) or more difficult (i.e., barriers) for physicians to share their burnout with others. Participants described five ways disclosure is made easier: others acknowledging burnout as a normal experience rather than a personal flaw; others sharing their own burnout experiences; shared professional experiences; perceived confidentiality; and their role as an attending physician. Additionally, participants identified three barriers that make disclosure more difficult: stigma and fear of judgment; perception that no one cares; and perception that support is unavailable.

Easier to Disclose

When describing instances of disclosure, participants said some factors made them feel more comfortable sharing with others. Sometimes others' actions served as a catalyst and encouraged sharing, whereas in other instances, physicians' perception of the situation influenced their decisions about sharing. Overall, participants described feeling more comfortable and more willing to share their burnout experiences when others acknowledged burnout as normal, shared their own burnout experiences, worked in the medical field, or held the information confidential. Additionally, participants said their role as an attending physician gave them more autonomy and made it easier to disclose burnout without professional consequences.

Others Acknowledging Burnout as Normal. Many participants said it is easier to disclose burnout when others acknowledge the experience as something that is normal and not an indicator of a personal flaw. Blake stated: "What would make it easier [to talk about burnout] is if we actually admitted that this is a very real problem or not necessarily

a problem even. That this is a really common experience." Peyton suggested the normalization of burnout also makes it easier for physicians to manage their symptoms:

> I think knowing about it, and understanding that it happens, and it's not something wrong with you as a person, makes it easier to talk about. Because I understand that, I can admit that to people. Because I know it's not me. It's something that's happening to me. And there are ways to make it better. I think the more we educate people and let them know that this is something that can be managed.

In these two examples, the participants said having others acknowledge the common nature of burnout experience made them more comfortable when sharing.

Some participants suggested that specifically acknowledging burnout more formally at work would make it easier to talk about. Avery said if the hospital administration recognized burnout as a valid experience, it would reframe how conversations about the topic were perceived in the workplace: "If the administration is open to it, they would see it as burnout, but if they're not open to it, then they say you're probably just complaining." Chris suggested more formal integration of the topic into already existing learning opportunities, such as continuing medical education (CME) requirements, and said doing so could help facilitate and encourage conversations for physicians who might not otherwise feel comfortable sharing:

> I think having mandatory CME on the topic is something [that makes talking about burnout easier], because whenever something is mandatory, we've got to do it…I think it would certainly make, if that group of physicians that are either introvert or feel like pride is holding them back from sharing, that might possibly push them more toward being open to talking about it and addressing it proactively.

Riley also expressed interest in having more conversations about burnout integrated into professional forums specifically for physicians, such as grand rounds meetings:

> We had a grand rounds, a medicine grand rounds a couple of weeks ago...It was about burnout and was great. Probably one of the best medical talks. So we went to the speaker afterwards and said, "I think it's the best medical talk I've ever been

> to." And so to have, I think, when we view these things as weaknesses and then have it publicly spoken about and a grand rounds presented talking about it, I think that certainly helps. If someone in that audience is feeling burnout to be able to say, "Hey, yeah, I haven't been feeling this [working as a physician]." And if we're having a grand rounds talking about it, then it might be okay for me to say something.

According to these participants, adding burnout as a topic of discussion to already existing formalized conversations among physicians could make it easier to talk about.

Others Sharing Burnout Experiences. When other physicians shared details about their burnout, participants said it was easier for them to disclose their own experiences. Lee recalled a time when another physician disclosed his burnout, and in an effort to support him, Lee reciprocated:

> It was difficult for me to even bring it up and then talk about it. In fact, I think I only did when he told me about one of his situations first. I guess partly I was doing it to support him, but honestly, it was also to support myself. I think we ended up supporting each other, not really purposefully, but I think it just kind of happened that way. Then I suppose I really had that kind of conversation with many physicians, and that is one of the ways we support each other is being able to talk about something that feels unfair or something. Yeah, just something that obviously hurts your pride.

Participants said they often compare themselves to their peers and can sometimes feel as though others are only experiencing successes while they are struggling. Cory said when well-respected physicians disclose their burnout experience, others feel it is easier for them to share: "When people know [about professional successes], and then you talk about all your failures, I think it opens up a conversation in a way that is fundamental that people understand." Chris echoed this sentiment and suggested the act of sharing can be contagious:

> The thing about burnout is, it's honestly quite contagious, because I think, just like cynicism is contagious in the emergency room, burnout, I think people, if they see that "Oh, man. Doctor Jones, here, God. He's the bomb and he's feeling burned out. I thought he was like a God, but he's feeling burned out so I guess it's okay."

Chris's example illustrates how, when one physician discloses, it becomes easier for others to reciprocate the same level of vulnerability.

Shared Professional Experiences. Participants explained it is easier for them to talk about burnout with others in the medical field who have also had difficult experiences at work. Shared professional experiences can eliminate the need to explain every detail of a situation because the other person likely understands the feelings and emotions that are involved. As Jamie said, "It's easier to talk to people on your same level doing the same job as you." Peyton described how a shared understanding can facilitate disclosure:

> The people inside of work know what you're going through, because they live it with you. And I think having that, that someone who does what you do, and understands the job can say, "It's okay. You're not a bad doctor. You're not a bad person. This is just a bad time. And let's talk about that."

Kerri recognized how a shared understanding among colleagues can be advantageous by encouraging helpful dialogue: "I think it's easier to share more with colleagues, fellow surgeons that are kind of in the same boat because they understand where you're coming from, so they can kind of be more blunt and honest." Finally, Charlie said it is easier for him to talk to other medical professionals about difficult experiences at work because he knows other physicians have likely had similar experiences:

> I can sit there and tell you what it's like to see a dead baby, but until you've seen it and been the one responsible for trying to save it and then have to go out and tell some young mother who's hanging on by a thread, that you want to come out there and say that their kids okay, and you're the one who's got to push them off the cliff, how fucking heartbreaking it is and have to do that a lot in your lifetime. I mean, I don't think you would understand that versus one of my peers.

In this instance, Charlie did not think others outside of work would understand how it feels to be the physician responsible for such a difficult situation and said even if other physicians had not experienced that exact situation, he felt they would still understand.

Perceived Confidentiality. According to participants in this study, it was easier to disclose burnout when they perceived their conversation would remain confidential and not be shared with others. Charlie explained how trust influences his decision to share: "I would not tell them that if I didn't trust them with that kind of information." Similarly, Riley said disclosing to others would be his last resort, but he said that if he did share, it would be to someone he considered a "safe person":

> I would exhaust every possibility that I can manage it on my own. And then if I figured out I couldn't manage it on my own, and I really think I needed to go to someone else, I would try to find someone that I thought one would be helpful, and number two would be a safe person for me to talk to.

Some participants identified groups of people with whom they would trust sharing information. For example, Jamie felt close with a group of other male physicians and said he trusted the conversations about burnout would be met with understanding and kept confidential:

> I feel like I've got my outlet for burnout with this group, because they would keep it confidential. I think for me, I wouldn't talk about it if it wasn't kept confidential by someone who understands what I'm going through...so that I can control the perception of myself."

Casey discussed feeling comfortable sharing details of her burnout in a Facebook group composed of other physician moms, saying that having the option to share anonymously made it easier to disclose: "It's incredibly helpful and supportive, and you can ask for advice anonymously on this group and/or just post on the group. Essentially, hundreds of people will comment or give advice." For all of these participants, sharing became easier

when they felt assured that their disclosure would remain confidential and they trusted the confidants.

When physicians perceived their conversation about burnout would be confidential, it was easier to disclose. Trusting that others would not share their information facilitated an honest dialogue and made participants feel more comfortable sharing details about burnout that might otherwise be difficult to disclose.

Role as Attending Physician. All of the participants in this study were attending physicians, and therefore, they had completed all of the necessary medical training programs (e.g., medical school, residency, fellowship). As a result, many participants said they felt more secure in their role as an attending than they did as a trainee, which made it easier to share their burnout with others. Kerri, a surgeon, described how she felt about disclosing burnout as a resident and compared it to how she feels in her current position:

> In surgery residency, I feel like it's, culturally you're not really allowed to [talk about burnout]...It doesn't really matter if you're tired and exhausted, because that's part of the job. As an attending, I think it's easier to talk about it, everything's easier to talk about as an attending, because you're your own boss.

Many participants explained how talking about burnout as an attending did not feel as risky as it did while they were in training. Mickey said: “I think it’s easier [to talk about burnout as an attending]. I’m not worried as much. I don’t need a letter of recommendation.” As an attending, Kim said there is less fear about the repercussions that could result from sharing burnout:

> There’s not fear of repercussions as much. What are they really going to do to me that I am admitting that I am burned out? Right? I know a little better what I can get away with and what corners I can cut and still do enough.

To summarize, when others helped normalize the burnout experience, participants felt more comfortable disclosing. More specifically, participants found it easier to talk

about burnout with other physicians, especially when others disclosed their own burnout first. Participants said having a common understanding of the work allowed them to talk about situations and feelings that others outside of medicine might not have experienced. Finally, participants said their role as an attending physician made it easier to disclose burnout, as it afforded them more job security than when they were in training.

Difficult to Disclose

The topic of burnout is difficult for physicians to disclose for many reasons. Participants in this study identified three specific factors that made disclosing burnout more difficult: stigma and fear of judgment, perception that no one cares, and perception that support is unavailable.

Stigma and Fear of Judgment. Burnout is an experience that is stigmatized, and physicians in this study said the stigma made it more difficult to talk about their burnout experience. They often feared others could view them as a flawed physician or someone not adhering to the expectations of being a physician. Blake said: "I think what makes it more difficult [to talk about burnout] is the fear of judgment." Nearly all of the physicians in this study identified fear of judgment as a barrier for sharing.

Personal Flaw. Participants wanted to avoid being seen by others as weak or flawed in any way, and if they admitted to experiencing burnout, they worried others might view them negatively. This made the disclosure about burnout difficult. Robin explained how the stigma surrounding burnout makes it difficult for others to separate a physician's work performance from their difficulties during burnout: "Some of it might be stigma of weakness....Or assuming that something impacts your work because you are

depressed or have this problem or have that problem." Peyton said the stigma surrounding burnout makes her feel embarrassed to talk about it:

> When you're in the middle of it, and you haven't been able to take a step back and say, "Yep. This is what's happening to me," then, it feels so personal. It feels like there's something wrong with me. Why can't I just stop thinking about this? Or why can't I just do better next time? And then it's embarrassing to talk about. It feels like something is wrong with you.

Other physicians, like Elliot, said her fear of judgment makes it difficult for her to talk about burnout with her administrators: "It would definitely have been hard to talk to my administrators about it, just because I think it shows the sign of weakness." Finally, Terry explained that physicians are expected to be emotionally strong and therefore, by talking about burnout, he could be perceived as exposing a weakness:

> Stigma. Weakness. I mean, medicine does not lend itself to people who are having difficulty dealing with stress. I started out in general surgery, I was a battalion doc with the Marines, and then I chose emergency medicine. You have to be able to manage stress. So most of medicine, and that includes even pediatricians. I mean, you have to be able to function under duress, because your patients depend upon that. So that's the tradition, it's a selfless tradition. I think it's only now that, and maybe over the last several years that physicians and the American public are beginning to wake up to the human side of what happens to providers.

In this narrative, Terry shared how his years of experience has allowed him to understand the stressors of the job, observe their impact on physicians' well-being and witness the way fear can keep physicians from sharing difficult experiences.

Does Not Fit Physician Narrative. A narrative exists about what it means to be a physician, including how physicians are expected to act. In multiple instances, participants said disclosing burnout can be difficult, because burnout does not fit the physician narrative. For example, physicians are expected to be able to handle any situation, and Elliot said disclosing burnout conflicts with that: "It's kind of like

admitting that you can't handle it, and that's not how we're trained." Kim explained why disclosing burnout is not accepted in the culture of medicine:

> The culture of being a physician is that we are on the up and up. We're doing everything right, that we're hard workers. And I think that sometimes stopping to say, "Hey, this is kind of hard, and I'm kind of tired, and I'm kind of frustrated," sort of bucks that paradigm of "We're the people who've excelled and done well and been the A students." You know? And we're supposed to be the ones that are sailing and winning and succeeding.

Riley discussed how physicians are trained to solve problems rather than be the ones who might be seen as having a problem. He said:

> I think we view ourselves as problem solvers, and we're the ones that are supposed to come in when you don't know what's wrong and figure out what's wrong and figure out how to fix that. So that's kind of diagnosing and then treating. And I think doctors also feel like they're the ones that are supposed to have strength and demonstrate that. So, talking about being burned out, I think that can be something that they're disinclined to talk about.

Similarly, Blake said physicians don't want to appear as the ones who are "broken":

> I don't think we want to admit that we're vulnerable. I think that we don't want to think there's anything wrong with us. We spend a lot of our time fixing other people. We don't want to see ourselves as something that's broken.

Finally, Cory equated being a physician with being part of a tribe, saying there is a fear of no longer belonging to the group:

> I think people are scared to death of being kicked out of the tribe. They're scared of being "one of them" instead of one of us. I firmly believe that conversation is literally killing people. The higher you score on the depression index, the less likely you are to disclose that you're depressed, to ask for help, the more likely you are to feel ostracized and feel like it's your fault.

Perception that No One Cares. Some participants had a difficult time disclosing burnout because they did not feel as though anyone cared. Kim said: "I didn't really reach out maybe as much as I could because I didn't think anyone would care." Taylor became frustrated thinking no one cared about his experience: "What makes it more difficult to

talk about burnout I think is really maybe the frustration that probably nobody really cares." Charlie explained the reason he believes others do not care about physician burnout is because they work in a high paying job and are expected to deal with difficult situations on their own:

> Nobody wants to hear it. I talked to my boss about it. You think they care? No…Nobody cares, and that's what you get. Again, it's just rich doctor problems. Nobody cares what weighs on your mind or how horrible things might be for you, you just have to accept it and move on, and that's the behavior that is perpetuated and that's what you learn to live with.

In this example, Charlie also referred to a time he tried discussing his burnout with a supervisor and did not feel supported. This contributed to his belief that no one cares.

Perception that Support is Unavailable. The final reason participants said burnout was difficult to talk about is because they perceived support is not available to them. Many of the physicians felt they did not have someone to talk to. For example, Mickey said: "I didn't feel like I had anybody I could talk to." Similarly, Blake said during two separate burnout experiences, he did not feel like he had anyone to talk to: "I didn't seek help either way in either one [referring to two episodes of burnout]…The extreme difficulty is I had no one to really turn to." Other participants, like Drew, explained they were not aware of who they could go to for help:

> I don't think I actually had a good understanding of who I should ask for help. I think I managed it well, and I think I'm happy to be able to find myself my way out of it, I guess. But I don't think I fully recognized what was going on and that something could be done about it.

Finally, Charlie said physicians are responsible for finding their own support and did not believe there was a hotline physicians could call when struggling: "If you want professional help, you'd have to go find it. There's no national emergency medicine number to call to say, 'Hey, I'm having some problems. I just dealt with a dead baby and

I'm cracking up over it.'" For all these physicians, a perceived lack of available confidants made it difficult for them to disclose their burnout to others.

In sum, some physicians in this study felt others did not care about their burnout and therefore, it made it difficult to disclose. When they perceived a lack of empathy from others, they avoided seeking support and instead continued working, regardless of the state of their well-being. Participants also said they were unaware of resources available to them and shared they did not think there were individuals with whom they could disclose. As a result, many of the physicians did not seek help and went without support.

RQ6: Supportive and Unsupportive Responses to Burnout Disclosure

The final research question addressed what responses physicians find to be more or less supportive when disclosing burnout. Participants in this study identified four responses they found to be supportive: listening first, supporting professional changes, sympathy and compassion, and validation. Participants also identified three responses to burnout disclosure that are not supportive: dismissal of feelings, canned responses, and forced support.

Supportive Responses

When participants shared examples of disclosing their burnout to others, they also discussed how others responded. They explained that some responses felt more supportive than others. Participants provided examples from interactions at work and outside of work.

Listening First. Many participants discussed how important they felt it was for someone to simply listen to them while they shared their burnout experience. Terry said

listening allowed others to better understand the situation before responding: “Whether it's burnout or anything else, the most important thing to do first is to listen, and try to understand where they are.” Blake explained how the act of listening can be supportive: “Do more listening. I think in the past I’ve done a lot more talking about burnout instead of done more listening. I think that the listening may actually be, I don’t know, could be more therapeutic for some people.”

