

# Understanding job frustration and coping strategies among mental health nurses in Oman: a qualitative study

Asiya Mohamed Al Zadjali · Yoke Yong Chen  · Keng Sheng Chew ·  
Rekaya Vincent Balang · Hamida Hamed Al Harthi · Md Mizanur Rahman ·  
Ling Choo Chiew

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## Abstract

**Background** Job frustration among mental health nurses can have determinant impact on staff wellbeing, retention, and quality of care. However, little is known about the factors contributing to job frustration and the coping strategies used by mental health nurses in Oman. An alarming sign of stress and discontent at work is the high intention to leave among mental health nurses in Oman.

**Aim** This study aimed to explore the factors contributing to job frustration and the adaptation strategies used by mental health nurses in Oman.

**Method** A qualitative descriptive design was adopted for this study. Forty-two participants who were purposively selected after obtaining consent were involved in six focus group discussions, divided equally between mental health nurses ( $n=21$ ) and mental health nursing leaders ( $n=21$ ) within a mental healthcare setting in Oman. Data were transcribed verbatim, translated where necessary, and analyzed using thematic analysis supported by NVivo 14 software. Ethical approvals were obtained from relevant institutional ethics committees in Malaysia and Oman.

**Results** Three main themes emerged: external factors (workplace environment, obligatory and blame culture, reciprocal communication, and job insecurity), internal factors (role perception and engagement, effort–reward imbalance, work–life balance, and self-efficacy) that contribute to job frustration, and adaptation strategies (personal and professional-oriented approaches). For both participant groups, perceived lack of recognition, communication obstacles, and leadership difficulties were major sources of frustration.

**Conclusion** Individual, organizational, and contextual factors lead to job dissatisfaction among mental health nurses in Oman. In mental health settings, addressing perceived limitation in leadership styles, communication procedures, workplace culture, and employee support systems may lessen job dissatisfaction and enhance employee retention and welfare.

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**Keywords** Mental health nurses · Workplace stress · Job frustration · Coping strategies · Qualitative research · Oman

## Introduction

Over the years numerous physical and psychological symptoms have emerged among employees adversely affecting their health and well-being [69]. Healthcare settings, in particular, are characterized by high levels of job stress, contributing to job frustration, burnout and turnover [49]. Given the unique pressures of the health-care environment, it is evident that the mental health setting's present additional psychological and interpersonal demands that may increase the risk of job frustration among nurses [55].

In any healthcare institution, nursing staff constitute the majority workforce and act in the first line interacting directly with patients and collaborating within multidisciplinary teams [15]. This unique position places them at a higher risk of job frustration than other team members. It is believed that one of the most difficult and specialized nursing areas is mental health nursing [38]. Working with patients who have severe and chronic mental health disorders can put a lot of emotional and physical strain on nurses in this sector. Mental health nurses encounter particular pressures and work-related annoyances in many nations, including Oman, which may have an impact on their retention, job satisfaction, and general well-being [72]. These elements include the emotional toll of patient care, organizational problems, workload, and pressures associated to the job [14, 38].

## Conceptualization of job frustration

Despite the similarities, the terms “job frustration,” “job dissatisfaction,” “occupational stress,” “burnout,” and “moral distress” are separate psychological phenomena. The psychological and physical reactions that occur when demands at work surpass a person's perceived resources or coping capacity are referred to as occupational stress. According to Maslach and Leiter [55], burnout is a long-term reaction to ongoing work-related stress and is typified by diminished personal achievement, depersonalization, and emotional exhaustion.

A negative assessment of one's job or working conditions is known as “job dissatisfaction,” and it indicates how unhappy individuals are with their work experience. Conversely, job frustration is defined as a mental state that emerges when a worker encounters obstacle that impede the achievement of their professional objectives [20]. The multifaceted experience of job frustration among mental health nurses is not adequately captured by stress, burnout, and discontent, even if these may be contributing factors.

The current study conceptualizes job frustration as a multifaceted construct that includes organizational, interpersonal, professional, emotional, and resource-related obstacles that prevent nurses from carrying out their professional responsibilities and producing significant work results. As a result, rather than being used interchangeably with stress, burnout, or job discontent, job frustration is considered a separate phenomenon.

## Job frustration among mental health nurses

Nurses' frustration and stress at work is a common observable fact that affects negatively their emotional well-being, power, motivation and work performance [49, 58]. Because of the special nature of MHNs' practice, they are the focus of this study specially when studies conducted in Oman on this groups of nurses are scarce. In contrast to nurses in other disciplines, MHNs must navigate complicated emotional and societal challenges while attending to patients' psychological needs [4]. To illustrate, the emotional strain of caring for patients with mental diseases can be unbearable, and MHNs frequently encounter people in crisis. This is in contrast to other nursing disciplines where the main emphasis may be on physical care. For instance, MHNs deal with psychological trauma, such as self-harm and aggressive attacks, which are less common in other nursing areas, but nurses in general medical wards may encounter stress due to physical sickness and medical procedures [63]. Another

element that sets the experiences of MHNs apart from those of other nurses was the stigma associated with mental illness [2]. Both patients and nurses might feel alienated as a result of this stigma [2]. The cultural stigma associated with mental illness in Oman might make MHNs feel alone in the healthcare system, which could lower their job satisfaction [2] causing dissatisfaction [13]. Additionally, specialized abilities such as therapeutic communication, crisis response, and a thorough comprehension of psychiatric diseases are necessary for mental health nursing [2]. It can be distressing to feel pressured to keep up these specific abilities, especially if nurses believe they lack the tools or support they need.

These nurses' coping mechanisms, which range from professional support networks to personal resilience, were essential for reducing stress and averting job frustration. Because MHNs' work is specialized and emotionally strenuous, their experiences differ greatly from those of other nurses, which is why they are the focus of this study. Improving these nurses' well-being, job satisfaction, and retention rates requires an understanding of the factors that lead to JF and their coping strategies.

Therefore, to effectively manage job frustration among nurses, it is required to first identify the underlying factors contributing to this phenomenon through the lived experiences of both mental health nurses and mental health nursing leaders in real settings in Oman.

### **Coping strategies in mental health nursing**

In order to cope with the stress, mental health nurses—especially those working in high-stress settings like Oman—develop a variety of coping strategies [19]. These tactics fall into two categories: professional and personal coping mechanisms [11, 19].

The individual coping strategies considers mainly emotional control, asking for social support from friends or family, and exercising are examples of personal coping strategies [19]. To refuel and preserve a positive work-life balance, nurses frequently partake in extracurricular activities like socializing or taking up hobbies [19]. In Oman, cultural customs such as community cohesion and family support systems can be quite helpful in assisting nurses in managing stress. Whereas workplace coping strategies addresses peer support, supervision, and involvement in in-service training programs are examples of professional coping mechanisms [28]. Nurses can preserve professional boundaries and avoid burnout by processing their emotional responses to patient care with the support of supervision, especially in clinical settings. It has been demonstrated that organizations in Oman that provide frequent debriefing sessions and sufficient training in managing mental health emergencies help nurses feel less stressed [6]. Therefore, resilience is frequently developed by mental health nurses via experience and by learning how to handle the emotional demands of their jobs [17]. Sustaining long-term job pleasure requires this resiliency. Programs for resilience training that emphasize problem-solving, stress management, and mindfulness can help people feel less frustrated and burnt-out [17].

### **The Omani mental health nursing context**

There is gradual expansion of healthcare services in Oman including mental health with staffing shortage [12]. This estimated to result in longer shifts, more patient care responsibilities and emotional exhaustion. Additionally, according to research by Hamaideh [43], mental health nurses may experience severe job dissatisfaction as a result of the emotional demands imposed on them. Cultural considerations may make this problem worse in Oman, where social stigma may prevent many individuals from seeking mental health treatment or from openly expressing their feelings [1]. Furthermore, job satisfaction in healthcare organizations are significantly influenced by the organizational structure and support networks in place. Feelings of annoyance and discontent can be exacerbated by inadequate training, a lack of supervisory support, and poor communication [18]. Inadequate professional development programs and a dearth of comprehensive mental health policies have been identified as contributing causes to the stress that mental health nurses in Oman endure [6]. Another influence may be the actual setting in which nurses operate including inadequate resources, overcrowded mental health facilities, and

patient privacy violations [18]. Research has shown that inadequate funding and inadequate infrastructure in certain Omani healthcare settings add to nurses' discontent [18].

The evidences indicated that there is reasonable level of anxiety in Oman which is identified as different than other GCC countries [67]. Although, there is quick educational and economic development in Oman, but it still reserves its cultural and societal values [67].