Finally, Casey said listening first is better than talking before understanding what the person experiencing burnout needs or is asking for: “Just being a listening human where you just listen and hear the person out, because I think that there's nothing worse than over speaking to someone that's trying to come to you for help.” Most participants said when they disclosed burnout, it was often with hesitation, and therefore, when others listened before interjecting, they felt supported.

Supporting Professional Changes. As previously described, participants often described feeling “stuck” when experiencing burnout. Therefore, when others responded to their burnout disclosure by acknowledging the possibility of changes in their professional life, they felt supported. Most often this type of support came from a spouse. For example, Terry recalled a time when his [spouse] supported his decision to change the direction of his career:

> She just said, “If you have to change, then change. You can't keep going like this,” which is a lot of support really. When your [spouse] gives you the freedom to make a big, huge career move that might affect her negatively...My [spouse]'s support in allowing me to make a decision that I had to make was huge.

Similarly, Elliot felt supported by her [spouse] when he was willing to move across the country and change his job to support her:

> He saw how unhappy I was, and he saw how much I struggled, and he knows I work really hard and that I care a lot. And all that kind of stuff. And so he was kind of like, “Whatever you feel like you need to do, and we need to move here for a little while and kind of see how this is, and maybe this is a better fit.” And he was willing to uproot his business.

Although not as common, some participants said they felt supported when colleagues responded to their disclosure by helping modify their hours and work responsibilities. Avery recalled a time when his supervisor responded by saying: “We need to figure out a way to change your schedule to allow you to have a little bit more administrative time where you just separate it from the clinicals."

Sympathy and Compassion. When physicians disclosed burnout and were met with a response they perceived as sympathetic and compassionate, they felt supported. Kim explained: “It's okay to find a compassionate way to say, ‘Gosh, I feel like you're going through a lot. I'm here for you’...More phrases that are rooted in emotion than phrases that can be construed as criticism." Peyton provided an example of a response from her friend that she viewed as supportive because it showed compassion and encouragement:

> In a conversation with a good friend, I finally said, “I suck as a doctor. This is terrible. I've made a horrible life decision and I've ended up in a job that I'm not good at, and I shouldn't be in this profession.” And luckily I happened to share that with somebody that was not involved in medicine, and they said, “Oh my God, you're one of the nicest, sweetest, most compassionate people I know.”

Cory shared a different scenario, explaining how a fellow attending physician was burned out and she became suicidal. The physician had missed diagnosing her child’s brain tumor and blamed herself so much that she shared with Cory she was considering killing both her daughter and herself. Cory said, while he had not experienced that exact

situation, he understood the guilt that can be involved when missing medical diagnoses and responded with compassion:

> I didn't know exactly what to say, but I said, "Well, I sort of understand how you felt responsible for it." And it was the right thing to say, because it opened up the whole conversation, and she knows how weird it is in our social environment to say "Yeah, I was thinking about killing my kid"...It helped her. So you validate people's feelings. You don't judge like "Oh my God, you're a fucking monster." No matter what they say to you, to say "Yeah, that must have been difficult. Or I felt like that before."

Cory said he believed that by expressing compassion rather than judgment, he was able to facilitate an honest conversation with his co-worker.

Reassurance. The last type of response participants identified as being supportive were statements that reassured to physicians they are not alone in their experience. Some participants, like Kerri, said it was helpful when others reminded them of this: "Knowing you're not alone. Having somebody to talk to about it. I think that helps more than anything." Parker suggested how he might respond to another physician experiencing burnout: "Say 'Hey, you're not alone. I mean, there are people that had went through this or are going through this with you. You're not in the boat by yourself.'" Alex explained how reassurance from others helps him pause and make the adjustments necessary to approach his job in a different way:

> It's nice to hear them complain too. Because you're not the only one...It's helpful, because you're not alone. It's not just you, and this is just the industry. It's the nature of the job, and then you just have to readjust and recalibrate how you're going to approach it, because burnout and all these things are a result of expectations being misaligned from what they actually are.

Finally, Cory shared how, through his own experiences, he has learned it is more supportive to validate others' feelings rather than offer solutions: "I don't offer them a solution. I try to talk about or validate why they felt that way."

To summarize, participants felt most supported when others responded to a burnout disclosure by first listening before offering any type of advice or potential solutions. Physicians explained the most supportive responses from others were those that were sympathetic and compassionate and those that provided reassurance to them that they were not alone in their experience with burnout. Finally, participants said they felt supported when others responded to their disclosure by agreeing to help them with changes to their professional career, even if doing so was not always convenient or easy.

Unsupportive Responses

Participants who had disclosed burnout to others described the type of responses that were not supportive, described by participants as occurring both at work and outside of work.

Dismissal of Feelings. Sharing burnout can make physicians feel vulnerable, as it exposes feelings that may be viewed by others as a weakness. As a result, participants felt less supported when others responded to their disclosure by dismissing their feelings. Some participants shared examples from work. For instance, Casey said this can happen when junior physicians talk about burnout with senior physicians:

> I think that if younger physicians maybe tried to talk about burnout with older physicians, there's the, "Don't complain about 20-hour shifts, because I had to work 48-hour shifts," or whatever. Like, "It was worse back in my day" situation. There was a lot of that in residency [with] attendings. It was just like, "Well, it was a lot worse back in my day. You have no room to complain."

Cory also suggested that generational differences and expectations about being a physician may lead to dismissal of feelings: "If you ask the old guard, they may just say, 'Well, yeah, life's hard. Get a helmet.'"

Participants also shared examples of family and friends responding in unsupportive ways. Jamie explained how his Dad would dismiss his feelings if he were to disclose burnout:

> My dad's very stoic, so I don't think he's somebody I would [talk to]. He doesn't really agree with a career in surgery at all. If I did complain to him about burnout, he'd be like, "Well you did that to yourself."

Shawn shared a similar scenario, saying that despite her [spouse]'s good intentions, she felt his response dismissed her feelings and was not supportive:

> There were several times when you go home, and you try to explain what you've been through, or you talk to someone that wasn't there to understand, and they're like, "Well, you did a really good job today." And I'm like, "No, I didn't."

When physicians shared their burnout with others and their feelings were dismissed, they felt unsupported and were unable to share additional details or seek any help for the situation.

Canned Responses. Participants felt less supported when others responded to their burnout disclosure by providing what were perceived by physicians as "canned" responses. For example, Casey said she found it unhelpful when others encouraged her to ignore the burnout and continue working:

> I think that a lot of people just say, like, especially in residency, it's like, "Just keep your head down and keep on moving." It's like, that's just not helpful. I think that a lot of people say that, "Just push through." The more you push through, I think the worse it gets.

Kerri shared an example of an unsupportive response from her mother:

> I don't expect coddling, but she's like, "Well..." I think she really does feel bad for me, but she doesn't really know what to say. She's like, "Well, keeps you off the streets." I'm like, "That is not helpful. I'd rather be on the streets." I'm kidding, but you know what I mean.

Kim said sometimes canned responses can actually add more negative feelings:

> Don't say, “Oh, just snap out of it.” That's not constructive. Actually, probably would make the person feel worse and guilty, because nobody's really happy with their burnout. And burnout kind of happens because of lots and lots of disappointment, I think. At least that's been that way for me. So making someone feel even more disappointed that now they're not even feeling what they were trying to feel makes them probably feel more disappointed and more like a failure.

Many participants acknowledged that sometimes these responses occur when others don’t know what to say; however, in some cases, it could be more harmful by adding guilt and disappointment to the situation.

Inadequate Professional Support. The final type of responses participants described as being unsupportive were those that made them feel as though support were being forced upon them. Many participants in this study attributed their burnout to the amount of work they were responsible for. Therefore, when their burnout disclosure was met with responses they perceived as adding more work, they found it to be less supportive. These responses were only described as occurring at work. For example, Jordan said that without asking him, the administration at his hospital responded to his burnout by making changes to the workflow in the emergency room. He believed the modifications negatively impacted his efficiency at work and his ability to safely care for patients:

> They'll try to be supportive, but it's usually unhelpful. They'll say, “Oh, well, we'll get seven patients a bed at 2:00 AM,” but then that means all my help is gone, so then I have to see seven patients at once that they moved from the lobby to the room. So, that is not only unhelpful, it is also detrimental to patient care.

Jordan acknowledged the support from administration was well-intentioned; however, he said their approach and lack of concern for his perspective made it feel unsupportive.

Other participants appreciated attempts made by their employers to address burnout by offering non-clinical activities; however, they were often unhelpful and added

more work for physicians. For example, Kim said the workshops offered at her hospital just added to her full work schedule:

> Occasionally there's workshops, and sometimes it's like, I don't have the time for that. It's great that you're trying, that there's something out there that's offered, but sometimes it doesn't help me if it takes up more of my day or makes me get home later.

Taylor recognized these how activities may be helpful for others, but said he does not attend:

> I mean, for me this is all even adding to my workload if I have to do burnout initiatives at work...The "feel happy" activity, you know, like all the burnout seminars we have here. I mean, some people might get a whole benefit out of it. I never attend them.

Peyton suggested the activities are a temporary solution to burnout and do not address the underlying issues:

> It's easier to say "Here's your yoga session, and here, let us teach you how to meditate, and let's talk about mindfulness instead of fixing the problems that exist about the nurse staffing ratios, and the inability to get the equipment that you need to do the thing that you need to do."

Peyton said responses to burnout would be more helpful if they helped provide practical solutions for physicians that directly impacted their daily work rather than adding what she perceives as more work.

Similarly, participants shared examples of when they felt others responded to their burnout disclosure by quickly offering solutions rather than listening. Terry said: "I think the most significant mistake any of us can make is to try and advise someone without truly taking it in and understanding where they are. You have to meet people where they are." Casey shared this perspective, describing when her employer invited someone from outside of the hospital who was not a physician to talk to a group of physicians about burnout:

> I know that as far as a physician's concerned, the least helpful thing is to have an employer bring in somebody that's not a physician to talk about physicians about physician burnout. It's like the most frustrating thing, I'd say.

After one of Charlie's patients died, he struggled to cope. He described the response from others as unhelpful:

> I found out about [a bad patient outcome] the next day, and it weighed on my mind a lot. Not only did I not have anybody from the hospital ever say, "Hey man, are you okay?" or "Hey, you did a good job that day. I'm sorry this happened to you." What I had was the inquisition that goes on when something bad happens in the hospital, when everybody starts pointing fingers, "You should've done this, you should've done that."

Charlie said he had feelings of guilt associated with the death of this particular patient, although he stated there was not anything he could have done to save the patient's life. Even so, he explained he did not feel supported when others did not ask how he was impacted and instead immediately critiqued his care and began providing solutions.

To summarize, when disclosing burnout, participants found when others responded before listening, they felt less supported. Physicians said unsupportive responses dismissed their feelings and offered canned responses that did not meet their needs. Additionally, although participants appreciated the efforts made by their employers to address the issue of burnout by adding various activities, they perceived this type of support to create more work for them and felt it was forced and unhelpful.

Chapter Seven: Discussion

In this study, I used the multiple goals theoretical perspective broadly and a normative approach more specifically to investigate the disclosure of burnout by attending physicians. I found that physicians' descriptions of their burnout experience provided examples of two new categories that are not yet used when defining this phenomenon (RQ1). The results identify multiple goals that are salient for physicians when disclosing burnout (RQ2), sometimes creating conversational dilemmas (RQ3) that are managed using various strategies (RQ4). Finally, I found reasons physicians may feel more or less comfortable disclosing burnout (RQ5), and identified some responses to burnout disclosure that are perceived by physicians as being more or less supportive (RQ6). In this chapter, I discuss the theoretical and practical implications of the results of this dissertation.

Theoretical Implications

There are multiple theoretical implications of the findings from my study. There is limited research focusing on communication about physician burnout, and more specifically, the disclosure of these experiences. By utilizing multiple goals and the normative perspectives, the results of this study provide new insight about the burnout experience, goals in disclosing burnout, and the evaluation of supportive responses.

Conceptualizing the Burnout Experience

The burnout experience is defined most often in research by using three categories: emotional exhaustion, depersonalization, and loss of work fulfillment (Shanafelt et al., 2012). While participants in my study described experiences consistent with these categories, my study contributes to this body of research by introducing two

sub-categories to the loss of work fulfillment category, specific to the context of medicine.

First, when participants described the loss of work fulfillment, they often expressed feeling "stuck" in their field of work and wanting to leave medicine altogether. Some physicians said they felt "stuck" for financial reasons (e.g., medical school loans, high cost of living), or because they had already dedicated many years of their life to the profession. Others perceived their skillset to be too specific for them to be successful in another field. Regardless of the reason, all of these individuals expressed that, when they were burned out, they no longer wanted to work in medicine, but they said it was unlikely they would actually leave. When talking about leaving, these participants often described where they dreamed of working, with ideas ranging from opening a craft store or a surf shop on the beach (i.e., work that is very different than medicine in nature).

The second sub-category that emerged in the category of loss of work fulfillment was an awareness by physicians that something about themselves had changed. Some participants recognized changes in the way they interacted with others (e.g., more irritable, easily annoyed, less patience), while others said they were not performing professionally at the same level they had been previously (i.e., before experiencing burnout).

Additional research is necessary to understand if these two subcategories are unique to the experiences of attending physicians specifically or medical professionals in general. It is possible the feelings of being "stuck" and wanting to leave medicine are specific to this demographic of individuals, and in that instance, these findings would only apply in this context. Finally, the changes physicians recognize in themselves could

also be an outward expression or sign of burnout that could potentially help others identify the burnout; however, further research is necessary to confirm this.

Conversational Goals when Disclosing Burnout

In the current study, I identified the types of goals physicians have when disclosing burnout, which included sharing knowledge, seeking advice, normalizing the burnout experience, seeking validation, attempting to control others' perceptions, and being seen as a friend. Interestingly, all participants' goals were either task or identity goals. This does not mean relational goals are not important in this context, and in fact, research suggests disclosure can affect the quality of close relationships (Barbee et al., 1998). However, relational goals were not a theme that was found in this particular study. If anything, the lack of salience of relational goals points to the socially isolating nature of the burnout experience; perhaps relational goals were not reported by participants because burnout hindered relational connection with others. This finding is consistent with previous research (e.g., Derlega et al., 2002), which suggests that stigmatizing experiences (such as burnout) can lead individuals to conceal information from others, cutting off potential access to support networks and relational connection.

When participants in this study discussed goals, they often identified having more than one goal during a disclosure event, and when these goals conflicted, they were faced with conversational dilemmas (i.e., when achieving one goal came at the expense of achieving another). These results are consistent with a great deal of previous research, which has documented how individuals sharing sensitive health information are faced with the dilemma of wanting to disclose to access needed support while also not wanting to disclose to avoid stigmatization (see Greene, 2000). It is interesting to note that, in my

study, all dilemmas occurred between two task goals or between a task goal and an identity goal. Participants in my study did not report any dilemmas between two identity goals, and this is likely because all dilemmas included the goal of wanting to disclose burnout, which is a task goal.

The first dilemma participants experienced was a tension between two task goals: the desire to disclose burnout without burdening others. (A few participants described dilemmas that alluded to relational and identity goals in the goal of not burdening others, but the focus was always on managing workload for others, which is a task-oriented goal.) When faced with this dilemma, physicians made decisions about disclosure by weighing potential advantages and disadvantages.

The potential advantages of disclosure are well documented and include several benefits to the physician, such as building a support system (Reminen et al., 1992; Serovich et al., 2000) and decreasing stress by relieving the burden of keeping a secret (Lepore & Smyth, 2002). Participants in my study recognized these advantages, but they did not want to add more work or stress for others, which they saw as a significant disadvantage to disclosure. This is consistent with research which points to avoiding burdening others as a reason some individuals decide not to disclose information. For example, Winstead et al. (2002) found mothers living with HIV avoided disclosing their illness to others to protect them, fearing that disclosure might be a burden for others and have negative consequences.

The second dilemma participants described was a desire to disclose their burnout without being labeled by others in some way (i.e., wanting to disclose to another attending physician for support without being labeled as weak; wanting help from a

spouse without impacting their role as the family provider; and wanting to disclose for reassurance from others without being labeled "crazy"). All instances of this dilemma were between a task goal and an identity goal. Consistent with past research (e.g., Derlega et al., 1998), participants in my study wanted to disclose their burnout with others to receive support, reassurance, or vent; however, similar to other stigmatized disclosure experiences (e.g., Winstead et al., 2002), physicians in my study feared rejection, judgment, and stigmatized reactions from others. This second dilemma highlights how there is a stigma that is unique to physicians when it comes to the disclosure of information regarding their own emotional or mental health.