In Oman's mental health Hospital, approximately 18% out of 600 total nursing workforces were identified to have mental and physical health problems in the year 2018 according to local statistics reported by the head of nursing at that period [60]. In addition, the process of turnover is fast, especially for those who completed more than 15 years in a mental health setting. Senior nurses with specialized qualifications in mental health strive to either higher management positions or transfer out from the hospital for better opportunities. At the time of data collection, 11% of the nurses in Oman Mental Health Hospital were senior according to the local statistics resulting in the impacted proficiency. Therefore, this study is intended to examine the factors related to job frustration among nurses and nursing leaders in mental health settings in Oman.

Moreover, it is believed that the culture-related sensitivity within Arab regions due to exceptional societal and religious aspects requires closer focus for a better understanding towards job frustration [39]. The possibility of distinctive connection of multiple factors such as personal, professional and organisational into job frustration requires deeper exploration. Therefore, this qualitative exploration is needed to provide insight into culturally defined sources of job frustration among nurses working in mental health settings in Oman. Additionally, the team dynamics among mental health nurses and mental health nursing leaders might be affected by these factors. To illustrate, leaders having low empathy pose pressure on mental health nurses for shift duties whom may experience frustration as a result leading to lack of cohesiveness among the team [40].

## Research gap and rationale

Despite growing research regarding burnout, stress, and job satisfaction among nurses internationally, little is known about the particular variables contributing to job frustration among mental health nurses in Oman. The multifaceted nature of workplace irritation is still little understood, and previous research has mostly concentrated on burnout, workload, and job satisfaction. Additionally, no culturally relevant tool has been created to gauge Omani mental health nurses' job frustration. As a result, less is known about the underlying causes, coping strategies, and environmental factors influencing job frustration in this workforce. Healthcare organizations' capacity to create focused measures meant to enhance nurses' well-being, retention, and professional performance is hampered by this knowledge gap.

Furthermore, the bulk of the research that is now accessible comes from Western settings, despite the fact that job frustration among healthcare professionals has been observed globally. These studies show the relevance of organizational, interpersonal, and professional aspects contributing to frustration; nevertheless, cultural differences may alter how frustration is experienced and conveyed. Consequently, there remains a need for contextually relevant evidences capable of capturing the specific experiences of Omani nurses.

## Conceptual framework

Understanding JF necessitates a comprehensive approach that considers various human behavioral factors at work, especially in high stress workplace i.e. mental health. In this study, factors such as role clarity, ability, motivation, situational factors and coping measures were acknowledged as key aspects influencing nurses experience towards JF. Applying the MARS model, which stands for Motivation, Ability, Role perception, and Situational factors, provides a robust framework for this analysis [56] which aids in explaining the multidimensional nature of JF among nurses in mental health setting. Mental health nurses in response to these stressors, get engaged in adaptation processes and coping mechanisms considering general adaptation syndrome (GAS).

In order to provide a clear framework of the precipitating factors, the dichotomy of internal versus external factors is applied. This will allow a better understating and a holistic view of the forces and their intensity toward job frustration [33]. The subsequent measure will depend on this dichotomy including the management strategies and the focus on controlled factors to enhance job satisfaction. The connection of these divisions with the theories in the conceptual framework Fig. 1 is a guide to better handling and defining approaches to enhance wellbeing in mental health setting.

The study's conceptual orientation was influenced by the MARS model and General Adaptation Syndrome. In particular, these frameworks ensured that workplace causes of job frustration and participants' adaptation strategies were explored during the preparation of the semi-structured interview guide Table 1. Instead than imposing preconceived theoretical categories, the study used an inductive thematic analytic technique, enabling themes to arise from the data. The frameworks were then applied to help analyse and contextualize the results.

## Objectives

Therefore, the objectives of this study were to explore the internal and external factors that contribute to mental health nurses' job frustration, as well as the adaptation strategies employed by these nurses to cope with their job frustration by answering the following research questions:

1. What are the internal and external factors affecting mental health nurses' and mental health nursing leaders' job frustration in mental health setting in Oman?
2. What are the adaptation strategies by both groups of mental health nurses to job frustration?

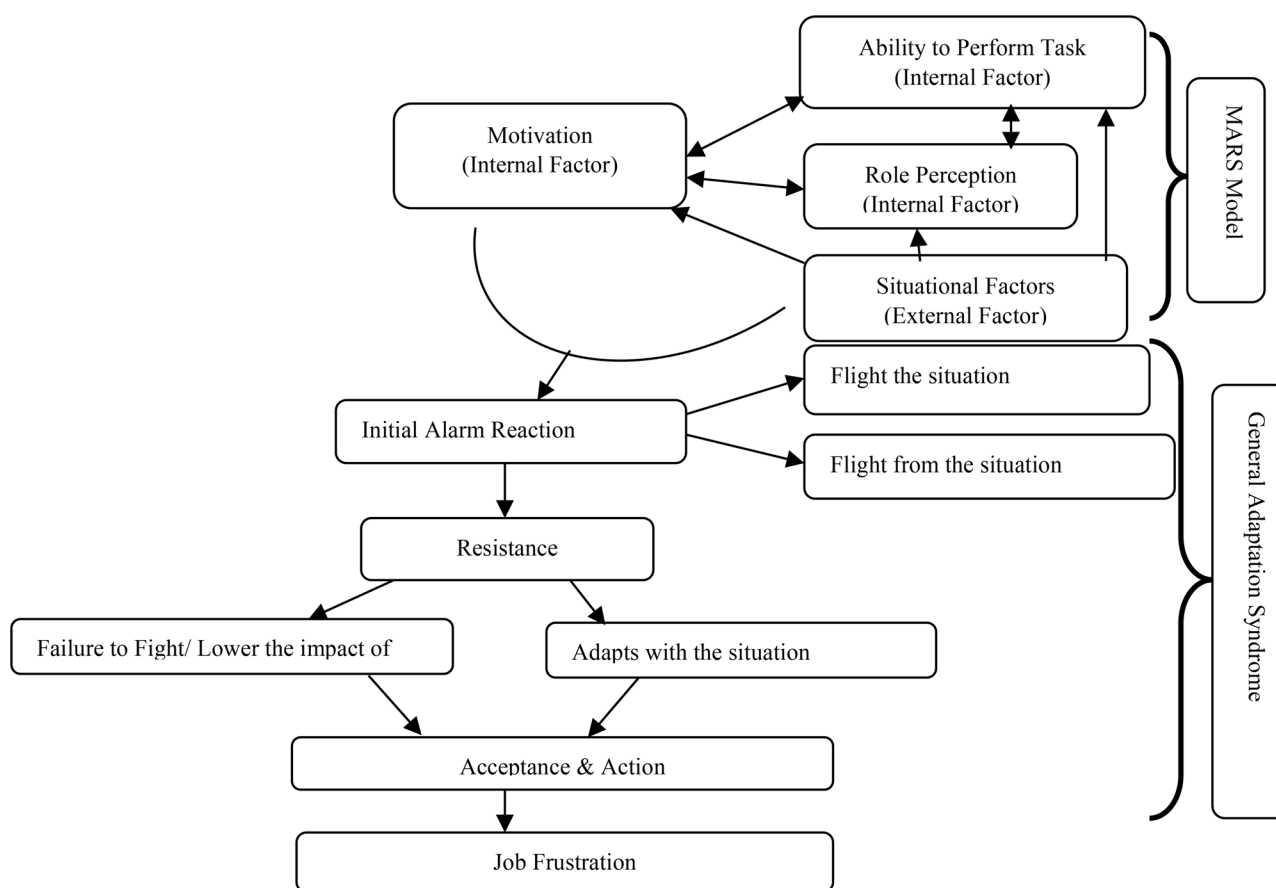


**Fig. 1** Conceptual framework of job frustration

**Table 1** Semi-structured interview guidelines in the FGDs

| Guide               | Questions/ Directions                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Introductory        | Greeting<br>Explaining the purpose<br>Obtaining consent, assure confidentiality and anonymity and right to withdraw at any time                                                                                                                                                                                                                                                                                                                                                                       |
| Opening             | Introduce self and brief about roles as mental health nurse<br>What encouraged you to work in mental health nursing                                                                                                                                                                                                                                                                                                                                                                                   |
| Main Questions      | Themes and objectives related:<br>What comes into your mind when I say “Motivation”, “Role Clarity” “Leadership” and “work-life balance”?<br>What influences job frustration in your work environment?<br>Describe specific challenges you face in clinical and leadership tasks?<br>Does job related stress impact your performance or social life? How?<br>What strategies help you to cope with or adapt to these challenges?<br>Are there work policies or practices that help reduce job stress? |
| Transition/ Probing | Can you provide examples/ elaborate / expressions of feelings/ meaning?<br>How did you cope up or adapt with the situation?<br>Was that helpful in managing the stress and how?                                                                                                                                                                                                                                                                                                                       |
| Closing             | Acknowledgement of participants<br>Asking if they have additional information to share                                                                                                                                                                                                                                                                                                                                                                                                                |

## Method

### Study design

A qualitative descriptive research design aimed to explore the various internal and external sources of job frustration among mental health nurses and mental health nursing leaders within the mental healthcare setting in Oman was employed in this study. Thematic analysis of transcribed data obtained from the focus group discussions (FGDs) was performed.