Much of the past research about physician communication is centered around physician-patient communication, with a focus on patient care, patient safety, and reducing medical errors. Literature highlighting the unique stigma associated with physicians' communication about their own emotional and mental health is limited; however, from this limited body of research, it appears acknowledging psychological illness can be extremely difficult for physicians, as it is often viewed as a weakness or character flaw (Thompson et al., 2001; Wallace, 2010) and can lead others to consider them "occupationally impaired" (Carr, 2008; Harrison, 2008). Physicians are often reluctant to assume the role of patient (Klitzman, 2008), as doing so can undermine a physician's personal and professional identity (Wallace, 2010).

My study provides evidence of specific instances of this unique stigma, illustrating how it influences disclosure during the burnout experience. According to participants in my study, stigma related to burnout was described in at least two ways. First, physicians said the stigma surrounding burnout led them to view burnout as a

discrediting feature that negatively reflected on their abilities as a physician. In these instances, burnout was perceived to be a personal weakness or even a character flaw that impacted work performance. Second, participants explained that, due to the unique stigma associated with burnout, disclosing burnout could be dehumanizing (e.g., perception that no one cares or wants to hear about their mental state). According to Haque & Waytz (2012), dehumanization is "a diminished attribution and consideration of others' mental states" (p.177) that has been incorporated into medical training and can be both functional and dysfunctional. In my study, this type of influence appeared to be dysfunctional, as it was a barrier for physicians wanting to disclose burnout.

To resolve the dilemma of wanting to disclose without being labeled, some physicians chose to disclose their burnout while others remained quiet. Among those who chose to disclose, often their goals were centered around their desire to engage in protective disclosure, or disclosing in a way that guards their emotions and allows them to plan disclosure behaviors ahead of the conversation (Charmaz, 1991). In these instances, physicians were careful to control who and when specific individuals knew about their burnout experience, and when they were unable to do so, disclosure was often avoided altogether. Finally, there were some physicians who chose to disclose, but they did not use the word "burnout" to describe their experience and used others words instead (e.g., "crispy," "fatigue"). Perhaps by avoiding use of this label, these participants felt they could avoid or limit the stigma associated with burnout.

Supportive and Unsupportive Responses to Burnout Disclosure

According to a normative theoretical perspective, the quality of communication is conceptualized as the extent to which a person is able to effectively and appropriately

manage the dilemmas presented by competing conversational goals (Goldsmith, 2004). Consistent with the normative approach, physicians in the current study often evaluated supportive attempts based on what was said in a message, how it was said, and the meaning that was attributed. This evaluation depended on how the supportive message defined their burnout experience (e.g., a problem to be solved, an insignificant experience, a situation they were responsible for, a common experience among physicians) and affirmed or challenged their identity (e.g., compassion, encouragement, character flaw, weakness).

Physicians in the present study evaluated some responses to their burnout disclosure as being more helpful and supportive than others, and their evaluation of the supportiveness of responses was based on how well the other person's response allowed them to resolve the competition between their conflicting goals in disclosing burnout. Specifically, participants described the helpful forms of social support they received when disclosing burnout, which included others responding to their disclosure by listening first, supporting professional changes, exhibiting sympathy and compassion, and providing reassurance. Next, physicians identified forms of social support which were unhelpful, including responses that dismissed feelings, canned responses, or what was perceived to be inadequate professional support.

Some responses were evaluated differently by participants, with some being perceived as helpful, while others considered the intended support to be unhelpful, which is consistent with past research that suggests that different people may respond differently to the same disclosure (Greene & Faulkner, 2002). Goldsmith (2004) suggests that one way supportive messages are evaluated are with reference to their instrumental or

problem-solving utility. Physicians in this study often referred to themselves as "problem solvers" and therefore, for some, burnout was seen as a problem needing to be "fixed". When these particular individuals received support related to professional changes, such as an alternative work schedule or a career move, they evaluated the response as helpful. However, for other physicians, "solutions" from others were evaluated negatively. For example, some physicians said they felt unsupported when others responded to their burnout disclosure with a canned response or with what they viewed as more work (e.g., workshops). These individuals said they would have preferred others simply listen to them rather than attempting to provide solutions.

To further illustrate how goals and evaluations of supportive responses may be related, Table 7.1 highlights each participant's goals for disclosure as well as what they identified as being the most helpful and unhelpful responses from others. While it is outside this study to assume correlations between these specific categories, it is important to recognize patterns that may exist between goals physicians had when disclosing their burnout and how they evaluated responses. Some participants did not provide enough information about responses they deemed unhelpful, and therefore, it is not included in the table.

Table 7.1 Participant Goals and Evaluations of Supportive Responses

	Participant	Goal	Helpful response	Unhelpful response
1.	Chris	**Share knowledge** **Seek advice**	Listening	Inadequate prof. support
2.	Cory	*Normalize burnout*	Sympathy/compassion	Dismissal of feelings
3.	Jamie	*Seek validation* *Control perceptions*	Reassurance	Dismissal of feelings
4.	Lee	*Normalize burnout* *Be seen as a friend*	Sympathy/compassion	Inadequate prof. support
5.	Jordan	**Share knowledge** *Control perceptions*	Listening Sympathy/compassion	Inadequate prof. support
6.	Shawn	*Control perceptions* *Be seen as a friend*	Reassurance	Dismissal of feelings
7.	Casey	**Vent** **Seek advice**	Listening	Dismissal of feelings Canned responses Inadequate prof. support
8.	Pat	**Share knowledge** *Control perceptions*	Listening	-
9.	Robin	*Normalize burnout* *Be seen as a friend*	Reassurance	-
10.	Kerri	**Seek advice** *Control perceptions*	Reassurance	Canned responses
11.	Terry	**Share knowledge** *Control perceptions*	Listening Supporting prof. changes	Inadequate prof. support
12.	Charlie	*Seek validation*	Reassurance	Inadequate prof. support
13.	Elliot	**Share knowledge**	Supporting prof. changes Sympathy/compassion	Inadequate prof. support
14.	Riley	**Vent** *Be seen as a friend*	Reassurance Sympathy/compassion	-
15.	Jessie	**Share knowledge**	Listening Supporting prof. changes	-

	Participant	Goal	Helpful response	Unhelpful response
16.	Avery	*Normalize burnout*	Supporting prof. changes	-
17.	Peyton	**Share knowledge** *Normalize burnout* *Control perceptions*	Sympathy/compassion	Inadequate prof. support
18.	Parker	**Share knowledge** *Control perceptions*	Reassurance	Canned response
19.	Mickey	**Vent** **Share knowledge**	Listening	Inadequate prof. support
20.	Leslie	**Vent** **Share knowledge**	Listening Supporting prof. changes	Inadequate prof. support
21.	Kim	*Seek validation*	Sympathy/compassion	Canned response Inadequate prof. support
22.	Austin	**Share knowledge** **Vent**	Sympathy/compassion	Dismissal of feelings
23.	Alex	Vent *Control perceptions*	Reassurance	Canned response
24.	Drew	**Seek advice** **Share knowledge**	Sympathy/compassion	-
25.	Sawyer	**Share knowledge**	Supporting prof. changes	Dismissal of feelings
26.	Taylor	**Vent** *Control perceptions*	Listening	Inadequate prof. support
27.	Kennedy	**Share knowledge** *Normalize burnout*	Listening Sympathy/compassion Supporting prof. changes	Inadequate prof. support
28.	Blake	*Normalize burnout* *Seek validation* *Be seen as a friend*	Listening Sympathy/compassion	-
29.	Mason	**Seek advice**	Supporting prof. changes	-
30.	Adrian	**Vent**	Listening Sympathy/compassion	Inadequate prof. support

Note. Goals in **bold** identify task goals and *italicized* words indicate identity goals.

Overall, participants evaluated responses as most helpful when the response matched their goal for disclosure. Among participants who had a goal of sharing knowledge found it most helpful when others responded by simply listening. This makes sense, as their goal was to share information and by having another person listen, they were able to accomplish that goal. Similarly, when participants wanted to vent, they found it most helpful when others listened.

The pattern of helpful responses being related to a match between goals and responses is not limited to participants with task goals, as it is also relevant for identity goals. For example, among the participants that wanted to use disclosure as a way to normalize the burnout example, all but one person identified sympathy or compassion as a helpful response. This was similar to when the goal was to seek validation, as all of these participants evaluated responses as most helpful when they included sympathy, compassion, or reassurance. Finally, the majority of participants who had a goal of either controlling perceptions or wanting to be seen as a friend evaluated responses as most helpful when they provided reassurance. These findings may indicate that some responses (e.g., sympathy/compassion; reassurance) may be helpful even for individuals who have different, yet related, goals (e.g., normalize burnout/seek validation; control perceptions/be seen as a friend).

When there was a mismatch between goals and responses, these responses were evaluated as less helpful or supportive. When participants only had task goals, they were most likely to identify inadequate professional support as the most unhelpful. Perhaps for these individuals, when professional support did not meet their expectations, it also may not have accomplished tasks related to their disclosure. More specifically, when

participants had a goal of sharing knowledge with others, nearly all of them identified inadequate professional support as unhelpful. Interestingly, half of the participants with a goal of normalizing the burnout experience also reported inadequate professional support as unhelpful. Although some participants did not clearly articulate how they evaluated unhelpful responses, these findings may indicate that inadequate professional support may be unhelpful to physicians who have differing goals when disclosing burnout.

These findings are in line with existing research which demonstrates that support is helpful when there is a match between the support that is given and the recipient's view of the situation (Goldsmith, 2004) and that, even if well-intentioned, some messages are not always viewed as favorable (Goldsmith et al., 2006). While the results of my study support Goldsmith's (2004) argument that there are no "one-size-fits-all behaviors that are uniformly supportive across contexts" (p.162), they give insight into what is more likely to make a response more or less helpful. Further research is needed to determine if there is a correlation between the type of goals physicians have during disclosure and their evaluations of intended support responses.

Practical Implications

The findings of my study have several practical implications for various stakeholders to consider. These recommendations can serve as a starting point for physicians, healthcare administrators, and friends and family of physicians wanting to better understand physician burnout and how best to support physicians as they navigate this experience.

Practical Implications for Physicians

Much of the research about burnout in medicine has been studied among medical students, residents, and nurses. When attending physicians are included, communication is not the primary focus. Attending physicians have high-stakes outcomes of burnout (e.g., suicide, drug use), have dedicated many years to the field of medicine, and are often dependent on a high standard of living. As some participants in my study discussed, this can make it difficult for this group of individuals to talk about burnout or make any significant changes to their professional lives. Factors such as these make the burnout experience among attending physicians unique, which is why it is important for researchers to specifically study attending physicians' experiences with burnout.

According to the results from my study, dilemmas posed by conflicting conversational goals can essentially function as barriers for physicians wanting to disclose burnout. Participants identified three primary barriers that make it more difficult for them to disclose their burnout with others: fear of judgment, a perception that no one cares, and a perception that support is unavailable. While these barriers can prevent disclosure, Scott, et al. (2020) suggest rather than seeking to eliminate these barriers, physicians may find more success by learning to successfully manage their multiple goals in these conversations. By reframing these barriers as opportunities to learn how to better manage their multiple goals during a burnout disclosure, physicians may find more success in meeting their conversational goals of disclosing burnout and accessing support.

Another takeaway from this study for physicians is the potential benefits that may result from disclosure. Some participants found that disclosing burnout helped normalize the experience, relieve stress, validate their feelings, and encourage others to talk about

their own experiences. Additionally, participants said it was not always natural to bring up the topic of burnout during conversations at work; however, when they were able to frame the disclosure as an opportunity to educate others, they were more comfortable discussing the topic. In these instances, participants said they were able to share knowledge and seek advice from others, which not only gave them a purpose for sharing but also had the potential to help them learn from others about ways to cope and find support. Physicians who want to disclose their burnout but have reservations in doing so might consider seeking out opportunities to disclose as a way to teach others about the burnout experience (e.g., grand rounds presentations) or seek advice from others who may be able to share information about helpful ways to cope or find support.

Practical Implications for Healthcare Administrators

A primary finding in my study pointed to a disconnect between the type of support physicians hoped to receive at the workplace and the support they actually received. As a result of this disconnect, physicians perceived many supportive attempts as inadequate. The solutions offered by workplaces, which ranged from workshops to workflow process alterations, were perceived by physicians as adding more work rather than actually helping. Many participants also expressed feeling as if no one at work cared about their burnout and said they were unaware of any support resources available to them at the workplace.

Given this information, there are a number of practical implications for healthcare administrators. First, when a support group is formed in the workplace or there is an individual available to help physicians dealing with burnout, it is important that the facilitator or individual be a physician. Participants who had experience with this type of

support at work said that when the facilitator was an individual who was not a physician, they did not feel that the person had the most accurate understanding of the experience, and they were not comfortable participating. It would be more helpful for the person leading this type of support to also be a physician so they could relate to the experiences of participants and be perceived by others as more credible.

Second, many of the physicians in my study suggested that high-level systemic changes may be more effective in helping with burnout than workshops or additional presentations. One-off solutions (such as workshops or presentations) were perceived by participants to add more work to their already busy workload, and often participants said they were not asked for their opinion about what they thought would be helpful content to cover in the workshops or presentations, so these solutions sometimes felt forced upon them and inconsistent with their needs. It would be helpful for healthcare administrators to directly ask attending physicians about their burnout (perhaps anonymously) and provide an opportunity for them to share feedback regarding the best ways to provide support for physicians experiencing burnout. Additionally, physicians in my study said they were unaware of supportive resources available to them at the workplace and expressed interest in support that was confidential. Therefore, in workplaces where such resources are available, regularly communicating this type of information with attending physicians would likely be helpful.

Finally, as mentioned previously, physicians in my study said the topic of burnout was difficult to discuss in everyday conversations at work. Therefore, healthcare administrators and individuals managing physicians should consider integrating this topic into already existing conversations. For example, attendings could share their personal

experience with burnout at conferences, grand rounds meetings, or with residents and medical students as part of medical education. Doing so would help normalize the experience and provide a more natural way for attending physicians to share this information with others and to encourage others to talk about their burnout as well in a safe context.

Practical Implications for Friends and Family of Physicians

There are a few ways the current results may be helpful for friends and family of attending physicians who are experiencing burnout. First, some participants realized they were burned out when they noticed their behaviors deviating from how they would normally act. These participants said they were less patient, easily annoyed, and had more difficulty communicating with others. This is important to consider, as individuals close to physicians may be able to identify behavior changes even before physicians do and begin providing support. Additionally, findings of this study indicated physicians who are burned out do not always use the word "burnout" when describing their experience. Knowing this information, friends and family members may be able to help physicians identify burnout by listening for alternative words they might use to describe their experience, such as feeling crispy, fatigued, irritable, or unmotivated.

Finally, physicians shared insight about what responses they deemed most supportive when disclosing burnout with others. Participants said they felt most supported when others responded first by listening *before* offering advice or solutions. Regardless of the support they preferred (e.g., showing sympathy or compassion, validating the experience), most physicians in my study said timing was important and suggested responses that are most helpful begin with listening and are followed by

problem-solving or validation. It is important for friends and family members of physicians to consider this information when deciding how to respond to someone who may be disclosing their burnout, as the timing may influence how the response is evaluated.

Limitations and Future Research

As with all research, there are limitations to my study. In this section, I acknowledge the limitations of my dissertation and outline opportunities for future research. The first two limitations are related to the sample, while the third and fourth limitations are related to the methodological procedures of my study. Each of these limitations suggest future research opportunities.

First, my sample of 30 participants is small and does not allow me to make broad generalizations regarding my findings. Despite my best efforts to recruit a representative sample, findings in my study are specific to burnout disclosure among attending physicians in the specialties represented in the sample, and because the sample was recruited out of convenience, it may only be representative of this specific population. Despite this limitation, the coding team reached theoretical saturation and was confident there was enough consistency across the data for meaningful themes to emerge.

The second limitation of my study was the unequal representation of specialties, years of experience, and working environment in the sample. The majority of participants worked in emergency medicine at the time of my study, while the remaining participants worked in family medicine, internal medicine, OBGYN, or surgery. Participants also reported a wide range of experience working as an attending physician, with experience ranging from 4 years to more than 26 years. Participants worked in different states (e.g.,

Kentucky, North Carolina, Indiana, Michigan, Virginia, and West Virginia) and in different work environments (e.g., community hospital, teaching hospital, office-based specialty, or another combination of clinical settings). Given these differences, the results may not be representative of all physicians, and I cannot draw conclusions about how the burnout disclosure experience differs among these sub-groups of physicians. Finally, by volunteering to participate in this study, it is likely these individuals were motivated to share their experiences with burnout. This is a limitation, as physicians who highly valued privacy or were nervous about disclosing burnout – even to a researcher – likely did not participate.

In future research, researchers should aim to gather data from a more diverse population. For example, while some of the participants in my study were from different states, most physicians were working in Kentucky at the time of their interview. Although this is not necessarily problematic for an exploratory study, a more geographically diverse and evenly distributed sample would provide valuable insight. In addition, given the potential for differences in work experience and working environments among specialties, there is an opportunity for future research to seek out attending physicians from different specialties. Doing so would complement my study by gathering data by specialty and determine if there are specific differences between physicians working in these areas. Some of the participants in my study alluded to cultural differences between specialties and this would build on those findings.

Building on findings from this current study, there are additional future research opportunities. First, research should include larger scale studies to understand gender trends among physicians who are experiencing burnout to examine potential gender

differences more systematically. Finally, future studies should focus on targets of disclosure, or the individuals physicians choose to share their experiences with. By doing so, researchers could begin to investigate how physicians' disclosure decisions as well as how the target of disclosure may impact outcomes.

Next, regarding methodological limitations, my initial plan was to conduct all face-to-face interviews; however, due to participants' schedules, some interviews took place over the phone. During phone interviews, I was unable to recognize nonverbal cues; however, this mode of interviewing still afforded me the opportunity to gather data from individuals that might not have otherwise been available for a face-to-face interview. The fourth limitation concerns my presence as a researcher during interviews, as it may have created face threats associated with disclosing information about the burnout experience. The nature of interviewing requires participants to recall specific situations and can leave room for potential "false recalls" of events (Bernard et al., 1984), and it also does not always allow participants to have the time to engage in more creative thought processes when reflecting on their experiences (Lindlof & Taylor, 2011). Future research should include a mixed methods approach to capture more nuanced information about the burnout experience.

For instance, one area that is ripe for future research concerns the ways physicians describe burnout. One finding from my study was that the word "burnout" was not always used by physicians to describe their experience. Future research could use textual analysis or a diary study to investigate this further to better understand the reasons physicians choose to avoid this word. These reasons may allow researchers to help determine what type of verbiage about burnout resonate most with physicians to enhance

communication. Another example lies in the potential for further exploration of supportive communication in this context. The findings from my study indicate physicians seek out and find support from different places (and sometimes not at all). It would be valuable to understand how and why physicians choose specific sources of support as well as what they find to be most supportive from these individuals. This may be done by asking physicians only; however, it might also be helpful to conduct dyadic interviews with physicians and their support person. Finally, my study aimed to identify what goals physicians have when disclosing burnout to others. Future research could build on these findings by focusing on goal management to see if there are systematic patterns between what types of goals or goal dilemmas lead to certain management strategies, which would require larger-scale surveys or experimental research. It would also be valuable to examine whether some strategies are consistently more effective than others at achieving these goals by examining the association between enacted goal attention and outcomes of burnout disclosure.

It is important to note that the data collection phase of my study was completed right before the COVID-19 pandemic started in the United States. Given the multiple ways this situation has impacted physicians (e.g., increased work hours, pay cuts, increased exposure to critically ill patients), it is possible that burnout has also increased. Future research should investigate if rates of burnout have changed, how physicians describe their burnout during a pandemic, and whether their desired support is different from what was expressed by participants in my study.

Conclusion

Many physicians are burned out, leaving them feeling emotionally exhausted, disconnected, and unhappy at work. Despite their need for support, they do not always feel comfortable talking about their experiences. Before others can begin providing support, they must first understand how complex burnout can be, as well as how various factors, such as stigma, may influence a physician's willingness to disclose. By identifying what goals physicians have when disclosing, it is possible to reframe these conversations, moving away from the perception that disclosure is a revelation of weaknesses and begin viewing these interactions as opportunities for understanding, connection, and shared knowledge.

The present findings have important implications for physicians experiencing burnout as well as for individuals wanting to provide support. For physicians, disclosing their burnout may not only help them relieve stress and validate their feelings, but doing so may also help normalize the experience and encourage others to talk about their own experiences with burnout. The results from this study can also inform healthcare administrators and friends and family of physicians about the most supportive ways to respond to disclosure. It is important for these individuals to understand that although burnout is a complex experience, providing support does not necessarily have to be, and in fact, the most helpful way to respond to a physician's disclosure may be to simply listen. It is only when physician experiences are heard that it is possible for them to disclose and ultimately feel supported.

APPENDICES

Appendix A: Pilot Study Recruitment Email

Subject Line: Seeking participants for a health communication research study

Alison Buckley, M.A., a doctoral student in communication studies is looking for participants for her research study. You are receiving this email because you are a healthcare provider working in the surgery department at UK hospital.

This study aims to explore the extent to which medical providers feel comfortable sharing information about their mental health with others. Information from this study will help researchers better understand how sharing may have implications for social support, coping, and relational satisfaction. Participants in the study will be asked to take part in a one-hour conversation with the researcher, followed by a brief survey.

All participants will receive a $25 Starbucks gift card.

To sign up for this study, please send an email to alison.buckley@uky.edu.

Thank you for your time,

Alison Buckley, M.A.

Appendix B: Pilot Study Interview Guide

General Medical Culture/Mental Health Disclosure

1. How would you describe the impact your profession has on your mental health?
2. How do you think the culture of medicine influences expectations for physicians when it comes to them sharing a need for mental health support?

Relationships

1. How does the stressful nature of your profession impact your personal and professional relationships?
2. How does your ability to share information about your mental health impact your personal and professional relationships?

Stress/Coping

1. Are there specific things about your job that negatively impact your mental health more than others?
    a. What do you do to cope?
2. Can you think of an example of a time when a relationship with a co-worker has helped you cope?
3. Can you think of an example of a time when a relationship with someone outside of work has helped you cope?
4. Since you've worked in the medical field, are there specific ways you've seen the profession negatively impact others' mental health?
    a. What did they do to cope?
5. Can you think of an example of a time when you helped a co-worker cope with mental health issues?

Social Support

Due to intense work environments, medical professionals often experience different types of stress that negatively impacts their mental health. One of the ways people cope with stress is to talk with other people who have experienced a similar situation. We refer to these individuals as peers. One of the things people experiencing stress might communicate with each other involves support. When we think of support, we mean things like providing information, helping to deal with our emotions, or offering assistance or advice.

1. Have you experienced peer support related to your mental health?
    a. If yes, where did you receive this support?
    b. Have you found this type of support difficult or easy to get?
2. Do you feel there are specific advantages to getting this type of support from peers?
    a. Do you feel there are any specific disadvantages to getting this type of support from peers?
    b. Does it matter if this support is received at work or outside of work? (Probe for examples)

3. Can you think of an example of a time when someone was trying to give you mental health support and you thought it was particularly helpful?
    a. What about a time when this support was unhelpful?
    b. Why was it helpful or unhelpful?
4. Can you think of an example of a time when you were trying to give mental health support to another health professional and it was particularly helpful?
    a. What about a time when this support was unhelpful?
    b. Why was it helpful or unhelpful?

Disclosure

1. Do you feel like you can share your need for mental health support at work?
2. Do you feel like you can share your need for mental health support outside of work?
3. What makes it easier or more difficult to talk about your need for this type of support?
4. Can you think of an example of a time when you planned to share your need for mental health support, but decided not to share as much information or not at all?
    a. What influenced you to change the plan?
5. Can you think of an example of a time you specifically chose not to share your need for mental health support? What influenced your decision not to share?

Closing

1. If you wanted to provide support or help a physician who was needing mental health support, what would you tell them?
2. Is there anything that we didn't cover that you would like to add?

Appendix C: Pilot Study Informed Consent

PROVIDERS IN DISTRESS: HOW DISCLOSURE EFFICACY IMPACTS MENTAL HEALTH AND PERCEIVED SUPPORT

WHY ARE YOU BEING INVITED TO TAKE PART IN THIS RESEARCH?
You are being invited to take part in a research study about provider mental health support. You are being invited to take part in this research study because you are a medical provider. If you volunteer to take part in this study, you will be one of about 80 people to do so at the University of Kentucky.

WHO IS DOING THE STUDY?
The person in charge of this study is Alison Buckley, a doctoral student in the Department of Communication at the University of Kentucky. She is being guided in this research by Dr. Allison Gordon. There may be other people on the research team assisting at different times during the study. While the surgical faculty are facilitating the collection of this data, the study is not being done by the surgical faculty and participation will not have an impact on rotation grades.

WHAT IS THE PURPOSE OF THIS STUDY?
By doing this study, we hope to learn the extent to which medical providers feel comfortable sharing information about their mental health with others. This information will help researchers better understand how sharing may have implications for social support, coping, and relational satisfaction.

ARE THERE REASONS WHY YOU SHOULD NOT TAKE PART IN THIS STUDY? Individuals uncomfortable with sharing emotional and sensitive information relating to mental health experiences may decide not to take part in this study. Participants will not be forced to disclose any information they do not want to and may withdraw from the study at any time.

WHERE IS THE STUDY GOING TO TAKE PLACE AND HOW LONG WILL IT LAST? The research procedures will be conducted at UK hospital. You will visit one time, lasting about one and a half hours. The total amount of time you will be asked to volunteer for this study is one and a half hours over the next six months.

WHAT WILL YOU BE ASKED TO DO?
As a participant in the study, you will be asked to participate in a one-hour conversation with the researcher about the following topics: comfort sharing mental health information with others, access to support, coping techniques. Following the interview, you will be asked to complete a survey to complete the visit.

WHAT ARE THE POSSIBLE RISKS AND DISCOMFORTS?
To the best of our knowledge, the things you will be doing have no more risk of harm than you would experience in everyday life. You may find some questions we ask you to be upsetting or stressful. We will give you information for people who may be able to

help you with these feelings.

WILL YOU BENEFIT FROM TAKING PART IN THIS STUDY?
There is no guarantee that you will get any benefit from taking part in this study; however, some people have found sharing their experiences and feelings about stigmatized topics to be therapeutic. Your willingness to take part, may, in the future, help society as a whole better understand this research topic.

DO YOU HAVE TO TAKE PART IN THE STUDY?
If you decide to take part in the study, it should be because you really want to volunteer. You will not lose any benefits or rights you would normally have if you choose not to volunteer. If you decide not to take part in this study, your decision will have no effect on the evaluation of your work.

IF YOU DON'T WANT TO TAKE PART IN THE STUDY, ARE THERE OTHER CHOICES? If you do not want to be in the study, there are no other choices except not to take part in the study.

WHAT WILL IT COST YOU TO PARTICIPATE?
There are no costs associated with taking part in the study.

WILL YOU RECEIVE ANY REWARDS FOR TAKING PART IN THIS STUDY?
You will receive a $25 Starbucks gift card for taking part in this study. The gift card amount will be prorated should you choose to withdraw early.

WHO WILL SEE THE INFORMATION THAT YOU GIVE?

We will make every effort to keep confidential all research records that identify you to the extent allowed by law. Your information will be combined with information from other people taking part in the study. When we write about the study to share it with other researchers, we will write about the combined information we have gathered. You will not be personally identified in these written materials. We may publish the results of this study; however, we will keep your name and other identifying information private. Any electronic data, including audio recordings, will be secured on a password protected computer only accessible to the research team. Upon completion of the study, all information that matches up individual respondents with their answers will be destroyed.

We will make every effort to prevent anyone who is not on the research team from knowing that you gave us information, or what that information is.

We will keep private all research records that identify you to the extent allowed by law. However, there are some circumstances in which we may have to show your information to other people. For example, the law may require us to show your information to a court if you pose a danger to yourself or someone else. Also, we may be required to show information which identifies you to people who need to be sure we have done the research correctly; these would be people from such organizations as the University of Kentucky. Please be aware, while we make every effort to safeguard your data once received from the online survey/data gathering company, given the nature of online surveys, as with anything involving the Internet, we can never guarantee the confidentiality of the data while still on

the survey/data gathering company's servers, or while en route to either them or us. It is also possible the raw data collected for research purposes may be used for marketing or reporting purposes by the survey/data gathering company after the research is concluded, depending on the company's Terms of Service and Privacy policies.

CAN YOUR TAKING PART IN THE STUDY END EARLY?
If you decide to take part in the study you still have the right to decide at any time that you no longer want to continue. You will not be treated differently if you decide to stop taking part in the study. Additionally, you may skip questions at any time during the study. The individuals conducting the study may need to withdraw you from the study. This may occur if you are not able to follow the directions they give you, if they find that your being in the study is more risk than benefit to you, or if the agency funding the study decides to stop the study early for a variety of scientific reasons.

WHAT ELSE DO YOU NEED TO KNOW?
There is a possibility that the data collected from you may be shared with other investigators in the future. If that is the case the data will not contain information that can identify you unless you give your consent or the UK Institutional Review Board (IRB) approves the research. The IRB is a committee that reviews ethical issues, according to federal, state and local regulations on research with human subjects, to make sure the study complies with these before approval of a research study is issued.

Contacting Research Subjects for Future Studies
Do you give your permission to be contacted in the future by Alison Buckley regarding your willingness to participate in future research studies about how to prevent, detect, or treat mental illness? Yes No _____Initials
UK general surgery research group is providing financial support for this study.

WHAT IF YOU HAVE QUESTIONS, SUGGESTIONS, CONCERNS, OR COMPLAINTS?
Before you decide whether to accept this invitation to take part in the study, please ask any questions that might come to mind now. Later, if you have questions, suggestions, concerns, or complaints about the study, you can contact the investigator, Alison Buckley at Alison.buckley@uky.edu. If you have any questions about your rights as a volunteer in this research, contact the staff in the Office of Research Integrity at the University of Kentucky between the business hours of 8am and 5pm EST, Mon-Fri. at 859-257-9428 or toll free at 1-866-400-9428. We will give you a signed copy of this consent form to take with you.

_____ _____
Signature of person agreeing to take part in the study Date

_____
Printed name of person agreeing to take part in the study

_____ _____
Name of (authorized) person obtaining informed consent Date

Appendix D: Pilot Study Demographic Questionnaire

Please provide the following information:

1. Age: ____ years old
2. Sex: _____ M/F
3. Marital status:
    - Married
    - Divorced
    - Separated
    - Widowed
    - Single
4. Years of medical experience _____
5. Professional title:
    - physician
    - physician assistant/nurse practitioner
    - resident
    - medical student

Appendix E: Current Study Recruitment Email

Good morning:
My name is Alison Buckley and I am a doctoral student at the University of Kentucky in the Department of Communication. I am looking for physician participants for my research study about physician burnout and social support. You are receiving this email because you are a physician who may be eligible to participate.

This study aims to explore how attending physicians talk about burnout. This information will help researchers better understand how communication about burnout experiences may impact social support and overall well-being. Participants will be asked to take part in a one-hour conversation with the researcher and complete a brief survey.

All participants will receive a $25 Starbucks gift card.

To sign up for this study, please send an email to alison.buckley@uky.edu.

Thank you for your time,
Alison Buckley, M.A.

Appendix F: Current Study Informed Consent

KEY INFORMATION FOR TALKING ABOUT BURNOUT:
HOW PHYSICIANS USE COMMUNICATION FOR SUPPORT

We are asking you to choose whether or not to volunteer for a research study about communication related to physician burnout experiences. We are asking you because you are an attending physician working in one of the following areas: emergency medicine, family medicine, obstetrics and gynecology, internal medicine, or surgery. This page is to give you key information to help you decide whether to participate. We have included detailed information after this page. Ask the research team questions. If you have questions later, the contact information for the research investigator in charge of the study is below.

WHAT IS THE STUDY ABOUT AND HOW LONG WILL IT LAST?
By doing this study, we hope to learn more about how attending physicians experience and talk about burnout. This information will help researchers better understand how communication about burnout experiences may impact social support and overall well-being. Participation involves having a face-to-face conversation with the researcher and completing a questionnaire.

Your participation in this research will last up to 1 hour and 20 minutes.

WHAT ARE KEY REASONS YOU MIGHT CHOOSE TO VOLUNTEER FOR THIS STUDY?
Individuals may choose to participate in this study to inform others about their experience with burnout and/or to support research that is focused on the topic of burnout among medical personnel.

WHAT ARE KEY REASONS YOU MIGHT CHOOSE NOT TO VOLUNTEER FOR THIS STUDY?
Individuals uncomfortable with sharing emotional and sensitive information relating to burnout experiences may decide not to take part in this study. Participants will not be forced to disclose any information they do not want to and may withdraw from the study at any time.

DO YOU HAVE TO TAKE PART IN THE STUDY?
If you decide to take part in the study, it should be because you really want to volunteer. You will not lose any services, benefits, or rights you would normally have if you choose not to volunteer.