A qualitative design was used as it is most appropriate for studying complex, context-dependent experiences and meanings related to job frustration and adaptation among mental health nurses. Given the exploratory nature of the study and the limited existing evidence on culturally specific manifestations of job frustration in the Omani mental health nursing context, a qualitative approach allowed for in-depth understanding of participants' perceptions, interpretations, and lived experiences that cannot be adequately captured through predefined quantitative measures.

Furthermore, qualitative inquiry is particularly suitable when the purpose is theory formation and contextual comprehension rather than hypothesis testing. It made it possible to identify subtle internal and environmental elements that affect job frustration in this study, as well as the coping and adaption techniques employed by nurses in their actual workplace. In order to ensure that the domains of a locally grounded measuring instrument (OJFQ) represent genuine, data-driven constructs rather than imported assumptions, this technique was also crucial [3]. Additionally, the Omani Job Frustration Questionnaire (OJFQ) was developed using the qualitative phase as a foundational stage, guaranteeing that the instrument dimensions were based on participants' lived experiences and context-specific workplace realities [3].

### Ethics and consent

Prior ethical approval was obtained from the University Malaysia Sarawak (UNIMAS) Medical Research Ethics Committee (No.: FME/22/65) and the Research Approval Committee at MoH in Oman (No. Moh/CSR/22/25809). The study was conducted in accordance with the principles of the Declaration of Helsinki. Informed consent was obtained from all members of the purposively selected participants who agreed to participate in the study.

## Participants and recruitment

The recruited participants were purposively selected from Mental Health Hospital in Muscat, Oman, the only national tertiary mental health hospital in Oman to form the focus groups (mental health nurses and mental health nursing leaders) separately. The participants were included in the FGDs if they had more than two years of experience at the mental health hospital and performed shift-based 24-hour care. Despite having clinical administrative and supervisory responsibilities, mental health nursing leaders were also involved in the hospital shift system as clinical supervisors, making them qualified for the study. Leaders representing all managerial levels regardless of management qualifications, gender, and were actively on duty (i.e., not on official leave from work) for approximately three months before the start of the first interview. Participants who were on all kinds of regular leave such as annual, study, unpaid and maternity were excluded. The iterative process of recruitment was performed until ensuring saturation level was achieved with no newly generated perceptions and thoughts.

Therefore, participants were recruited using purposive sampling to guarantee inclusion of mental health nurses with appropriate clinical expertise and familiarity with the study environment. Potential participants were selected and invited by the primary investigator through email invitations and management referrals. All qualified nurses were informed about the study's goals, methods, confidentiality precautions, and planned use of the results prior to their involvement. Participation was fully optional, and participants were advised of their ability to decline participation or withdraw from the study at any stage without any ramifications to their career or professional position.

A total of 54 eligible nurses were approached for participation, of whom 42 consented to participate and 12 declined, largely owing to workload and schedule difficulties. There were no withdrawals from the study following enrolment.

To ensure the quality of the data obtained from this study, various strategies of saturation were achieved such as code frequency counts, stopping criterion and code meaning [48]. Code frequency counts were guided by reviewing the figures of new codes in each transcript until no new codes were recognized. The stopping criterion was guided by frequency counts where the number of FGDs is determined by no more additional new codes were identified. Code meaning is considered while reaching a full understanding of codes with no additional features, extents or distinctions of that particular code being acknowledged. In addition, triangulation was considered during the coding of the data which was independently done by two researchers.

## Data collection procedures

Because the study sought to capture shared understandings, social meanings, and collective patterns of workplace frustration among nurses working in similar situations, Focus Group Discussions (FGDs) were selected over individual interviews. The FGDs were conducted by the principal investigator (A.M. Al Zadjali), a female PhD candidate and Senior Specialist Mental Health Nurse with previous experience conducting qualitative research. The principle investigator had pre-existing professional contacts with several participants as colleagues and co-workers within the mental health services. The principle investigator had prior expertise in qualitative research through a master's degree phenomenology study and involvement in research review processes.

When examining workplace phenomena, FGDs are especially useful because participants can inspire each other's reflections, recall experiences more vividly, and expand on ideas that might not surface in one-on-one interviews. In order to comprehend job frustration in therapeutic contexts, this contact frequently produces greater data on organizational culture, typical stressors, and group-based coping mechanisms. Additionally, FGDs enabled the researcher to record the social construction of dissatisfaction and coping within the professional group rather than isolated individual narratives because nursing work is intrinsically team-based and affected by common organizational systems. This was particularly important for differentiating between individual coping variations and systemic problems (such as management, workload, and resources).

FGDs were also thought to be more effective in gathering a wide range of viewpoints in a condensed amount of time and encouraging discussion of delicate yet work-related topics in a peer setting where professionals are familiar with one another. To lessen power disparity and promote candid conversation, care was taken to guarantee homogeneity within groups (e.g., job similarities). However, individual variations and potentially delicate personal experiences were recognized as a limitation of FGDs and were lessened by appropriate moderating and confidentiality guarantees.

Therefore, the time and place of the interview were set by agreement between the recruited participants, hospital administration and the first author. A set of three semi-structured in-depth FGDs were conducted in the English language for each group of nurses (mental health nurses and mental health nursing leaders) separately in comfortable isolated meeting rooms for quality responses. The interview questions were developed for the purpose of this study Appendix 2. The investigator intended to facilitate the in-depth discussion through probing questions. The discussion in the focus group started with general topics and gradually got into more specific ones. In order to cover individual, organizational, and situational factors that contribute to job frustration as well as adaptation and coping mechanisms among mental health nurses, the interview guide was guided by the MARS model and GAS. The questions were the same for both nurses' group and leaders' group. The interview guidelines which was semi-structured illustrated in Table 1. The study objectives and pertinent literature served as the basis for the development of the FGD guide; however, it was not fully piloted before data collection. No significant changes to the guide were necessary because it was determined after the first talks that the questions were adequate and straightforward for gathering participants' experiences and viewpoints.

The 42 participants (21 mental health nurses and 21 mental health nursing leaders) were involved in six FGDs separated from each other with an average duration of 83 min interview period from January to May 2024. Each FGD consisted of 6–8 participants with consideration of homogenous grouping based on roles where mental health nurses' groups were separated from mental health nursing leaders' groups. This is to reduce any hierarchical influences on disclosure and to encourage conversation among people with comparable working roles and experiences. The groups were not further separated according to gender, nationality, seniority, or clinical unit, as participants shared a common organizational and clinical context inside the mental health facility. Data collection continued until thematic saturation was reached. The discussion was tape-recorded for future reference for data analysis. Transcripts and findings were not returned to participants for verification. During the first FGD, one co-investigator was present as an observer.

The FGD guide was made to be open-ended so that participants could freely share their experiences, even if it contained questions based on the MARS framework (such as motivation, role clarity, leadership, and work-life balance). New and unexpected topics emerged as a result of the use of probing inquiries to investigate problems outside of the predetermined boundaries.

## Language and translation process

Since English is the standard language for professional communication, clinical documentation, and multidisciplinary practice in the mental health institution, the FGDs were mostly performed in English. Every participant spoke English fluently and felt at ease using it during the conversations. Participants did, however, occasionally use Arabic terms or phrases to communicate culturally distinct ideas or professional experiences that were better conveyed in their mother tongue. The principle investigator, who is bilingual in Arabic and English, kept these expressions during transcription and then translated them into English. A bilingual co-investigator reviewed the translation for correctness and conceptual equivalency, and any issues were settled by debate and consensus. Instead of depending on a word-for-word translation, this method made guaranteed that meaning was maintained.

## Data analysis

Data were examined inductively using thematic analysis. Coding and topic development were data-driven and not limited to predetermined theoretical categories, even if the interview guide was informed by the theoretical frameworks. To enable themes to surface from the data, an inductive coding approach was used in the data analysis. The earliest sensitizing principles were informed by the MARS framework, although coding was not restricted by it. Rather, it was used to aid in the organizing and contextual comprehension of the results during the interpretation stage. This method made sure that both new and framework-aligned themes were recorded.

The data obtained for this study were transcribed and translated accurately as some participants used Arabic terminologies to ensure convenience and understanding by other authors. Data were analyzed using a framework-informed (hybrid inductive–deductive) thematic analysis aided by NVivo 14 software following the principles of a six-step process developed by Braun and Clarke [25], i.e., familiarizing with the data, coding, setting and examining themes, and generating written descriptions, while ensuring accuracy by referring to recorded data. However, NVivo 14 software was not used as analytic method. Incorporating MARS Model through the six phases of thematic analysis was considered throughout the analysis of the data aiding in identification of the themes [65] Table 2. This method blended deductive coding guided by the MARS framework, which offered sensitizing notions linked to motivation, ability, role clarity, and situational factors, with inductive coding, which allowed themes to arise directly from the data. After initial coding was finished, the framework was used to support theme organization and interpretation rather than limiting analysis to predetermined categories.

Initial coding was data-driven and inductive, while the conceptual framework was subsequently used to organize and interpret findings. Two independent researchers (the first and second authors) analyzed the data. Before beginning to code, both researchers independently read and re-read the transcripts to become familiar with the data. Inductive and deductive methods were combined to create the initial codes. While deductive coding was guided by the MARS framework to capture predetermined sensitizing concepts linked to motivation, ability, role clarity, and situational circumstances, inductive coding made it possible to identify concepts that emerged organically from the data. The first coding outputs of the two programmers were compared and discussed. Any

**Table 2** Incorporation of MARS model with six-step process of Braun and Clarke [25] of thematic analysis

|         |                              |                                                                                                                                                                                                                                                                                                                                                                                |
|---------|------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Phase 1 | Getting to Know the Data     | Reading through the qualitative data obtained from FGDs to familiarize with it. Clear out instances in which participants bring up elements of the MARS model, such as:<br>✓ situational factors (e.g., poor work environment),<br>✓ role perception (e.g., unclear job expectations),<br>✓ ability (e.g., feeling underqualified),<br>✓ or motivation (e.g., lack of rewards) |
| Phase 2 | Making the first codes       | As to begin to code the data, the codes are created that reflect the MARS factors. For example, codes could include terms like “effort-reward imbalance,” “role clarity,” “insufficient resources,” or “negative work conditions.”                                                                                                                                             |
| Phase 3 | Searching for themes         | The codes would be grouped into more general categories surfacing the MARS framework. A collection of codes pertaining to “lack of motivation” can, for example, create a topic regarding employee disengagement. Similarly, a theme about inadequate training and development may be formed by codes pertaining to capacity (e.g., role perception and clarity).              |
| Phase 4 | Examining the themes         | The themes would be examined and improved to make sure they appropriately depict the facts. They can be combined or reinterpreted themes of motivation (like irritation over unclear roles) if they appear to overlap with role perception themes (like confusion about job tasks) to ensure that they clearly relate to the MARS model.                                       |
| Phase 5 | Themes definition and naming | Each theme would explicitly be outlined after being decided on them. “Frustration Due to Role Ambiguity,” for instance, may be a theme that closely relates to role perception according to the MARS model. The theoretical foundation of each theme is ensured by connecting them to MARS.                                                                                    |
| Phase 6 | Putting together the report  | Writing the analysis would include making links between the MARS model and the themes that were found. It would describe how issues like low motivation or a lack of skills lead to job dissatisfaction and provide data examples to show how each MARS factor appears in workers’ experiences.                                                                                |

disagreements were settled by consensus and discussion. A third member of the study team was consulted to help resolve situations where consensus could not be achieved. After that, codes were arranged into first themes, which were then iteratively examined and improved to guarantee coherence and internal consistency with the dataset.

To guarantee agreement on interpretation and conceptual clarity, the entire research team examined and validated the final themes. Both framework-informed and data-driven discoveries were sufficiently reflected in the final analysis.

The MARS model offers a framework for comprehending the various reasons why people become frustrated at work, and theme analysis enables to find, arrange, and analyze the data in a way that emphasizes these reasons. In order to increase the validity of the study and guarantee that the conclusions are logically supported by the literature on organizational behavior, each stage of the thematic analysis method aids in identifying patterns and themes that can be directly mapped to the MARS variables.

The study was reported according to the Consolidated Criteria for Reporting Qualitative Research (COREQ) 32-item checklist to enhance transparency and completeness of reporting – Appendix 1, COREQ 32-item Checklist Summary.

### Trustworthiness and reflexivity

Alongside data collection and analysis, an iterative procedure was used to assess data saturation. The point at which subsequent FGDs produced no new codes, categories, or significant concepts and when new information only confirmed pre-existing themes was referred to as saturation. Both participant groups, saturation was evaluated. After the fourth FGD, no new codes were found among mental health nurses, but by the fifth FGD, mental health nursing leaders had attained saturation. Overall thematic saturation was indicated by the sixth FGD, which verified duplication in both groups and revealed no new conceptual information.

In reference to Schwandt et al. [68] Model regarding the trustworthiness of the qualitative data representing four criteria which are: credibility, transferability, dependability and confirmability [45]. The rigor of the method utilized is ensured through initial check for accuracy of interview interpretation (credibility), mutual agreement regarding coding of data throughout the data collection process (dependability), reflexive note keeping and peer discussion for agreement over ideas to control bias (confirmability) and clarity of the approach description particularly the context, setting and participants for applicability to different settings (transferability). Formal member checking was not undertaken following data analysis. Nevertheless, credibility and confirmability were enhanced through researchers review of coding decisions, maintenance of an audit trail, reflexive memo writing, and the use of participant quotations to support thematic interpretations.

Additionally, the researcher is being a mental health specialized professional with long clinical, administrative and academic experience had a potential influence toward data interpretation. In order to avoid such kind of bias, note keeping was considered throughout the research study and discussing it with co-researchers and experts to ensure the authentic representation of study participants' voice. The rich data which were generated from the qualitative phase had indicated multi-dimensional feature of job frustration and adaptive measures among nurses in mental health setting in Oman.

Although the principal investigator has contextual familiarity with the clinical setting and participant experiences, pre-existing professional ties with some participants may induce bias. Reflexivity was upheld during the entire study process in order to address this. In order to promote candid and open communication during data collection, the researcher used a neutral facilitation method and placed a strong emphasis on confidentiality and voluntary involvement. Participants received assurances that their answers would not have an impact on their professional status or career.

In order to critically assess interpretations and reduce the impact of individual presumptions, the research team participated in ongoing reflective discussions throughout data analysis. Interpretive rigor was further improved by two researchers coding independently and then reaching a consensus. These tactics made it possible for the results to stay based on participant narratives rather than the researchers' assumptions.

## Findings

In reference to Table 3, there were 42 participants equally representing mental health nurses and mental health nursing leaders working in mental health setting in Oman with their basic demographic details.

The three main themes are extracted from the data analysis represented in Table 4. Including the responses of both groups of participants. This was guided by the developed conceptual framework of the cycle and psychology of frustration in consideration of MARS Model and General Adaptation Syndrome (GAS) presented in Diagram1.

**Table 3** Demographic representation of the included sample ( $N=42$ )

| Characteristics                                       | $N$ (42)                        |                                          |
|-------------------------------------------------------|---------------------------------|------------------------------------------|
|                                                       | Mental health nurses ( $N:21$ ) | Mental health nursing leaders ( $N:21$ ) |
| <b>Age (years)</b>                                    |                                 |                                          |
| Less than 30                                          | 10                              | -                                        |
| 31–40                                                 | 11                              | 17                                       |
| <40                                                   | -                               | 4                                        |
| <b>Gender</b>                                         |                                 |                                          |
| Male                                                  | 9                               | 6                                        |
| Female                                                | 12                              | 15                                       |
| <b>Marital Status</b>                                 |                                 |                                          |
| Married                                               | 15                              | 17                                       |
| Single                                                | 6                               | 3                                        |
| Divorced/Widow                                        | -                               | 1                                        |
| <b>Children</b>                                       |                                 |                                          |
| 0                                                     | 6                               | 5                                        |
| 1–2                                                   | 3                               | 1                                        |
| <3                                                    | 12                              | 15                                       |
| <b>Qualification</b>                                  |                                 |                                          |
| General Diploma                                       | 5                               | 2                                        |
| Specialized Diploma (management and/or mental health) | 9                               | 15                                       |
| BSc                                                   | 7                               | 2                                        |
| MSc                                                   | -                               | 2                                        |
| <b>Years of experience</b>                            |                                 |                                          |
| <5                                                    | 6                               | -                                        |
| 5–15                                                  | 15                              | 11                                       |
| 15–25                                                 | -                               | 8                                        |
| >25                                                   | -                               | 2                                        |
| <b>Workplace</b>                                      |                                 |                                          |
| Adult Psychiatry                                      | 13                              | -                                        |
| Addiction                                             | 3                               | -                                        |
| Child and Adolescent                                  | 1                               | -                                        |
| Ambulatory                                            | 3                               | -                                        |
| Forensic                                              | 1                               | -                                        |
| Clinical Administration                               | -                               | 21                                       |
| <b>Financial Grade</b>                                |                                 |                                          |
| <4 (\$4500)                                           | -                               | 2                                        |
| 5–10 (\$2500-\$4500)                                  | 13                              | 19                                       |
| <10 (\$2000 -\$2500)                                  | 8                               | -                                        |