WHAT IF YOU HAVE QUESTIONS, SUGGESTIONS OR CONCERNS?
If you have questions, suggestions, or concerns regarding this study or you want to withdraw from the study contact Alison Buckley, Principal Investigator of the University of Kentucky, Department of Communication at alison.buckley@uky.edu.

If you have any concerns or questions about your rights as a volunteer in this research,

contact staff in the University of Kentucky (UK) Office of Research Integrity (ORI) between the business hours of 8am and 5pm EST, Monday-Friday at 859-257-9428 or toll free at 1-866-400-9428.

ARE THERE REASONS WHY YOU WOULD NOT QUALIFY FOR THIS STUDY?

You would not qualify for this study and could be excluded from participation if you:

- are currently a medical student or resident physician
- are not currently practicing medicine
- have never experienced burnout

WHERE WILL THE STUDY TAKE PLACE AND WHAT IS THE TOTAL AMOUNT OF TIME INVOLVED?

The research procedures will be conducted at a place convenient for you. You will need to come one time during the study. The total time you will be asked to volunteer for this study is up to one hour and 20 minutes.

WHAT WILL YOU BE ASKED TO DO?

If you agree to participate, you will be asked to meet with the researcher at a location convenient for you. You will be asked to complete a brief questionnaire and then participate in an interview with the researcher to talk about your experience with burnout. The conversation will be audio recorded and transcribed. Participating in this study will take approximately one hour and 20 minutes. I may call you to follow up with any questions or recommendations you might have for me.

WHAT ARE THE POSSIBLE RISKS AND DISCOMFORTS?

To the best of our knowledge, the things you will be doing have no more risk of harm than you would experience in everyday life; however, you may find some questions we ask you to be upsetting or stressful.

WILL YOU BENEFIT FROM TAKING PART IN THIS STUDY?

We do not know if you will get any benefit from taking part in this study. However, some people have found sharing their personal experiences to be therapeutic. If you take part in this study, information learned may help others understand the topic of burnout.

IF YOU DON'T WANT TO TAKE PART IN THE STUDY, ARE THERE OTHER CHOICES?

If you do not want to be in the study, there are no other choices except not to take part in the study.

WHAT WILL IT COST YOU TO PARTICIPATE?

You may have to pay for the cost of getting to the study site and a parking fee, if applicable.

WHO WILL SEE THE INFORMATION THAT YOU GIVE?

When we write about or share the results from the study, we will write about the

combined information. We will keep your name and other identifying information private. We will make every effort to prevent anyone who is not on the research team from knowing that you gave us information, or what that information is.

Your information will be combined with information from other people taking part in the study. An outside service will transcribe interviews and identifiable information will not be removed. When we write about the study to share it with other researchers, we will write about the combined information we have gathered. You will not be personally identified in these written materials. We may publish the results of this study; however, we will keep your name and other identifying information private.

We will make every effort to prevent anyone who is not on the research team from knowing that you gave us information, or what that information is.

You should know that there are some circumstances in which we may have to show your information to other people. For example, the law may require us to show your information to a court if you pose a danger to yourself or someone else. Also, we may be required to show information which identifies you to people who need to be sure we have done the research correctly; these would be people from such organizations as the University of Kentucky.

We will make every effort to safeguard your data, but as with anything online, we cannot guarantee the security of data obtained via the Internet. Third-party applications used in this study may have Terms of Service and Privacy policies outside of the control of the University of Kentucky.

CAN YOU CHOOSE TO WITHDRAW FROM THE STUDY EARLY?
You can choose to leave the study at any time. You will not be treated differently if you decide to stop taking part in the study.

If you choose to leave the study early, data collected until that point will remain in the study database and may not be removed.

The investigators conducting the study may need to remove you from the study. This may occur for a number of reasons. You may be removed from the study if:

- you are not able to follow the directions,
- they find that your participation in the study is more risk than benefit to you

WILL YOU RECEIVE ANY REWARDS FOR TAKING PART IN THIS STUDY?
You will receive either a $25 Starbucks gift card OR a dozen donuts delivered to your place of employment for taking part in this study. You will inform the researcher of your choice when agreeing to participate.

WILL WE CONTACT YOU WITH INFORMATION ABOUT PARTICIPATING IN FUTURE STUDIES?
The research staff would like to contact you with information about participating in future studies. If so, it will be limited to 1-2 times per year.

Do you give your permission for the investigator or staff to contact you regarding your willingness to participate in future research studies? □ **Yes** □ **No Initials**_____

WHAT ELSE DO YOU NEED TO KNOW?
The researcher, Alison Buckley, is a doctoral student at The University of Kentucky and she is being guided in this research by Dr. Allison Gordon. There may be other people on the research team assisting at different times during the study. Approximately 25-35 individuals are expected to participate.

WILL YOUR INFORMATION BE USED FOR FUTURE RESEARCH?
All identifiable information (e.g., your name) will be removed from the information collected in this study. After we remove all identifiers, the information may be used for future research or shared with other researchers without your additional informed consent.

INFORMED CONSENT SIGNATURES
This consent includes the following:

- **Key Information Page**
- **Detailed Consent**

You are the subject or are authorized to act on behalf of the subject. You will receive a copy of this consent form after it has been signed.

_____ _____ _
Signature of research subject **Date**

_____
Printed name of research subject

_____ _____
Printed name of [authorized] person obtaining informed consent Date

Appendix G: Current Study Interview Guide

Burnout

1. Can you please share with me your personal experience with burnout?
2. Have you ever felt like you've become disconnected from others (e.g., patients, coworkers)?
    a. Why or why not?
3. What is your personal experience with feeling emotionally exhausted?
    a. Can you share with me an example of a time this happened?
4. What is your experience with feeling personal achievement or fulfillment at work?

The academic definition of burnout often includes features such as depersonalization, emotional exhaustion, and personal achievement. In other words, individuals who experience burnout may feel disconnected from others, unable to emotionally care for others, or unfulfilled at work.

1. To what extent does your personal experience match that definition of burnout?
2. To what extent do you think burnout impacts physicians in general?

Disclosure

1. What makes it easier or more difficult to talk about burnout?
2. Can you think of an example of a time you specifically chose not to share your need for support?
3. Can you think of a time when you shared your need for help with burnout?
    a. How did others respond?
4. What makes it easier or more difficult to talk about your experience with burnout?
5. Do you think you are more or less likely to talk about burnout now that you are an attending physician (as compared to sharing while in training)?
    a. Why?
6. Do you think you would share your experience with burnout with medical students or residents?
    a. Why or why not?

Goals

Although we may not always be aware of it, we all have goals when we are talking to other people. For example, we may want to share information, show support, maintain a relationship, or persuade another person. We may even try to accomplish multiple goals at the same time. The goals we have can be related to what we hope to achieve in the conversation, how we want to present ourselves, or how we want to influence our relationship with another person.

1. What goals do you have when talking about burnout related to:
    a. What you hope to achieve in the conversation?
    b. How you want to present yourself?
    c. How the conversation may impact your relationship with another person?

2. What goals do you think others have when talking about burnout with you that is related to:
    a. What they hope to achieve in the conversation?
    b. How they want to present themselves?
    c. How the conversation may impact your relationship with them?
3. Can you think of an instance when one goal might be in conflict with another goal while sharing burnout? *(If needed: For example, you may want to talk to another physician in the hallway about personal matters, while also wanting to show that you are dedicated and focused on your work.)*
    a. What are ways you might handle this situation?
4. If you have more than one goal in a conversation, they aren't always in conflict. If you are sharing information about burnout, how would you decide which goal is more important?
    a. What would influence what you say or do?
5. Thinking about these ways of handling your goals that you just talked about, which ones are most effective?
    a. Which ones are less effective?
    b. Why?

<u>Social Support</u>

Due to the intensity that can sometimes come with working in the medical field, physicians can experience different types of stress with negative consequences. One of the ways people cope with stress is to talk with other people. One of the things people experiencing stress might communicate with each other involves support. When we think of support, we mean things like providing information, helping to deal with our emotions, offering assistance or advice, or just being there.

1. Have you experienced support related to burnout?
    a. If yes, where did you receive this support?
    b. Have you found this type of support difficult or easy to get?
2. Do you feel there are specific:
    a. advantages to getting this type of support from others?
    b. disadvantages to getting this type of support?
3. Does it matter if this support is received at work or outside of work? (Probe for examples)
4. Can you think of an example of a time when someone was trying to give you support related to burnout and you thought it was
    a. particularly helpful?
    b. unhelpful?

<u>Closing</u>

1. We have a few questions left. If you wanted to provide support or help another attending physician who was experiencing burnout, what would you tell them?
2. What advice would you have for any physicians going through burnout?
3. What advice would you have for any colleagues of physicians who might be going through burnout?
4. Is there anything that we didn't cover that you would like to add?

Appendix H: Current Study Demographic Questionnaire

To help us get to know more about you, please answer the following questions. Individual answers are kept confidential.

1. What is your sex?
_____ Male
_____ Female
_____ Other (please specify:_____)

2. How old are you? _____ years old

3. How would you describe your ethnicity or race?
_____ Black or African American
_____ Asian or Asian American
_____ Latino/a or Hispanic
_____ White or Caucasian
_____ Other (please specify: _____)

4. What is your marital status?
_____ Married
_____ Divorced
_____ Separated
_____ Widowed
_____ Single

5. What state do you currently work in?_____

6. How many years were you in medical training (**includes medical school and residency)**? _____ years

7. How many years have you worked as an attending physician? _____ years

8. What residency program did you complete?
_____ emergency medicine
_____ family medicine
_____ internal medicine
_____ obstetrics and gynecology
_____ Other (please specify:_____)

9. What specialty are you currently working in?
_____ emergency medicine
_____ family medicine
_____ internal medicine
_____ obstetrics and gynecology
_____ Other (please specify: _____)

10. What work setting have you worked in *as an attending?* (check all that apply) _____ teaching hospital
_____ community hospital
_____ urgent care
_____ office-based solo practice
_____ office-based single-specialty group practice
_____ office-based multispecialty group practice
_____ Other (please specify: _____)

Appendix I: Current Study Codebook

RQ1: The Burnout Experience

Code	Description	Examples
Emotional Exhaustion	Physicians feeling depleted of energy, unable to emotionally care for themselves or others (e.g., empty, numb, emotionally busted, nothing left, emotional toll)	"You feel like you've given all that you can, and people still want more, and you just don't have any left to give." "I just remember thinking, 'I have nothing left. There's nothing left in me'." "...it just gets where I don't even like to be around myself let alone anybody else...I get so irritable that people can't stand to be around me. I find myself snapping, and I know it's me, not them. Just because I'm so tired. Emotionally busted."
Depersonalization	Instances of detachment from others, including co-workers, patients, friends, and family (e.g., disconnection, diagnosis instead of patient, reduced empathy and emotion)	"When I walk in a room, and it's a diagnosis, it's not a patient, that's the worst. That's as far as it gets for me. That's real bad." "When I was obtaining a history, I'm just less patient with waiting for them to give me the right answer that I'm waiting for essentially." "I felt disconnected from everything. Everyone. Even myself. I didn't even know myself when I started looking."
Loss of Work Fulfillment	Participants express inability to enjoy their work and are unsatisfied (e.g., unsatisfied, unable to enjoy work, unfulfilled)	"I just looked in the mirror and it just hit me, I don't want to do this anymore. It hit that fast. So, [burnout] started that way. I tried to work my way through it, because I couldn't believe that it

		actually happened to me. I used to really love what I did, and I never saw it coming." "I was losing my mind. I wasn't sleeping well. I would love medicine. I always have. And I was hating going to work." "Imagine spending the next 30 years going to work and hating what you do. You hate it every day that you get up to go do it. It's just like essentially waking up every morning and there's somebody there to punch you in the face. Eventually get tired of waking up. That's exactly what it's like."
Wanting to Leave Medicine	Participant describe burnout experience by wanting to leave medicine, but felt they were "stuck" working as a physician (e.g., making plans to leave, reasons why they are stuck or do not see leaving as an option)	"You get to the point where you start thinking about, 'Why did I do medicine, what can I do?' I told my [spouse] recently, it's been crazy, so you get these feelings like maybe I'm going to quit medicine, we can sell our house and let's just do something drastic and go do anything else." "I have a dream. Leave medicine and open a thrift shop. I don't thrift. I don't want to be in the sun with skin cancer. I'm going to sit inside and sell lip balm and sunscreen and see the ocean." "I was thinking about leaving medicine. I bet that's not the first time you've heard that because it's just like, 'What am I doing? I can't do this anymore.'"

Changes to Self	Participants identify burnout by recognizing changes to their normal behavior (e.g., did not act like themselves, actions impacting interactions and relationships with others)	"It was like, 'Oh my. What is wrong with me? This is not me. This is not who I am. I don't talk to people that way.' And that was really profound for me." "I just wasn't myself. Like, my [spouse] and I weren't getting along, and that's just really not like us…It was like my threshold, like, my patience, was gone." "I wasn't the happy-go-lucky guy I used to be. My [spouse] noticed that I didn't seem to be happy. I wasn't performing what I thought to my level on everything I was doing. It sort of touched everything in my life, actually."

RQ2: Conversational Goals

Code	Description	Examples
Task Goals	Goals to accomplish specific tasks while talking about burnout with others (e.g., sharing knowledge, venting, relieving stress seeking advice or solutions).	"Sharing knowledge. That's always the point. The more we share knowledge, the more we talk about it, the more people understand what it is, and why it happens, and how to make it better, and how to not let it get you into the black hole that you can't crawl out of. So, that's always the goal." "Sometimes it's just about venting, like, 'Can you believe this is happening to me?'" "If I'm talking to one of the physicians that has been around for a while, I expect that they probably have had some burnout and maybe advice on how they've gotten through it."
Identity Goals	Goals that address how participants wanted to present themselves to others or hoped others would perceive them (e.g., normalizing the experience, seeking validation, avoid being seen as weak or incompetent, viewed as a friend).	"To let people know that even somebody like me has and experiences [burnout] and it's okay." "I will talk to her about [burnout]. And it's kind of more along the lines of just seeking validation, maybe, like, 'Yeah girl, that sucks.'" "I try and present myself as a friend and colleague. You know? Even though I'm an attending, they're in medicine; you're still a colleague."
Relational Goals	Goals pursued by participants to affirm or undermine the relationship	N/A

	(e.g., relational harmony/growth)	

RQ3: Multiple Goal Dilemmas

Category	Description	Examples
Wanting to Disclose Without Being Labeled	Participants identify conflicting goals of wanting to disclose their burnout to others while also being concerned they could be labeled negatively (e.g., weak, unhappy, crazy, incompetent).	"I definitely try to talk about it, or maybe I have to talk about it because I'm such a vocal person. But I don't want to seem weak." "What is the goal you're trying to do? One is you want to get something off your chest, right? So that's super important, and helps release kind of the tension that you're carrying inside of you. But then too, what impact would that have on the person you're talking to." I think it's good to have support to go talk to somebody or some guidance or some reassurance. Just somebody near to listen to…The problem with that though, as a medical professional, in the back of your mind, when you start going down that road, you probably wonder, "Well, if someone found out that I'm having to talk to somebody, then you're going to have the stigma. Well he's crazy."
Wanting to Disclose Without Burdening Others	Participants identify conflicting goals of wanting to disclose their burnout to others while also being aware that doing so could burden others (e.g., emotionally, adding more work)	"Burnout would be associated with working too much. so if you are working too much, you complained about it and then you would work less. So if you work less, somebody else is going to work more. Then you're kind of punishing someone else." "I have a supportive spouse but I know she's busy too, and she works in healthcare, so I try not to burden her."

		“Even when I talk to my [spouse], like, I can tell she's being supportive, but I mean, I'm talking about something that she doesn't really, it's not enjoyable to hear about. It's just adding...it's just making someone else sad.”

RQ4: Disclosure Strategies

Category	Description	Examples
Not Calling it Burnout	Avoiding use of the word "burnout" to describe experience and using other words or phrases instead (e.g., crispy, tired, fatigued)	"I think not calling it by that term, it's a roundabout way." "I was getting what I used to call 'crispy.'" "With a coworker, when I get snappy or irritable, I'll step back and say, 'This isn't me. This is just fatigue.'"
Share Knowledge with Other Physicians	Participants find opportunities to disclose burnout as a way to share with or teach other physicians (e.g., mentoring, presentations)	"I've got a lot of experience under my belt, so sometimes I can give examples of what I did that other younger folks may not have really thought about." "We have residents and fellows in our program, and so I think I try to talk about burnout with them as with my partners just to try to help." "I gave a round to my fellowship on learning to fail. Failure medicine. I started by saying, 'You probably never heard anyone that did that and certainly never heard anyone talk about their burnout in an open book'…I put myself out there. "
Choose Appropriate Confidants	Intentionally selecting and avoiding specific recipients when disclosing burnout experience (e.g., co-workers, spouse, friends)	"You take it to the right person. You're selective with who you talk to those things about." "I would definitely not want to share it with a junior provider. I would want to go to somebody who was in a healthy situation."

		I still don't talk a whole lot about [burnout] out of work…It's a downer to people who don't do this. And away from work, those people are my safe place. Those people are my "You're the most awesome person in the entire world" people, and I don't know. Sometimes you don't want to admit to them that you're not the most fabulous person in the whole world."
Share Selective Information	Intentionally selecting and avoiding specific information to reveal and conceal when disclosing burnout experience (e.g., limiting details of experience, omitting unhealthy coping strategies)	"I mentioned to my closest friends in my group that I was struggling with burnout, and that's all I told them." "If part of how you're dealing with your burnout is drinking a little more or doing something else, then you might be reluctant to talk about the burnout, because it might lead to revealing other things that you're doing that are maybe troubling." "I don't want to look bad when I'm having this conversation, so I try to justify why I did what I did."
Do Not Disclose	Concealing burnout experience and deciding not to disclose to others for various reasons (e.g., fear of others finding out, personal or professional concerns, cultural expectations).	"I never shared it at all. Even towards the end, when people knew that I was planning to leave…It's not something people talk about, because I think it's something like PTSD for veterans that you just don't talk about." "I would also say that my age group and probably a little bit older, we don't talk about this stuff at all. We just don't. I mean, you just suck it up and do it."

		“I choose just to push my feelings aside. And just when my family's needs come first, I push mine aside.”

RQ5: Disclosure Catalysts and Barriers

Category	Description	Examples
Easier to Disclose	Participant identifies something that makes it easier for them to disclose burnout to others (e.g., mutual disclosure, professional role, perceived confidentiality).	"What would make it easier [to talk about burnout] is if we actually admitted that this is a very real problem or not necessarily a problem even. That this is a really common experience." "It was difficult for me to even bring it up and then talk about it. In fact, I think I only did when he told me about one of his situations first." "I think it's easier [to talk about burnout as an attending]. I'm not worried as much. I don't need a letter of recommendation."
Difficult to Disclose	Participant identifies something that makes it difficult for them to disclose burnout to others (e.g., stigma, fear of judgment, support unavailable).	"I think what makes it more difficult [to talk about burnout] is the fear of judgment." "It would definitely have been hard to talk to my administrators about it, just because I think it shows the sign of weakness." "The extreme difficulty is I had no one to really turn to."

RQ6: Supportive and Unsupportive Responses to Burnout Disclosure

Category	Description	Examples
Supportive Responses	Participant describes response to burnout disclosure they evaluate as helpful or supportive (e.g., listening, supporting professional changes, sympathy).	"Whether it's burnout or anything else, the most important thing to do first is to listen, and try to understand where they are." "It's okay to find a compassionate way to say, 'Gosh, I feel like you're going through a lot. I'm here for you'." "I don't offer them a solution. I try to talk about or validate why they felt that way."
Unsupportive Responses	Participant describes response to burnout disclosure they evaluate as unhelpful or unsupportive (e.g., dismissing feelings, cliches, inadequate professional support).	"If you ask the old guard, they may just say, 'Well, yeah, life's hard. Get a helmet.'" "I think that a lot of people just say, like, especially in residency, it's like, "Just keep your head down and keep on moving." It's like, that's just not helpful." "Occasionally there's workshops, and sometimes it's like, I don't have the time for that. It's great that you're trying, that there's something out there that's offered, but sometimes it doesn't help me if it takes up more of my day or makes me get home later.'

REFERENCES

Aiken, L. H., Clarke, S. P., Sloane, D. M., Sochalski, J., & Silber, J. H. (2002). Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction. *Journal of the American Medical Association*, *288*(16), 1987-1993.

Altman, I., & Taylor, D. A. (1973). *Social penetration: The development of interpersonal relationships*. New York, NY: Holt, Rinehart and Winston.

Andrew, L. B., & Brenner, B. E. (2018, August 1). *Physician suicide*. Medscape. https://emedicine.medscape.com/article/806779-overview

Anonymous (2018, September 17). A resident physician's story of depression. *KevinMD.* https://www.kevinmd.com/blog/2018/09/a-resident-physicians-story-of-depression.html

Ariely, D., & Lanier, W. L. (2015). Disturbing trends in physician burnout and satisfaction with work-life balance. [Editorial]. *Mayo Clinic Proceedings, 90*(12), 1593-1596. doi:10.1016/j.mayocp.2015.10.004

Baldisseri, M. R. (2007). Impaired healthcare professional. *Critical Care Medicine*, *35*(2), S106-S116.

Barbee, A. P., Derlega, V. J., Sherburne, S. P., & Grimshaw, A. (1998). Helpful and unhelpful forms of social support for HIV-positive individuals. In V. J. Derlega & A. P. Barbee (Eds.), *HIV and social interaction* (pp. 83-105). Sage Publications.

Barney, L. J., Griffiths, K. M., Jorm, A. F., & Christensen, H. (2006). Stigma about depression and its impact on help-seeking intentions. *Australian and New Zealand Journal of Psychiatry*, *40*(1), 51-54. doi:10.1080/j.1440-1614.2006.01741.x

Beach, M. C., Roter, D., Larson, S., Levinson, W., Ford, D. E., & Frankel, R. (2004). What do physicians tell patients about themselves? A qualitative analysis of physician self- disclosure. *Journal of General Internal Medicine*, *19*(9), 911-916.

Bender, C. E., Parikh, J. R., Arleo, E. K., & Bluth, E. (2016). The radiologist and depression. *Journal of the American College of Radiology*, *13*(7), 863-867. doi:10.1016/j.jacr.2016.03.014

Benson, J., & Magraith, K. (2005). Compassion fatigue and burnout: The role of Balint groups. *Australian Family Physician*, *34*(6), 497-498.

Berger, C. R. (2002). Goals and knowledge structures in social interaction. In M.L. Knapp & J.A. Daly (Eds.), *Handbook of interpersonal communication*, (3rd ed. pp. 181-212). Sage.

Bernard, H. R., Killworth, P., Kronenfeld, D., & Sailer, L. (1984). The problem of informant accuracy: The validity of retrospective data. *Annual Review of Anthropology, 13*, 495-517.

Bianchi, R., Schonfeld, I. S., & Laurent, E. (2015). Burnout–depression overlap: A review. *Clinical Psychology Review*, *36*, 28-41. doi:10.1016/j.cpr.2015.01.004

Blackstone, A. (2012). *Principals of sociological inquiry: Qualitative and quantitative methods.* Saylor Foundation.

Bodenheimer, T., & Sinsky, C. (2014). From triple to quadruple aim: Care of the patient requires care of the provider. *The Annals of Family Medicine, 12*(6), 573-576. doi:10.1370/afm.1713

Boyd, J.W. (2017). Substance and addictive behaviors among physicians. In K. J. Brower & M. B. Riba (Eds.), *Physician mental health and well-being: Research and practice* (pp. 177-193). Springer.

Brashers, D. E., Goldsmith, D. J., & Hsieh, E. (2002). Information seeking and avoiding in health contexts. *Human Communication Research*, *28*(2), 258-271. doi:10.1111/j.1468-2958.2002.tb00807.x

Braithwaite, D. O. (1991). "Just how much did that wheelchair cost?": Management of privacy boundaries by persons with disabilities. *Western Journal of Speech Communication*, *55*(3), 254-274. doi: 10.1080/10570319109374384

Brigham, T., Barden, C., Dopp, A. L., Hengerer, A., Kaplan, J., Malone, B., Martin, C., McHugh, M., Nora, L. M. (2018). *A journey to construct an all-encompassing conceptual model of factors affecting clinician well-being and resilience* (Discussion Paper). National Academy of Medicine. https://www.nam.edu/journey-construct-encompassing-conceptual-model-factors-affecting-clinician-well-resilience. doi:10.31478/201801b

Brown, P., & Levinson, S. C. (1987). *Politeness: Some universals in language usage* (4th ed.). Cambridge University Press.

Brown, T. N., Ueno, K., Smith, C. L., Austin, N. S., & Bickman, L. (2007). Communication patterns in medical encounters for the treatment of child psychosocial problems: Does pediatrician–parent concordance matter?. *Health Communication*, *21*(3), 247-256.

Burleson, B. R. (1984). Age, social- cognitive development, and the use of comforting strategies. *Communications Monographs*, *51*(2), 140-153. doi:10.1080/03637758409390190

Burleson, B. R. (2009). Understanding the outcomes of supportive communication: A dual-process approach. *Journal of Social and Personal Relationships*, *26*(1), 21-38. doi:10.1177/0265407509105519

Burleson, B. R., Liu, M., Liu, Y., & Mortenson, S. T. (2006). Chinese evaluations of emotional support skills, goals, and behaviors: An assessment of gender-related similarities and differences. *Communication Research*, *33*(1), 38-63. doi:10.1177/0093650205283101

Bute, J.J., & Brann, M. (2015). Co-ownership of private information in the miscarriage context. *Journal of Applied Communication Research*, *43*(1), 23-43. doi:10.1080/00909882.2014.982686

Canary, D. J., & Dainton, M. (Eds.) (2003). *Maintaining relationships through communication: Relational, contextual, and cultural variations.* Routledge.

Carr, G. D. (2008). Physician Suicide –A problem for our time. *Journal Mississippi State Medical Association, 49*(10), 299-303.

Caughlin, J. P. (2010). Invited review article: A multiple goals theory of personal relationships: Conceptual integration and program overview. *Journal of Social and Personal Relationships*, *27*(6), 824-848. doi:10.1177/0265407510373262

Caughlin, J. P., Brashers, D. E., Ramey, M. E., Kosenko, K. A., Donovan-Kicken, E., & Bute, J. J. (2008). The message design logics of responses to HIV disclosures.

Human Communication Research, *34*(4), 655-684. doi:10.1111/j.1468-2958.2008.00336.x

Caughlin, J. P., Mikucki-Enyart, S. L., Middleton, A. V., Stone, A. M., & Brown, L. E. (2011). Being open without talking about it: A rhetorical/normative approach to understanding topic avoidance in families after a lung cancer diagnosis. *Communication Monographs*, *78*(4), 409-436. doi:10.1080/03637751.2011.618141

Caughlin, J. P., & Vangelisti, A. L. (2009). Why people conceal or reveal secrets: A multiple goals perspective. In T. Afifi & W. Afifi (Eds.), *Uncertainty, information management, and disclosure decisions: Theories and applications* (pp. 279-299). Routledge.

Chang, P. F., & Bazarova, N. N. (2016). Managing stigma: Disclosure-response communication patterns in pro-anorexic websites. *Health Communication*, *31*(2), 217-229. doi:10.1080/10410236.2014.946218

Charmaz, K. (1991). *Good days, bad days: The self in chronic illness and time*. Rutgers University Press.

Charmaz, K. (1999). Stories of suffering: Subjective tales and research narratives. *Qualitative Health Research*, *9*(3), 362-382. doi:10.1177/104973239900900306

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis.* Sage Publications.

Chaudoir, S. R., & Fisher, J. D. (2010). The disclosure processes model: Understanding disclosure decision making and postdisclosure outcomes among people living

with a concealable stigmatized identity. *Psychological Bulletin*, *136*(2), 236-256. doi:10.1037/a0018193

Checton, M. G., & Greene, K. (2012). Beyond initial disclosure: The role of prognosis and symptom uncertainty in patterns of disclosure in relationships. *Health Communication*, *27*(2), 145-157. doi:10.1080/10410236.2011.571755

Clark, R. A., & Delia, J. G. (1979). TOPOI and rhetorical competence. *Quarterly Journal of Speech*, *65*(2), 187-206. doi:10.1080/00335637909383470

Cohen, D., & Crabtree, B. (2006, July). *Qualitative research guidelines project.* Robert Wood Johnson Foundation. http://www.qualres.org/

Cohen, S., & Hoberman, H. M. (1983). Positive events and social supports as buffers of life change stress. *Journal of Applied Social Psychology*, *13*(2), 99-125. doi:j.1559-1816.1983.tb02325.x

Cole, S. W., Kemeny, M. E., & Taylor, S. E. (1997). Social identity and physical health: Accelerated HIV progression in rejection-sensitive gay men. *Journal of Personality and Social Psychology*, *72*(2), 320-335. doi:10.1037/0022-3514.72.2.320

Collins, N. L., & Miller, L. C. (1994). Self-disclosure and liking: A meta-analytic review. *Psychological Bulletin*, *116*(3), 457-475. doi:10.1037/0033-2909.116.3.457

Cook, A. F., Arora, V. M., Rasinski, K. A., Curlin, F. A., & Yoon, J. D. (2014). The prevalence of medical student mistreatment and its association with burnout. *Academic Medicine*, *89*(5), 749-754. doi:10.1097/ACM.0000000000000204.

Corbin, J. M., & Strauss, A. (1990). Grounded theory research: Procedures, canons, and evaluative criteria. *Qualitative Sociology*, *13*(1), 3-21.

Coupland, N., Coupland, J., & Giles, H. (1991). *Language, society and the elderly: Discourse, identity and ageing.* Basil Blackwell.

Cozby, P. C. (1973). Self-disclosure: A literature review. *Psychological Bulletin*, *79*(2), 73-91. doi:10.1037/h0033950

Creswell, J. W., & Clark, V. L. P. (2017). *Designing and conducting mixed methods research.* Sage Publications.

Delia, J., & O'Keefe, B., & O'Keefe, D. (1982). The constructivist approach to communication. In F.E. Dance (Ed.), *Human communication theory.* (pp. 147-191). Harper and Row.

Denzin, N. K. (1970). *The research act: A theoretical introduction to sociological methods.* Aldine.

Derlega, V. J. (1984). Self-disclosure and intimate relationships. In V. J. Derlega (Ed.), *Communication, intimacy and close relationships* (pp. 1-10). Academic Press.

Derlega, V. J., & Grzelak, J. (1979). Appropriateness of self-disclosure. In G. Chelune (Ed.), *Self-disclosure: Origins, patterns, and implications of openness in interpersonal relationships* (pp. 151-176). Jossey-Bass.

Derlega, V. J., Lovejoy, D., & Winstead, B. A. (1998). Personal accounts of disclosing and concealing HIV-positive test results: Weighing the benefits and risks. In V.J. Derlega & A.P. Barbee (Eds.) *HIV and social interaction*, (pp. 147-164). Sage Publications.

Derlega, V. J., Metts, S., Petronio, S., & Margulis, S. (1993). *Self-disclosure.* Sage Publications.

Derlega, V. J., Winstead, B. A., Greene, K., Serovich, J., & Elwood, W. N. (2002). Perceived HIV-related stigma and HIV disclosure to relationship partners after finding out about the seropositive diagnosis. *Journal of Health Psychology, 7*(4), 415-432. doi:10.1177/1359105302007004330

Derlega, V. J., Winstead, B. A., Greene, K., Serovich, J., & Elwood, W. N. (2004). Reasons for HIV disclosure/nondisclosure in close relationships: Testing a model of HIV–disclosure decision making. *Journal of Social and Clinical Psychology*, *23*(6), 747-767. doi:10.1521/jscp.23.6.747.54804

Derlega, V. J., Winstead, B. A., Mathews, A., & Braitman, A. L. (2008). Why does someone reveal highly personal information? Attributions for and against self-disclosure in close relationships. *Communication Research Reports*, *25*(2), 115-130. doi:10.1080/08824090802021756

Doan-Wiggins, L., Cooper, M. A., Meyers, D. L., & Chen, E. H. (1995). Practice satisfaction, occupational stress, and attrition of emergency physicians. *Academic Emergency Medicine, 2*(6), 556-563. doi:0.1111/j.1553-2712.1995.tb03261.x

Dillard, J. P., Segrin, C., & Harden, J. M. (1989). Primary and secondary goals in the production of interpersonal influence messages. *Communications Monographs*, *56*(1), 19-38. doi:10.1080/03637758909390247

Donovan-Kicken, E., & Caughlin, J. P. (2010). A multiple goals perspective on topic avoidance and relationship satisfaction in the context of breast cancer. *Communication Monographs*, *77*(2), 231-256. doi:10.1080/03637751003758219

Donovan-Kicken, E., Tollison, A. C., & Goins, E. S. (2012). The nature of communication work during cancer: Advancing the theory of illness trajectories.