**Table 4** Main themes and sub-themes emerged from the interview analysis with findings in both groups

| Themes                                                      | Sub-themes                                                       | Mental health nurses                                                                                                                          | Nurse leaders                                                                                                                                                                                                                                                                    |
|-------------------------------------------------------------|------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <i>Theme 1:</i><br>Internal factors to job frustration      | 1 Role perception and engagement                                 | No engagement<br>No clear roles                                                                                                               | No engagement, unclear job description, low value to abilities, interests and qualifications                                                                                                                                                                                     |
|                                                             | 2. Effort-reward imbalance                                       | no reward in doing key nursing<br>Reward is internal feelings after helping patients                                                          | Absence of grade promotion with position or qualification, power and authority, equality in rewarding, putting right person in right place                                                                                                                                       |
|                                                             | 3. Work-life balance                                             | Family is priority<br>Family pressure<br>Shift duties                                                                                         | Lack of awareness of personal and professional relationships among staff<br>Duty extends beyond working hours/ days                                                                                                                                                              |
|                                                             | 4. Self-efficacy                                                 | Regret to enter nursing and mental health specialty, learn art of dealing with others in life                                                 | Not kept in right place<br>Does not belong to psychiatric field<br>Selection of leaders are by face                                                                                                                                                                              |
| <i>Theme 2:</i><br>External factors to job frustration      | 1. Workplace environment                                         | Ward acuity level, Workload, staff shortage, Foreign staff Lack of assertiveness                                                              | Lack of understanding/ empathy and support<br>Underestimation of nursing in decision making                                                                                                                                                                                      |
|                                                             | 2. Obligatory and blame culture                                  | Excess of policies/ papers, blame to nursing, Lack of acknowledgement                                                                         | Lack of acknowledgment & clarity of policies, excess of rules and protocols<br>Focus on negative aspects of incidents                                                                                                                                                            |
|                                                             | 3. Reciprocal communication                                      | Limited open communication with leaders, Command-oriented leadership style                                                                    | Miscommunication, No change after reporting, coercion, Uncooperative multidisciplinary team                                                                                                                                                                                      |
|                                                             | 4. Job insecurity                                                | Reallocations, Internal transfers/ attachment, Omanization                                                                                    | Omanization<br>Reallocation or shuffling of staffs                                                                                                                                                                                                                               |
| <i>Theme 3:</i><br>Adaptation strategies to job frustration | 1. Personal-oriented                                             | Acceptance, Silence, adjusting, Escape through transfer in/ out or, Retirement, Positive thought about stress, Believing the stress is normal | Acceptance, Ignorance, Silence, Adjusting mindset to stress, Escape through transfer in/ out or Retirement, Emotional intelligence, Interest in psychiatric field, Professional isolation                                                                                        |
|                                                             | 2. Professional-oriented (Role, Leadership and Work environment) | Believe that it is humane duty<br>Believe that it is low stress than other medical fields                                                     | Believe that it is humane duty, Ignorance, supporting subordinates, seek opportunities, Staff rotation, Debriefing sessions, Reflection on experience, keep staff on regular morning shift as a reward, extend cooperation with colleagues at times of shortage, improve mindset |

## Theme 1: Internal factors of job frustration

### Subtheme 1.1 Role perception and engagement

#### Mental health nurses' perceptions

Participants from both groups highlighted the importance of clear job descriptions for nurses. The following statements are indicating this:

*Mental health nurse participant (MHNP) 1: 'we will be un-satisfied when the role is not fully clear'.*

In addition to role clarity, most of the participants in both groups visualized the non-engagement intentions of the leaders in a severe disappointing statement where the reaction was not favorable:

MHNP 11: *'just drag and shackle'*

MHNP 14: *'and ... what happened, most of the nurses did not come for duty'*.

### **Mental health nurses' perceptions**

Most of the participants visualized the non-engagement intentions of the leaders in a disappointing statement where the reaction was not favorable:

*Mental health nursing leader participant (MHNLP) 16: 'You have to convince the staff. Me I am not convinced how I will convince the staff it was very frustrating'.*

*MHNLP 9: 'Especially if they are taking decisions without consulting the end users...so, it will cause stress for the in charges for the supervisor, even for the staff'.*

For nurses being allocated a new task without prior information, some of the leaders conveyed understanding of not being involved during the decision-making phase but objected on the provision of prior information before the implementation of the decision. The following statements represents this as:

*MHNLP 12: '...expanding the team might bring many conflicting ideas... [therefore] the top management may say, 'I cannot consult everyone.'*

They added that having a gap between levels of management could be main reason for non-engagement attempts. The following is an example:

*MHNLP 16: 'there is a gap in between us and the top management in terms of the decision making, we are in charges, we are not involved in all decisions.'*

The leaders linked the role perception with their level of qualification and experience. The following statements support this:

*MHNLP 3: 'According to our qualifications and experience, we are not kept in the right place... [sometimes] we feel we have the ability to give more, but we are not given the opportunity to do so.'*

The results show that work dissatisfaction among mental health nurses and mental health nursing leaders is greatly influenced by ambiguous role expectations and little participation in decision-making. This implies that in clinical and management professions, perceived lack of engagement lowers professional ownership and discontent. Mental health nursing leaders concentrated more on structural gaps between management levels and the restricted chance to participate in higher-level choices, whereas mental health nurses mainly encountered this issue through its direct impact on daily work organization and task execution. Overall, this subtheme identifies limited participative leadership and role uncertainty as major sources of workplace frustration.

### **Subtheme 1.2 Effort-reward imbalance**

#### **Mental health nurses' perceptions**

Mental health nurses presented demotivation as follows:

*MHNP 19: 'I don't want to be a key nurse because it is additional work without any reward.'*

Some of participants feel satisfied internally supported by their believed and values by doing good for the patients. They said:

*MHNP12: 'you help somebody, it is very rewarding.'*

### **Mental health nursing leaders' perceptions**

This point is mostly highlighted by mental health nursing leaders group perceiving that there is no special compensation for those who have higher qualifications as well as additional workload as stated:

*MHNLP 3: 'I obtained a master's degree, yet it made no difference to my salary or recognition'.*

*MHNLP 1: 'being appointed to the position and given a lot of responsibility, which you are not paid for'.*

*MHNLP 5: 'Greater responsibilities without corresponding compensation reduce motivation to take leadership roles.'*

There is limited motivation among junior to undergo succession planning because of low motivation. This is supported by following statement:

*MHNLP 18: 'after seeing the senior how struggling and even they don't have the power, authority and the junior definitely will not have the interest'.*

*MHNLP 16: 'Even the shift in charge they are not interested to do'.*

In addition, the acknowledgment of one's capabilities is perceived as a form of effort-reward balancing attempt. This is supported by following statement:

*MHNLP 3: 'Formal motivation is acknowledgement and promotion... [by] putting the right person in the right place and giving them the opportunity to contribute according to their abilities.'*

Moreover, there is a perception of inequality while appreciating the staff. It is stated by participant as follows:

*MHNLP 16: 'Recognition loses its value when staff perceive appreciation as unequal.'*

The finding shows that both groups clearly see an imbalance between effort and reward, especially when it comes to workload, credentials, and recognition. This implies that feelings of professional undervaluation and motivation are weakened by perceived unfairness in incentive systems. While mental health nursing leaders highlighted systemic disparities in promotion, pay advancement, and recognition associated with hierarchy, mental health nurses concentrated more on the emotional and task-related load without commensurate incentives. Overall, this indicates a structural mismatch in reward systems that disseminates work dissatisfaction at various organizational levels.

### **Subtheme 1.3 Work-life balance**

#### **Mental health nurses' perception**

It has got two dimensions among participants in considering the mental health workplace which are: a choice having an obstacle, non-choice without obstacle. The choice is explained in being interested in mental health specialty or having no choice to go elsewhere with less workload than mental health setting and closer to accommodation. Whereas, the obstacle is explained as the location of the hospital for some participants. In Omani culture, people value their family and personal life more than work as evident with some clear statements from the participants:

MHNP11: *'we are thinking all about our family we need to work near from our house'.*

MHNP1: *'I can manage stress inside the hospital... but stress from outside the hospital, such as [family and personal] responsibilities, creates additional pressure.'*

Similarly, gender-oriented pressure is expressed by some of the participants from general nursing group thinking that this is a shared challenge of nursing as a profession, as follows:

MHNP1: *'Shift work creates additional challenges for women in balancing family and professional responsibilities.'*

MHNP11: *'Family responsibilities during shift work often increase stress and distraction at work.'*

### **Mental health nursing leaders' perception**

In addition to valuing social life, the female mental health nursing leaders perceive themselves frustrated due to work pressure affecting their personal life as illustrated in the following statement:

MHNP6: *'Leadership responsibilities frequently extend beyond official working hours and continue during days off.'*

Furthermore, due to the social relations outside work, the positions at work gets affected by one's role. The following is example statements from the participant:

MHNP5: *'Personal relationships sometimes interfere with professional leadership responsibilities.'*

The findings imply that, despite being experienced differently by each group, work-life imbalance is a common stressor. While mental health nursing leaders emphasized the extension of work demands beyond official working hours due to managerial obligations, mental health nurses largely linked this mismatch to shift work and family responsibilities. This suggests that work-life conflict is not simply personal but also ingrained in the organization's structure. In general, this subtheme illustrates how a major factor in job dissatisfaction is the blurring of personal and professional boundaries.

### **Subtheme 1.4 Self-efficacy**

#### **Mental health nurses' perceptions**

Some of the participants joined mental health field without interest and trying to adjust, however, they find themselves more in medical field. The following statements are examples:

MHNP16: *'it's a mistake. I don't have that much experience. And I'm expecting to like it here.'*

MHNP20: *'that was not my choice... actually I like the critical care area, I adjusted here.'*

There is who even wished to have worked out of nursing as a profession:

MHNP19: *'to be in nursing is a big mistake. Till now, I'm still settling'.*

Mental health nurses determined psychiatric field as a way to learn how to deal with people in personal life outside work as a self-determination. This was supported by following statements:

*MHNP 2: 'you can learn from psychiatry, how you are dealing with others in your personal life like more patience with your children with your family'.*

### **Mental health nursing leaders' perceptions**

Respondents highlighted an important dimension which indicates that their expectations exceed the allocated tasks causing disappointment and frustration in long term as stated:

*MHNLP 3: I don't feel myself that I am kept in the right place, so my self-efficacy is unstable.*

Others thought of returning back to medical field where they feel themselves belong to and well-determined:

*MHNLP 12: 'I realized later that I belonged in ICU... because that was what I thought nursing itself would be.'*

In the recent years, there is reluctance to hold managerial position as well as disappointment from leaders towards training next successors where they stated:

*MHNLP 1: 'Participants perceived that leadership selection was not always based on capability or merit.'*

The findings show that perceived misalignment between individual competency, job placement, and professional expectations shapes self-efficacy in both groups. This implies that employees' confidence and motivation suffer when they believe they are not properly positioned or have no influence over their career path, which can lead to long-term discontent. Although some obtained adaptive awareness of the area via patient engagement, mental health nurses often voiced confusion about their career choice and sensed mismatch with psychiatric nursing. Similar feelings of misplacement, unfulfilled professional expectations, and a lack of opportunity for succession planning and leadership development were expressed by mental health nursing leaders. Overall, this subtheme illustrates how self-efficacy is weakened and persistent job frustration in mental health services is exacerbated by a decreased perceived fit between position, identity, and career goals.

### **Cross-group synthesis of Theme 1 (internal factors to job frustration)**

Internal factors of job frustration were consistently associated with position ambiguity, perceived effort-reward imbalance, work-life conflict, and decreased self-efficacy in both mental health nurses and mental health nursing leaders. But there were clear disparities in how these things were perceived. While mental health nursing leaders also stressed organizational and structural limitations affecting their capacity to exercise autonomy and leadership, mental health nurses mainly focused on the immediate effects of unclear roles and workload on day-to-day clinical practice. Despite these distinctions, both groups agreed that work dissatisfaction in mental health settings is greatly influenced by internal psychological and professional issues.

## **Theme 2: External factors to job frustration**

### **Subtheme 2.1 Workplace environment**

#### **Mental health nurses' perception**

Mental health nurses highlighted the stressful environment in mental health setting as indicated in terms of the ward situation with loaded care to mentally ill patients. The following statement are examples:

*MHNP13: 'High patient acuity and staff shortages contribute to burnout and frustration.'*

As an expatriate nurse, it is believed that they must not refuse any task allocated; therefore, they are frustrated with workload. The following statement represents this:

*MHNP15: 'As expatriate nurses, we often feel unable to refuse additional responsibilities.'*

### **Mental health nursing leaders' perceptions**

The general feature of the work environment in mental health hospital is described as good due to the team, however, there are some pressure on mental health nursing leaders to be understood as stated by participants:

*MHNLP 1: 'The culture in psychiatric nursing is very pleasant, with good communication and interaction... but when people do not understand you, it becomes difficult to grow professionally.'*

Similarly, it has identical view in terms of the support from management and different view in terms of the overall work environment as follows:

*MHNLP 16: 'I previously worked in a smaller setting where teamwork and support were stronger.'*

There is underestimation of nursing profession in mental health institution as stated by one of the participants who joined mental health hospital lately:

*MHNLP 16: 'compared from where I came, here honestly I feel like some decisions that is different, totally different, like under estimating staff nurses'.*

The workplace environment emerged as a significant external source of job frustration, but it was experienced differently by the two groups in terms of intensity and emphasis. The immediate clinical impact of high patient acuity, staffing shortages, and ongoing exposure to emotionally demanding behaviors like violence and distress were highlighted by mental health nurses. Feelings of burnout and emotional tiredness were reinforced by these circumstances, which led to a perception of continuous workload pressure with little restoration time.

In contrast, while acknowledging the generally pleasant team environment, mental health nursing leaders also brought attention to structural and relational conflicts within the system. Concerns about interprofessional understanding, organizational support, and the perceived undervaluation of mental health nursing within larger institutional hierarchies were all evident in their reports.

For both groups, the workplace was a psychosocial context that influenced stress exposure rather than just a physical location. Nonetheless, mental health nursing leaders concentrated on system-level limitations and recognition problems, whereas mental health nurses concentrated on the direct care load, showing disparate positioning experiences within the same setting.

## **Subtheme 2.2 Obligatory and blame culture**

### **Mental health nurses' perceptions**

In an environment with limited freedom of action and a more obligatory and blame approaches, nurses revealed frustration stating:

*MHNP 2: 'Whatever it's happening with the patient they are blaming the nurse'.*

*MHNP 12: 'I think one of the problems is we have lots of paper, lots of policy'.*

## Mental health nursing leaders' perceptions

In an environment with high restrictions perceived, one may develop frustration with prolonged stay in this place. It gets worsen if manifested with blame culture. Mental health nursing leaders revealed frustration in this dimension stating:

*MHNLP 5: 'All responsibilities seem to fall on the in-charge... and when every mistake comes back to us, we eventually reach a point of frustration.'*

*MHNLP 1: 'You may do your best for the patient, staff, and the system... but at the end, a small blame remains and there is little recognition for what you have done.'*

*MHNLP 12: 'Many years of good performance can be overshadowed by a single mistake.'*

Moreover, participants perceived that any incident happens they will be blamed even if they have nothing to do with it. The following statement represents this:

*MHNLP 13: 'Any incident tends to become a blame on nursing because we are with the patients 24 hours a day... even when it is not a nursing mistake.'*

Additionally, the excess of policies and practice guidelines keeps the nurses mislead and ultimately frustrated. This was evident by various participants as:

*MHNLP 5: 'even the rules, there is conflict with what we have, as a system we work in, and we don't have a clear path for the problem resolution'.*

*MHNLP 3: 'sometime high authority put you in a situation you feel lost you cannot give anything to patients because of the protocols rules which they provide'.*

As well as, the conflicting interest out of new policies may cause frustration and breakdown of interpersonal relationships, as stated:

*MHNLP 1: 'Frustration comes when things are not clear... a policy may be clear to one person but not to another, and eventually relationships become affected.'*

The existence of an obligatory, rule-bound, blame-oriented corporate culture that restricted psychological safety was a recurring theme in both groups. Regardless of the situation, mental health nurses reported feeling always responsible for unfavorable outcomes, which increased defensive behavior and fostered a dread of making mistakes. A feeling of limitation and diminished autonomy in clinical decision-making was further exacerbated by the volume of policies and procedural documentation.

Mental health nursing leaders also felt more accountable, but from a managerial perspective, this was made worse by hierarchical expectations and a lack of effort acknowledgment. The emotional strain of being the "final responsible person," even in situations when judgments were impacted by higher administrative levels or ambiguous instructions, was highlighted by leaders in particular.

Together, the two groups created a common narrative about a punitive society that emphasized mistakes above accomplishments. In addition to causing irritation, this culture also led to lower motivation, damaged relationships, and a decreased inclination to take initiative.