Health Communication, *27*(7), 641-652. doi:10.1080/10410236.2011.629405

Dyrbye, L. N., Eacker, A., Durning, S. J., Brazeau, C., Moutier, C., Massie, F. S., Standford, F., Satele, D., Sloan, J.A., & Shanafelt, T. D. (2015). The impact of stigma and personal experiences on the help-seeking behaviors of medical students with burnout. *Academic Medicine*, *90*(7), 961-969. doi:10.1097/ACM.0000000000000655

Dyrbye, L. N., Satele, D., & Shanafelt, T. D. (2017). Healthy exercise habits are associated with lower risk of burnout and higher quality of life among U.S. medical students. *Academic Medicine, 92*(7), 1006-1011. doi:10.1097/ACM.0000000000001540

Dyrbye, L. N., Shanafelt, T. D., Balch, C. M., Satele, D., Sloan, J., & Freischlag, J. (2011). Relationship between work-home conflicts and burnout among American surgeons: A comparison by sex. *Archives of Surgery*, *146*(2), 211-217. doi:10.1001/archsurg.2010.310

Dyrbye, L.N., Thomas, M. R., Stanford, M., Power, D. P., Eacker, A., Harper, W., Durning, S., Moutier, C., Szydlo, D.W., Novotny, P. J., Sloan, J. A., & Shanafelt, T.D. (2008). Burnout and suicidal ideation among U.S. medical students. *Annals of Internal Medicine, 149*(5)*,* 334-341.

Dyrbye, L. N., Varkey, P., Boone, S. L., Satele, D. V., Sloan, J. A., & Shanafelt, T. D. (2013). Physician satisfaction and burnout at different career stages. *Mayo Clinic Proceedings, 88*(12), 1358-1367. doi:10.1016/j.mayocp.2013.07.016

Eckleberry-Hunt, J., Kirkpatrick, H., & Hunt, R.B. (2017). Physician burnout and wellness. In K. J. Brower & M. B. Riba (Eds.), *Physician mental health and well-being: Research and practice*. (pp. 4-24). Springer.

Fontana, A., & Frey, J. H. (2005). The interview: From neutral stance to political involvement. In N. K. Denzin & Y. S. Lincoln (Eds.), *The Sage handbook of qualitative research* (3rd ed., pp. 695–727). Sage Publications.

Frattaroli, J. (2006). Experimental disclosure and its moderators: A meta-analysis. *Psychological Bulletin*, *132*(6), 823-865. doi:10.1037/0033-2909.132.6.823

Glaser, B. (1978) *Theoretical Sensitivity: Advances in the methodology of grounded theory.* Sociology Press.

Glaser, B., & Strauss, A. (1967). *The discovery of grounded theory: Strategies for qualitative research.* Aldine.

Goffman, E. (1959). The moral career of the mental patient. *Psychiatry*, *22*(2), 123-142. doi:10.1080/00332747.1959.11023166

Goffman, E. (2009). *Stigma: Notes on the management of spoiled identity*. Simon & Schuster, Inc. (Original work published 1963)

Gold, K. J., Andrew, L. B., Goldman, E. B., & Schwenk, T. L. (2016). "I would never want to have a mental health diagnosis on my record": A survey of female physicians on mental health diagnosis, treatment, and reporting. *General Hospital Psychiatry*, *43*, 51-57. doi:10.1016/j.genhosppsych.2016.09.004

Gold, K. J., Sen, A., & Schwenk, T. L. (2013). Details on suicide among US physicians: Data from the national violent death reporting system. *General Hospital Psychiatry*, *35*(1), 45-49. doi:10.1016/j.genhosppsych.2012.08.005

Goldberg, R., Boss, R. W., Chan, L., Goldberg, J., Mallon, W. K., Moradzadeh, D., Goodman, E. A., & McConkie, M. L. (1996). Burnout and its correlates in emergency physicians: Four years' experience with a wellness booth. *Academic Emergency Medicine*, *3*(12), 1156-1164. doi:10.1111/j.1553-2712.1996.tb03379.x

Goldman, M. L., Shah, R. N., & Bernstein, C. A. (2015). Depression and suicide among physician trainees: Recommendations for a national response. *JAMA Psychiatry*, *72*(5), 411-412. doi:10.1001/jamapsychiatry.2014.3050

Goldsmith, D. J. (2001). A normative approach to the study of uncertainty and communication. *Journal of Communication*, *51*(3), 514-533. doi:10.1111/j.1460-2466.2001.tb02894.x

Goldsmith, D. J. (2004). *Communicating social support*. Cambridge University Press. doi:10.1017/CBO9780511606984

Goldsmith, D. J. (2015). Uncertainty and communication in couples coping with serious illness. In T. Afifi & W. Afifi (Eds.) *Uncertainty, information management, and disclosure decisions: Theories and applications* (pp. 203-225). Routledge.

Goldsmith, D. J., & Fitch, K. (1997). The normative context of advice as social support. *Human Communication Research*, *23*(4), 454-476. doi:10.1111/j.1468-2958.1997.tb00406.x

Goldsmith, D. J., Lindholm, K. A., & Bute, J. J. (2006). Dilemmas of talking about lifestyle changes among couples coping with a cardiac event. *Social Science & Medicine*, *63*(8), 2079-2090. doi:10.1016/j.socscimed.2006.05.005

Goppelt, J. W. (1978). A patient is not a disease [Letter to the editor]. *Journal of the American Medical Association*, *239*(6), 495. doi:10.1001/jama.1978.03280330031007

Greene, K. (2000). Disclosure of chronic illness varies by topic and target: The role of stigma and boundaries in willingness to disclose. In S. Petronio (Ed.), *Balancing the secrets of private disclosures* (pp. 123-135). Psychology Press.

Greene, K. (2015). An integrated model of health disclosure decision-making. In T. Afifi & W. Afifi (Eds.), *Uncertainty, information management, and disclosure decisions: Theories and applications* (pp. 226-253). Routledge.

Greene, K., Derlega, V. J., & Mathews, A. (2006). Self-disclosure in personal relationships. In A. Vangelisti & D. Perlman (Eds.), *The Cambridge handbook of personal relationships* (pp. 409-427). Cambridge University Press.

Greene, K., Derlega, V. J., Yep, G. A., & Petronio, S. (2003). *Privacy and disclosure of HIV in interpersonal relationships: A sourcebook for researchers and practitioners*. Lawrence Erlbaum Associates, Inc.

Greene, K., & Faulkner, S. L. (2002). Expected versus actual responses to disclosure in relationships of HIV- positive African American adolescent females. *Communication Studies*, *53*(4), 297-317. doi:10.1080/10510970209388595

Grice, T., Alcock, K., & Scior, K. (2018). Factors associated with mental health disclosure outside of the workplace: A systematic literature review. *Stigma and Health*, *3*(2), 116-130. doi:10.1037/sah0000079

Guille, C., Zhao, Z., Krystal, J., Nichols, B., Brady, K., & Sen, S. (2015). Web-based cognitive behavioral therapy intervention for the prevention of suicidal ideation in

medical interns: A randomized clinical trial. *JAMA Psychiatry*, *72*(12), 1192-1198. doi:10.1001/jamapsychiatry.2015.1880

Hammersley, M. (2013). *What is Qualitative Research?* Bloomsburry.

Harrison, J. (2008). Doctors' health and fitness to practice: Assessment models. *Occupational Medicine, 58*(5), 318-322. doi:10.1093/occmed/kqn079

Hawke, L. D., Parikh, S. V., & Michalak, E. E. (2013). Stigma and bipolar disorder: A review of the literature. *Journal of Affective Disorders*, *150*(2), 181-191. doi:10.1016/j.jad.2013.05.030

Haque, O. S., & Waytz, A. (2012). Dehumanization in medicine: Causes, solutions, and functions. *Perspectives on Psychological Science, 7*(2), 176-186. doi:10.1177/1745691611429706

Hayden, S. (1993). Chronically ill and "feeling fine": A study of communication and chronic illness. *Journal of Applied Communication Research, 21*(3)*,* 263-278. doi:10.1080/00909889309365371

Helgeson, V. S. (1993). Two important distinctions in social support: Kind of support and perceived versus received. *Journal of Applied Social Psychology*, *23*(10), 825-845. doi:10.1111/j.1559-1816.1993.tb01008.x

Heru, A., Gagne, G., & Strong, D. (2009). Medical student mistreatment results in symptoms of posttraumatic stress. *Academic Psychiatry*, *33*(4), 302-306. doi:10.1176/appi.ap.33.4.302

Hoff, T., & Scott, S. (2016). The gendered realities and talent management imperatives of women physicians. *Health Care Management Review*, *41*(3), 189-199. doi:10.1097/HMR.0000000000000069.

Holmes, A. (2014, March). *Researcher positionality: A consideration of its influence and place in research.* [Paper] https://www.scribd.com/document/305906312/Researcher-Positionality-a-Consideration-of-Its-Influence-and-Place-in-Research

Hopper, R. (1992). *Telephone conversation*. Indiana University Press.

Hughes, P. H., Storr, C. L., Brandenburg, N. A., Baldwin Jr., D. C., Anthony, J. C., & Sheehan, D. V. (1999). Physician substance use by medical specialty. *Journal of Addictive Diseases*, *18*(2), 23-37. doi:10.1300/J069v18n02_03

Hulkower, R. (2016). The history of the Hippocratic Oath: Outdated, inauthentic, and yet still relevant. *Einstein Journal of Biology and Medicine*, *25*(1), 41-44. doi:10.23861/EJBM20102542

Ignatius, E., & Kokkonen, M. (2007). Factors contributing to verbal self-disclosure. *Nordic Psychology*, *59*(4), 362-391. doi:10.1027/1901-2276.59.4.362

Kane, L. (2019, January 19). *Medscape national physician burnout, depression & suicide report 2019*. [Slideshow] https://www.medscape.com/slideshow/2019-lifestyle-burnout-depression-6011056

Karp, D. A. (2017). *Speaking of sadness: Depression, disconnection, and the meanings of illness*. Oxford University Press.

Kealy, D., Halli, P., Ogrodniczuk, J. S., & Hadjipavlou, G. (2016). Burnout among Canadian psychiatry residents: A national survey. *The Canadian Journal of Psychiatry*, *61*(11), 732-736. doi:10.1177/0706743716645286.

Keeton, K., Fenner, D. E., Johnson, T. R., & Hayward, R. A. (2007). Predictors of physician career satisfaction, work–life balance, and burnout. *Obstetrics & Gynecology*, *109*(4), 949-955. doi:10.1097/01.AOG.0000258299.45979.37

Kjeldmand, D., & Holmström, I. (2008). Balint groups as a means to increase job satisfaction and prevent burnout among general practitioners. *The Annals of Family Medicine*, *6*(2), 138-145. doi:10.1370/afm.813

Kjeldmand, D., Holmström, I., & Rosenqvist, U. (2004). Balint training makes GPs thrive better in their job. *Patient Education and Counseling*, *55*(2), 230-235. doi:10.1016/j.pec.2003.09.009

Klitzman, R. (2008). *When doctors become patients.* Oxford University Press.

Knox, S., & Burkard, A. W. (2009). Qualitative research interviews. *Psychotherapy Research, 19*(4-5), 566-575. doi:10.1080/10503300802702105

Lafreniere, J. P., Rios, R., Packer, H., Ghazarian, S., Wright, S. M., & Levine, R. B. (2016). Burned out at the bedside: Patient perceptions of physician burnout in an internal medicine resident continuity clinic. *Journal of General Internal Medicine*, *31*(2), 203-208. doi: 10.1007/s11606-015-3503-3

Lepore, S. J., & Smyth, J. M. (Eds). (2002). *The writing cure: How expressive writing promotes health and emotional well-being.* American Psychological Association. doi:10.1037/10451-000

Liamputtong, P. (2007). *Researching the vulnerable: A guide to sensitive research methods*. Sage Publications.

Lindlof, T. R., & Taylor, B. C. (2011). *Qualitative communication research methods* (3rd ed.). Sage Publications.

Loos, R. L. (2018). *Interpreting the essence of social support: A phenomenological analysis of physicians' experiences of social support* (Publication No. 10788209) [Doctoral dissertation, University of Nebraska at Omaha]. ProQuest Dissertations Publishing.

Malterud, K., & Hollnagel, H. (2005). The doctor who cried: A qualitative study about the doctor's vulnerability. *The Annals of Family Medicine*, *3*(4), 348-352. doi:10.1370/afm.314

Maslach, C. (1982). *Burnout: The cost of caring*. Prentice-Hall.

Maslach, C., & Jackson, S. E. (1979). Burned-out cops and their families. *Psychology Today*, *12*(12), 58-62.

Mata, D. A., Ramos, M. A., Bansal, N., Khan, R., Guille, C., Di Angelantonio, E., & Sen, S. (2015). Prevalence of depression and depressive symptoms among resident physicians: A systematic review and meta-analysis. *Journal of the American Medical Association*, *314*(22), 2373-2383. doi:10.1001/jama.2015.15845

Matthews, C. K., & Harrington, N. G. (2000). Invisible disability. In D. O. Braithwaite & T. L. Thompson (Eds.), *Handbook of communication and people with disabilities: Research and application* (pp. 405– 421). Lawrence Erlbaum Associates Publishers.

McDaniel, S. H., Beckman, H. B., Morse, D. S., Silberman, J., Seaburn, D. B., & Epstein, R. M. (2007). Physician self-disclosure in primary care visits: Enough about you, what about me?. *Archives of Internal Medicine*, *167*(12), 1321-1326. doi:10.1001/archinte.167.12.1321

MacQueen, K. M., McLellan-Lemal, E., Bartholow, K., Milstein, B., & Guest, G. (2008). Team-based codebook development: Structure, process, and agreement. In G. Guest & K. M. MacQueen (Eds.), *Handbook for team-based qualitative research*. (pp. 119-136). AltaMira Press.

Mills, E., Jadad, A. R., Ross, C., & Wilson, K. (2005). Systematic review of qualitative studies exploring parental beliefs and attitudes toward childhood vaccination identifies common barriers to vaccination. *Journal of Clinical Epidemiology*, *58*(11), 1081-1088. doi:10.1016/j.jclinepi.2005.09.002

Misra-Hebert, A. D., Kay, R., & Stoller, J. K. (2004). A review of physician turnover: Rates, causes, and consequences. *American Journal of Medical Quality*, *19*(2), 56-66. doi:10.1177/106286060401900203

Mongeau, P. A., Jacobsen, J., & Donnerstein, C. (2007). Defining dates and first date goals: Generalizing from undergraduates to single adults. *Communication Research*, *34*(5), 526-547. doi:10.1177/0093650207305235

Moore, D., Ayers, S., & Drey, N. (2016). A thematic analysis of stigma and disclosure for perinatal depression on an online forum. *JMIR Mental Health*, *3*(2). doi:10.2196/mental.5611

Morgan, D. L. (1993). Qualitative content analysis: A guide to paths not taken. *Qualitative Health Research, 3*(1), 112-121. doi:10.1177/104973239300300107

Myers, M.F. (2017). Suicidal behaviors in physicians. In K. J. Brower & M. B. Riba (Eds.), *Physician mental health and well-being: Research and practice*. (pp. 87-106). Springer.

O'Keefe, B. J. (1988). The logic of message design: Individual differences in reasoning about communication. *Communications Monographs*, *55*(1), 80-103. doi:10.1080/03637758809376159

Petersen, M. R., & Burnett, C. A. (2007). The suicide mortality of working physicians and dentists. *Occupational Medicine*, *58*(1), 25-29. doi:10.1093/occmed/kqm117

Piccinini, R. G. G., McRae, K. D., Becher, J. W., Hayden, A. Z., Hentges, C. B., Kalcec, A., Kinkhabwala, P., Halvorsen, V. W., White-Faines, A., & Escobar, D. (2017). Addressing burnout, depression, and suicidal ideation in the osteopathic profession: An approach that spans the physician life cycle [PDF file]. Retrieved from https://nam.edu/wp-content/uploads/2017/03/Addressing-BurnoutDepression-and-Suicidal-Ideation-in-the-OsteopathicProfession.pdf.

Popa-Velea, O., Trutescu, C. I., & Diaconescu, L. V. (2019). The impact of Balint work on alexithymia, perceived stress, perceived social support and burnout among physicians working in palliative care: A longitudinal study. *International Journal of Occupational Medicine and Environmental Health*, *32*(1), 53-63. doi:10.13075/ijomeh.1896.01302

Price, R. H., & Bouffard, D. L. (1974). Behavioral appropriateness and situational constraint as dimensions of social behavior. *Journal of Personality and Social Psychology, 30*(4), 579.