## Subtheme 2.3 Reciprocal communication

### Mental health nurses' perceptions

The general nurses concern mostly focused on the limited open communication with the leaders who are giving commands for clinical-related practices, they stated as follows:

*MHNP 8: 'We raised concerns about admitting aggressive patients because of risks to others... but some supervisors did not accept our concerns.'*

*MHNP 3: 'I worked in the same ward for a long time and repeatedly requested a transfer... my frustration was related more to leadership decisions than patient care itself.'*

*MHNP 9: 'being a leader is not just only giving commands with your work'.*

### Mental health nursing leaders' perceptions

The participants supported the fact of limited accessibility to top managers is a threat to their stress control and counter approved it being evident in their stated views from own experiences:

*MHNLP 1: 'if you set a policy or protocol, which I can say not supporting me... you should come and listen to me first talk to me.'*

*MHNLP 5: 'There are times when concerns raised by frontline leaders do not appear to reach senior management.'*

*MHNLP 3: 'Meetings focus mainly on administrative issues rather than staff concerns.'*

However, there is a contradicting thought from higher level of nursing management in terms of accessibility and approach. The following statement is an example:

*MHNLP 10: 'Formal communication channels exist, although their effectiveness is perceived differently across staff groups.'*

The leader related approach and accessibility is questioned where employees are unable to be assertive towards additional time bound tasks. The following statements are examples of this:

*MHNLP 3: 'sometimes they give you assignments that you cannot say no sometimes you have to do it because it is late'.*

It is also linked with multidisciplinary team i.e. doctors who are not willing to cooperate:

*MHNLP 12: 'Limited cooperation within multidisciplinary teams can contribute to frustration.'*

Overall, the participants have stressed on the importance of clear communication between various groups. As stated,

*MHNLP 9: 'Communication can either reduce frustration or intensify it depending on how it is managed.'*

Reciprocal communication, which reflects failures in the bidirectional flow of information between frontline mental health nurses, mental health nursing leaders, and larger multidisciplinary teams, has been identified as a major factor of job discontent. Communication was characterized as hierarchical, directive, and frequently insensitive to feedback from clinical practice rather than as an impartial exchange of information. Mental health nurses

perceived communication primarily as top-down teaching with little room for clinical discourse or debate. In spite of frontline concerns about patient risk, staffing capacity, and safety, mental health nurses reported instances in which clinical judgments, including patient allocation or task distribution, were enforced. This strengthened beliefs that their clinical judgment was underappreciated and led to a feeling of diminished professional autonomy. As a result, communication was seen as directive control rather than collaborative, which led to dissatisfaction and disengagement.

However, from a different positioned stratum, mental health nursing leaders brought attention to communication problems. They highlighted a “gap” in upward communication where issues brought up from clinical areas were thought to not be completely acknowledged or addressed, and they highlighted the restricted access to top management. Additionally, mental health nursing leaders cited administrative meetings that limited meaningful discussion about workplace stressors by concentrating mostly on operational problems rather than emotional or practice-related difficulties. As a result, there was a feeling of being torn between frontline reality and executive orders, with little ability to change either.

Despite these disparities in positional experience, both groups converged on the occurrence of misunderstanding, delayed feedback loops, and ambiguous transmission of instructions across hierarchical levels. Furthermore, tensions were exacerbated in interdisciplinary encounters, especially with doctors, where emotional strain and diminished team cohesion were attributed to perceived lack of cooperation.

Overall, reciprocal communication functioned not only as an operational issue but as a relational stressor that influenced views of authority, inclusion, and professional respect. The results imply that communication breakdowns in this situation represented broader structural and power imbalances within the healthcare system rather than just informational gaps, which ultimately increased both groups’ job frustration.

## Subtheme 2.4 Job insecurity

### Mental health nurses’ perceptions

In this study, job insecurity had been mostly highlighted by expatriate mental health nurses, as stated:

*MHNP15: ‘I have been preparing already to transfer to another country, but if I have a good tenure ship here, I will stay’.*

*MHNP21: ‘Employment uncertainty creates significant stress for expatriate staff.’*

### Mental health nursing leaders’ perceptions

In this study, insecurity had taken two dimensions where foreign nurses jointly shared in different levels of practice being unsure of the length of their employment due to sudden termination policy. They stated:

*MHNLP 9: ‘but because of the threat of an Omanization of course job insecurity is there. So, we are ready for entertaining the possibility’.*

Even the Omani mental health nursing leaders approved this thought by statements:

*MHNLP 1: ‘they’re not feeling secure about their jobs’.*

In reference to local nurses, their insecurity was reflected in their sense of feeling de-valued as humane rather being treated objects in running the service. This is evident in their verbalized statements as:

*MHNLP 10: ‘Feeling undervalued reduced commitment to remain in the organization.’*

*MHNLP 16: 'The repeated postponement of staff shuffling affects trust in management and how staff perceive decisions they are not satisfied with.'*

Job insecurity was found to be a major psychological stressor, especially for foreign mental health nurses, but it also affected mental health nursing leaders in many ways. Contractual uncertainty, possible termination, and instability connected to migration were the main causes of insecurity among mental health nurses. Long-term dedication to the institution was often questioned, which led to a feeling of professional fragility.

Mental health nursing leaders used two different lenses to express their insecurity: local mental health nursing leaders highlighted a different type of insecurity related to perceived devaluation, organizational decisions, and lack of trust in administrative processes, while expatriate mental health nursing leaders expressed concerns similar to those of mental health nurses regarding employment stability.

Overall, job insecurity served as a more comprehensive structural stressor that went beyond employment status to encompass emotional instability, professional ambiguity, and diminished faith in organizational justice. The feeling of workplace instability was heightened by the convergence of these characteristics.

### **Cross-group synthesis of Theme 2 (external factors to job frustration)**

External factors, notably those pertaining to the workplace environment, organizational culture, communication processes, and job insecurity, were repeatedly cited as major causes of job discontent among mental health nurses and mental health nursing leaders. High workload demands, little organizational assistance, and a perceived blame-oriented culture that increased stress and decreased psychological safety at work were all mentioned by both groups. Feelings of being ignored and underappreciated were frequently attributed to communication problems between operational workers and upper management.

However, there were variations in how these outside forces were perceived. While mental health nursing leaders emphasized systemic and managerial issues like policy implementation, administrative limitations, and accountability pressures, mental health nurses primarily focused on the immediate effects of workload, staffing shortages, and direct exposure to clinical pressures. Both groups agreed that organizational structures and communication systems are crucial in determining job frustration in mental health settings, despite emphasis on these variances.

## **Theme 3: Adaptation strategies**

### **Subtheme 3.1 Personal-oriented**

#### **Mental health nurses' perceptions**

Silence behavior, mindset, escape, emotional intelligence, self-development, ignorance, isolation and acceptance are expressed thoughts to cope with frustration as stated:

*MHN12: 'We prefer to be silent. if no stress we will not learn'.*

*MHN21: 'It's more in the mindset actually if you don't condition your mind to do the stressful things, this just will continue'.*

*MHN15: 'Before you hit the rock bottom level, try to think of going up again, by doing other challenges in your life, going to different fields or different locations'.*

MHNP12: *'we prefer be silence. if no stress we will not learn. if you're helping other people with that, at least you have something that you feel that you're proud of yourself.'*

MHNP21: *'it's more in the mindset actually if you don't condition your mind to do the stressful things, this just will continue it will lead you up'.*

Nurses involved in long term mental health care for patients make sure they have insight about their own mental health and thinking positively about stress at work. The following statements support this:

MHNP12: *'If you are aware of what is happening around you, you are still okay, but if you think everything is fine and there is no stress, something may be wrong.'*

MHNP9: *'I think feeling stress is something normal. Because we are feeling stress in every field in our life. We are as mom we are feeling stressed. While here in hospital feeling stress, is normal'.*

Working on self-development and diverting to other workplaces is another measure for adaptation as stated by:

MHNP15: *'before you hit the rock bottom level, try to think going up again, by doing other challenges in your life, going different field or different location'.*

Ignorance and acceptance are additional measures to adapt and survive in the stressful situations. The participant stated:

MHNP12: *'Acceptance sometimes... if we keep having the same meetings, the same agenda repeats after two or three months... so why are we still discussing it instead of resolving it?'*

### **Mental health nursing leaders' perception**

Silence behavior is a way to adapt with the stressful environment or situation as indicated in the following statement:

MHNP16: *'we reach to the point that I have to accept it and finish, so I keep quiet. we'll reach to the point that I have to do and keep quiet that's all'.*

MHNP1: *'you will leave the situation just to go like that. Because you tried once twice three, maybe you blamed maybe they point to you.'*