Ramirez Jr., A. (2008). An examination of the tripartite approach to commitment: An actor-partner interdependence model analysis of the effect of relational maintenance behavior. *Journal of Social and Personal Relationships*, *25*(6), 943-965. doi:10.1177/0265407508100309

Rassolian, M., Peterson, L. E., Fang, B., Knight, H. C., Peabody, M. R., Baxley, E. G., & Mainous, A. G. (2017). Workplace factors associated with burnout of family physicians. *JAMA Internal Medicine*, *177*(7), 1036-1038. doi:10.1001/jamainternmed.2017.1391

Rawlins, W. K. (1983). Openness as problematic in ongoing friendships: Two conversational dilemmas. *Communication Monographs, 50*(1)*,* 1-13. doi:10.1080/03637758309390150

Reminen, R. H., Rabkin, J. G., Williams, J. B., & Katoff, L. (1992). Coping strategies and health beliefs of AIDS longterm survivors. *Psychology and Health 6*(4), 335-345. doi:10.1080/08870449208400441

Roberts, M. (2012). Balint groups: A tool for personal and professional resilience. *Canadian Family Physician*, *58*(3), 245.

Rose, J. S., Campbell, M. D., Yellowlees, P., Skipper, G. E., & DuPont, R. L. (2017). Family medicine physicians with substance use disorder: A 5-year outcome study. *Journal of Addiction Medicine, 11*(2), 93-97. doi:10.1097/ADM.0000000000000278

Rosenstein, A. (2017). Disruptive and unprofessional behaviors. In K. J. Brower & M. B. Riba (Eds.) *Physician mental health and well-being: Research and practice*. (pp. 61-85). Springer.

Rosta, J. (2008). Hazardous alcohol use among hospital doctors in Germany. *Alcohol and Alcoholism*, *43*(2), 198-203. doi:10.1093/alcalc/agm180

Rosta, J., & Aasland, O. G. (2005). Female surgeons' alcohol use: A study of a national sample of Norwegian doctors. *Alcohol and Alcoholism*, *40*(5), 436-440. doi:10.1093/alcalc/agh186

Rowland, D. L., Thornton, J. A., & Burnett, A. L. (2005). Recognizing the risk of erectile dysfunction in a urology clinic practice. *BJU International*, *95*(7), 1034-1038. doi:10.1111/j.1464-410X.2005.05460.x

Rüsch, N., Brohan, E., Gabbidon, J., Thornicroft, G., & Clement, S. (2014). Stigma and disclosing one's mental illness to family and friends. *Social Psychiatry and Psychiatric Epidemiology*, *49*, 1157-1160.

Saldaña, J. (2009). *The coding manual for qualitative researchers.* Sage Publications.

Sandelowski, M. (2000). Focus on research methods-whatever happened to qualitative description?. *Research in Nursing and Health*, *23*(4), 334-340. doi:10.1002/1098-240X(200008)23:43.0.CO;2-G

Sarason, B. R., Pierce, G. R., & Sarason, I. G. (1990). Social support: The sense of acceptance and the role of relationships. In B.R. Sarason, I.G. Sarason, & G.R. Pierce (Eds.) *Social support: An interactional view* (pp. 97-128). Wiley.

Saunders, B., Sim, J., Kingstone, T., Baker, S., Waterfield, J., Bartlam, B., Burroughs, H., & Jinks, C. (2018). Saturation in qualitative research: Exploring its conceptualization and operationalization. *Quality & Quantity*, *52*, 1893-1907.

Schutz, W. C. (1958). *FIRO: A three-dimensional theory of interpersonal behavior.* Rinehart.

Scott, A. M., & Caughlin, J. P. (2012). Managing multiple goals in family discourse about end-of-life health decisions. *Research on Aging*, *34*(6), 670-691. doi:10.1177/0164027512446942

Scott, A. M., & Caughlin, J. P. (2014). Enacted goal attention in family conversations about end-of-life health decisions. *Communication Monographs, 81*(3), 261-284. doi:10.1080/03637751.2014.925568

Scott, A. M., Caughlin, J. P., Donovan-Kicken, E., & Mikucki-Enyart, S. L. (2013). Do message features influence responses to depression disclosure? A message design logics perspective. *Western Journal of Communication*, *77*(2), 139-163. doi:10.1080/10570314.2012.694007

Scott, A. M., Harrington, N. G., & Spencer, E. (2020). Primary care physicians' strategic pursuit of multiple goals in cost-of-care conversations with patients. *Health Communication*, 1-13. doi:10.1080/10410236.2020.1723051

Scott, A. M., Martin, S. C., Stone, A. M., & Brashers, D. E. (2011). Managing multiple goals in supportive interactions: Using a normative theoretical approach to explain social support as uncertainty management for organ transplant patients. *Health Communication*, *26*(5), 393-403. doi:10.1080/10410236.2011.552479

Serovich, J. M., Brucker, P. S., & Kimberly, J. A. (2000). Barriers to social support for persons living with HIV/AIDS. *AIDS Care, 12*(5). doi: 10.1080/095401200750003824

Shanafelt, T. D., Balch, C. M., Bechamps, G., Russell, T., Dyrbye, L., Satele, D., Collicott, P., Novotny, P.J., Sloan, J., & Freischlag, J. (2009). Burnout and career satisfaction among American surgeons. *Annals of Surgery*, *250*(3), 463-471.

doi:10.1097/SLA.0b013e3181ac4dfd

Shanafelt, T. D., Balch, C. M., Bechamps, G., Russell, T., Dyrbye, L., Satele, D., Collicott, P., Novotny, P.J., Sloan, J., & Freischlag, J. (2010). Burnout and medical errors among American surgeons. *Annals of Surgery*, *251*(6), 995-1000. doi:10.1097/SLA.0b013e3181bfdab3

Shanafelt, T. D., Boone, S., Tan, L., Dyrbye, L. N., Sotile, W., Satele, D., West, C.P., Sloan, J., & Oreskovich, M. R. (2012). Burnout and satisfaction with work-life balance among US physicians relative to the general US population. *Archives of Internal Medicine*, *172*(18), 1377-1385. doi:10.1001/archinternmed.2012.3199

Shanafelt, T. D., Hasan, O., Dyrbye, L. N., Sinsky, C., Satele, D., Sloan, J., & West, C. P. (2015). Changes in burnout and satisfaction with work-life balance in physicians and the general US working population between 2011 and 2014. *Mayo Clinic Proceedings, 90*(12), 1600-1613. doi: 10.1016/j.mayocp.2015.08.023

Shanafelt, T. D., Mungo, M., Schmitgen, J., Storz, K. A., Reeves, D., Hayes, S. N., Sloan, J.A., Swensen, S.J., & Buskirk, S. J. (2016). Longitudinal study evaluating the association between physician burnout and changes in professional work effort. *Mayo Clinic Proceedings, 91*(4), 422-431. doi:10.1016/j.mayocp.2016.02.001

Shanafelt, T. D., & Noseworthy, J. H. (2017). Executive leadership and physician well-being: Nine organizational strategies to promote engagement and reduce burnout. *Mayo Clinic Proceedings, 92*(1), 129-146. doi: 10.1016/j.mayocp.2016.10.004

Sheppe Jr., W., & Stevenson, I. (1963). Techniques of interviewing. In H.I. Lief & N.R. Lief (Eds.) *The psychological basis of medical practice* (pp. 181-192). Harper & Row.

Shiralkar, M. T., Harris, T. B., Eddins-Folensbee, F. F., & Coverdale, J. H. (2013). A systematic review of stress-management programs for medical students. *Academic Psychiatry*, *37*(3), 158-164.

Shirom, A., Nirel, N., & Vinokur, A. D. (2010). Work hours and caseload as predictors of physician burnout: The mediating effects by perceived workload and by autonomy. *Applied Psychology: An International Review*, *59*(4), 539-565. doi:10.1111/j.1464-0597.2009.00411.x

Silver, R. L., Wortman, C. B., & Crofton, C. (1990). The role of coping in support provision: The self-presentational dilemma of victims of life crises. In B. R. Sarason, I. G. Sarason, & G. R. Piece (Eds.), *Social support: An interactional view* (pp. 397-426). Wiley.

Slade, P., O'Neill, C., Simpson, A. J., & Lashen, H. (2007). The relationship between perceived stigma, disclosure patterns, support and distress in new attendees at an infertility clinic. *Human Reproduction*, *22*(8), 2309-2317. doi:10.1093/humrep/dem115

Steuber, K. R., & Solomon, D. H. (2011). Factors that predict married partners' disclosures about infertility to social network members. *Journal of Applied Communication Research*, *39*(3), 250-270. doi:10.1080/00909882.2011.585401

Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (2nd ed.). Sage Publications.

Taku, K. (2014). Relationships among perceived psychological growth, resilience and burnout in physicians. *Personality and Individual Differences*, *59*, 120-123. doi:10.1016/j.paid.2013.11.003

Thompson, W. T., Cupples, M. E., Sibbett, C. H., Skan, D. I., & Bradley, T. (2001). Challenge of culture, conscience, and contract to general practitioners' care of their own health: Qualitative study. *BMJ, 323*(7315), 728-731. doi:10.1136/bmj.323.7315.728

Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*, *19*(6), 349-357. doi:10.1093/intqhc/mzm042

Tracy, S. J. (2013). *Qualitative research methods: Collecting evidence, crafting analysis, communicating impact.* Wiley.

Umberson, D., & Montez, J. K. (2010). Social relationships and health: A flashpoint for health policy. *Journal of Health and Social Behavior, 51*(1), S54-S66. doi:10.1177/0022146510383501

Vangelisti, A. L. (2009). Challenges in conceptualizing social support. *Journal of Social and Personal Relationships*, *26*(1), 39-51. doi:10.1177/0265407509105520

Venetis, M. K., Magsamen-Conrad, K., Checton, M. G., & Greene, K. (2013). Cancer communication and partner burden: An exploratory study. *Journal of Communication*, *64*(1), 82-102. doi:10.1111/jcom.12069

Wallace, J. E. (2010). Mental health and stigma in the medical profession. *Health, 16*(1), 3-18. doi:10.1177/1363459310371080

Wears, R. L., & Wu, A. W. (2002). Dealing with failure: The aftermath of errors and adverse events. *Annals of Emergency Medicine*, *39*(3), 344-346. doi:10.1067/mem.2002.121996

Weiss, R. S. (1994). *Learning from strangers: The art and method of qualitative interview studies.* The Free Press.

West, C. P., Shanafelt, T. D., & Kolars, J. C. (2011). Quality of life, burnout, educational debt, and medical knowledge among internal medicine residents. *Journal of the American Medical Association, 306*(9), 952-960. doi:10.1001/jama.2011.1247

Williams, D., Tricomi, G., Gupta, J., & Janise, A. (2015). Efficacy of burnout interventions in the medical education pipeline. *Academic Psychiatry*, *39*(1), 47-54. doi:10.1007/s40596-014-0197-5

Wilson, S. R. (2002). *Seeking and resisting compliance: Why people say what they do when trying to influence others.* Sage Publications.

Wilson, S. R. (2007). Communication theory and the concept of "goal." In B. B. Whaley & W. Samter (Eds.), *Explaining communication: Contemporary theories and exemplars* (pp. 73–104). Routledge.

Winstead, B. A., Derlega, V. J., Barbee, A. P., Sachdev, M., Antle, B., & Greene, K. (2002). Close relationships as sources of strength or obstacles for mothers coping with HIV. *Journal of Loss and Trauma, 7*(3), 157-184. doi:10.1080/10811440290057602

Wright, A. A., & Katz, I. T. (2018). Beyond burnout—redesigning care to restore meaning and sanity for physicians. *New England Journal of Medicine*, *378*(4), 309-311. doi:10.1056/NEJMp1716845

Zwack, J., & Schweitzer, J. (2013). If every fifth physician is affected by burnout, what about the other four? Resilience strategies of experienced physicians. *Academic Medicine*, *88*(3), 382-389. doi:10.1097/ACM.0b013e318281696

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Education

2013 - 2015	M.A., Communication Studies The University of North Carolina at Greensboro GPA: 3.95	Greensboro, NC
2006 - 2009	B.A., Communication Saginaw Valley State University	Saginaw, MI
	Study Abroad, Parapsychology	Dublin, Ireland
	Minors: Professional Writing/Marketing GPA: 3.89, Summa Cum Laude	

Publications

Darnell, W. H., **Buckley, A.N.,** & Gordon, A.M. (2018). "It's not something you expect a 15-year-old to be sad about": Sources of uncertainty and strategies of uncertainty management among adolescent women who have experienced miscarriage. *Health Communication,* 1-11. Doi:10.1080/10410236.2018.1536947

Buckley, A.N. (2017). A Dialectical perspective of perceived humor and openness during relational turning points. *Texas Speech Communication Journal, 41,* 1.

Buckley, A. N. (Forthcoming) *Conversations with 'Sammy': Exploring children's verbalized imagined interaction.* Socha, T.J. & Punyanunt-Carter, N. (Ed's.). The Children's Communication Sourcebook.

Kellett, P., **Buckley, A. N.**, & Frame, M. (2015). Communication, teaching and learning, and faculty disability: Lessons from a personal narrative. In Atay, A & Ashlock, M. (Ed's.). *The discourse of disability in higher education: Narrative-based research for social change.* New York: Peter Lang.

Conferences/Presentations

Buckley, A.N. (2019). *It's OK to not be OK.* Presented at Alphi Chi Omega, UK Chapter meeting. Lexington, KY.

Buckley, A.N. (2017). *Burnout among surgery providers: The role of disclosure and support.* Presented at the UK Hospital Surgery Department Grand Rounds meeting, Lexington, KY.

Buckley, A.N. (2017). *A Dialectical Perspective of Perceived Humor and Openness during Relational Turning Points.* Presented at the 2017 National Communication Association meeting, Dallas, TX.

Darnell, W. H., **Buckley, A.N.,** & Gordon, A.M. (2017). *"It's not something you expect a 15-year-old to be sad about": Sources of uncertainty and strategies of uncertainty management among adolescent women who have experienced miscarriage.* Presented at the 2017 National Communication Association meeting, Dallas, TX.

Buckley, A.N. (2017). *Crash and burn(out): Enhancing communication to build resilience and relationships.* Presented at 2017 Women's Forum Annual Conference, Lexington, KY.

Martin, J., & **Buckley, A.N.** (2017). *Balancing act: Strategies for grading assignments in a timely manner while also taking classes.* Presented as part of Instructional Communication & Research professional development series, Lexington, KY.

Buckley, A. N., Darnell, W. H., & Wehlage, S. J. (2017). *Senior sorority sisters: How older adults use friendships to cope with stress and make end-of-life decisions.* Presented at the 2017 annual convention of the District of Columbia Health Communication in Washington, D.C.

Beck, A. C., **Buckley, A. N.**, Matig, J. J., Harris, C. J., & Hadden, A. (2016). *Openness and Closed-ness in Parent-Child Relationships: Disclosing information about Becoming Sexually Active*. International Association for Relationship Research, Toronto, Canada.

Kellett, P., **Buckley, A. N.,** & Frame, M. (2015). Communication, teaching and learning, and faculty disability: Lessons from a personal narrative. In Atay, A & Ashlock, M. (Ed's.). *The discourse of disability in higher education: Narrative-based research for social change.* New York: Peter Lang. Presented at the 2015 National Communication Association meeting, Las Vegas, NV.

Buckley, A. N. (2014). *Take a Stand.* Carolina Communication Association, GIFTS Panelist. Greenville, SC.

Buckley, A. N. (2013). *A laughing matter: Using inside jokes to create healthy friendships.* Positive Communication Graduate Student Symposium, Greenville, NC.

Works in Progress

Patel, J., Charak, G.S., **Buckley, A.N.** (In progress). *The effects of smartphone access to the EMR and work-related smartphone use at home on surgical resident and attending wellness.*

Buckley, A.N., Darnell, W. H., & Gordon, A.M. (In progress). *Unplanned pregnancy*

and loss: College student experiences with support after miscarriage.

Academic Teaching Experience

Part Time Instructor Aug 2018 – May 2020
College of Communication and Information
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Graduate Teaching Assistant Aug 2015 – May 2018
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Graduate Teaching Assistant
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Pedagogy Student Teacher Fall 2013
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Courses Taught
CST 105: Introduction to Communication
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Student Research

Student Course Research Fall 2015
The University of Kentucky
Topic: A dialectical perspective of perceived humor and openness during relational turning points.

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Awards

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