In addition to remaining silent, mindset of the participant who moved from medical field to the psychiatric thinking of less physical workload which makes them adapt with the situation considering it as an escape. As well as, mindset of thinking internally satisfied of making a job done. The following are some statement by participants referring this measure:

MHNP1: *'the reason of the sudden shift from medical was the workload. so, I just suddenly shifted to mental health.'*

Another form of escape is represented in stepping down from position temporarily or going for early retirement:

MHNP5: *'There's chance also to ask for attachment, we want at least for a period of time.'*

MHNP2: *'Sometimes you face more stress you feel to go for retirement'.*

*MHNLP3: 'if we reached the age of retirement of course because sometimes we know that there is another life outside it's not all just to push yourself to work every day. It's my ambition'.*

Moreover, emotional intelligence is a way to cope with the stressors as stated:

*MHNLP9: 'This relates to emotional intelligence... higher emotional intelligence leads to greater resilience when facing challenges.'*

Self-attempts to be internally motivated and accepting the things as they are is another adaptation strategy, as stated:

*MHNLP13: 'I love my work... despite long travel, I am motivated by a supportive team and mutual support in the workplace.'*

Isolating self from unnecessary interaction is a way to get a peace of mind. The following statement is reflecting this:

*MHNLP 3: 'Living in peace with myself and accepting my capabilities makes me satisfied... I prefer to stay in peace and isolate myself to maintain comfort.'*

In both groups, the most common immediate reaction to job frustration was personal-oriented coping mechanisms. Emotional control techniques like silence, acceptance, cognitive reframing, and normalizing stress were crucial for both mental health nursing leaders and mental health nurses. These strategies served as defense mechanisms, enabling people to carry on working in a demanding atmosphere without having to deal directly with systemic problems.

But each group's interpretation of these strategies was different. Because they had little control over their workload and organizational choices, mental health nurses tended to employ silence and acceptance as adaptive survival strategies. Mental health nursing leaders, on the other hand, described such strategies as deliberate emotional control and resilience-building techniques, which are frequently associated with expertise and professional maturity.

Additionally, both groups reported mental changes that suggested an absorption of occupational pressure, such as the normalizing of stress and cognitive detachment. Although these measures helped people cope in the short-term, they can also be a sign of emotional detachment and lower expectations for organizational transformation.

### **Subtheme 3.2 Professional-oriented**

#### **Mental health nurses' perceptions**

The interest in mental health and doing a humane job are forms of adaptation, as stated:

*MHNLP10: 'Our stress is nothing compared to Royal Hospital ICU or Medical'.*

*MHNLP12: 'it's your duty as a human to help other people'.*

*MHNLP10: 'our stress is nothing, nothing compared to royal hospital ICU or Medical'.*

#### **Mental health nursing leaders' perceptions**

Respondents indicated personal coping measures towards work-related frustration by the fact of doing a humane job caring for mentally ill patients. The following statements are representation of this:

MHNLP 4: *'you feel of their suffering and then you attend to them. This is something that motivates me'.*

An interest to work in mental health field is a way to relief stress:

MHNLP 3: *'I prefer communicating with clients rather than performing procedures... it feels more comfortable and meaningful, like a gift.'*

MHNLP13: *'I have a strong intention to help psychiatric patients, who are often overlooked in society.'*

Sacrificing for sake of patients' needs who might be a victim is believed a way to adapt as stated:

MHNLP1: *'sometimes you need to sacrifice because the patient is a vulnerable person... it is a job that few people choose willingly.'*

As a leader, in order to cope with the related challenges, one may ignore the stressors coming on the way. As stated,

MHNLP1: *'Sometimes I ... ignore certain interferences to maintain my position, even though it affects me.'*

On the other hand, it was suggested to be a supportive leader in overcoming the challenges in the way, as stated:

MHNLP3: *'Give staff the chance to think, create, and be motivated... support them and reduce the blaming system... acknowledge their work... not only follow rigid systems.'*

MHNLP1: *'A good leader should not be restricted by higher authority rules... sometimes you need to create beyond those restrictions.'*

Staff rotation for a period of time and debriefing session are sort of release from stress as stated:

MHNLP12: *'we are trying different solution ... for example, rotation for them for one or two months to get released from their environment and to be refreshed again after that rotation.'*

MHNLP9: *'debriefing session, they will verbalize, they will speak their concerns'.*

MHNLP16: *'just do reflection'.*

Self-efforts from first line level leaders to motivate staff is applied by assigning them straight morning shift for a period of time as supported by following statement:

MHNLP12: *'it's like for them to get the motivation for them. So that they are happy for them, you didn't give me night shift'.*

As a leader, to support the colleagues and the department, taking risk is a way to cope up with shortage of facilities:

MHNLP16: *'Assigning in-charge of the light ward requires cooperation with colleagues (in-charges, bed managers, nursing staff) ... from my view, staff are taking risk.'*

Internal believe of participants that mental health setting is lower stress and the last choice to remain, as stated:

MHNLP3: *'sometimes even if we think to move on from that position, we know the place we are moving its might be worse. this is the truth; this is the fact.'*

MHNLP1: *'the options are limited and it's maybe you can see it worse than what you are in'.*

MHNLP7: *'stay there whatever it is. this is the only options'.*

Participants' use of professional identity and meaning-making to deal with job frustration was reflected in professional-oriented coping techniques. The perceived humanitarian benefit of mental health nursing, especially the chance to care for vulnerable patients, provided mental health nursing leaders and mental health nurses with psychological respite. Negative experiences at work were offset by this sense of purpose, which served as a stabilizing force.

The groups' operationalization of professional coping, however, varied. Self-sacrifice, obligation, and comparison reasoning (e.g., comparing stress levels with other specialties) were frequently cited by nurses as reasons for ongoing involvement. A more systemic approach to coping was demonstrated by the mental health nursing leaders' use of additional leadership-focused measures such as staff assistance, rotation systems, debriefing, and reflective practice.

Despite these distinctions, both groups identified professional identity, meaning, and compassion as key components of resilience. This implies that even in cases where structural issues remained unaddressed, professional values acted as a crucial buffer against job frustration.

### **Cross-group synthesis of Theme 3 (adaptation strategies to job frustration)**

A variety of adaptation strategies to deal with job frustration were described by both mental health nurses and mental health nursing leaders. These strategies included professional-oriented measures like patient care engagement, teamwork, and leadership support practices, as well as personal-oriented coping mechanisms like acceptance, emotional adjustment, silence, cognitive reframing, and psychological distancing. In the face of ongoing workplace stress, these strategies show an effort to preserve emotional stability and professional competence.

While both groups used a number of similar coping strategies, mental health nursing leaders also emphasized organizationally embedded strategies like staff rotation, debriefing sessions, reflective practice, and supportive leadership behaviors, while mental health nurses more often emphasized individual survival strategies like acceptance, silence, and thinking about job transfer. This implies that coping functions at both the human and organizational levels, with leaders actively influencing team-based and environmental adaptation strategies. Overall, in a high-demand mental health workplace, adaption techniques show a dynamic process of striking a balance between professional duty and personal resilience.

## **Discussion**

Mental health settings in Oman represent one of the high-risk areas within nursing profession due to the unique and complex demands of mental health care. Therefore, the stress experienced by nurses in mental health settings is typical of any other general critical areas of practice. However, local or Gulf Corporation Council (GCC) studies addressing this issue are notably scarce. The current study's findings confirmed the presence of several factors jointly detected in other critical care practices. Additionally, there are notable similarities and some variations between both groups of participants.

The researchers found several internal factors i.e. role clarity and engagement, effort-reward imbalance, work-life balance and self-efficacy and external factors i.e. work environment and leadership approach behind feelings of frustration [10, 44, 53].

It is evident from the findings of this study that the predictors of job frustration among nurses in mental health settings in Oman are categorized into internal and external factors. MARS Model addressed some of the factors affecting both mental health nurses and mental health nursing leaders in their perspectives towards job frustration. To illustrate, the role clarity for mental health nurses focusing on clinical practice and mental health nursing leaders on wider aspects added with administrative roles. In addition to this, the competence of mental health nursing leaders is affected due to limited engagement and autonomy. Whereas the mental health nurses added to non-engagement, the training and exposure to various clinical cases which is restricted due to the regulations. In

contrast, additional factors were traced in the analysis of this study which were not addressed in MARS Model i.e. competence, relatedness, autonomy, culture and societal believes, personality and personal factors. in terms of competence, relatedness and autonomy, Desi's Self-determination Theory is found to explain the connection of these factors to employee satisfaction and frustration which are mediating to employee motivation.

### **Role ambiguity and limited engagement**

The results show that job frustration among mental health nurses and mental health nursing leaders was significantly influenced by unclear responsibilities and little participation in decision-making. The reasons of these difficulties varied depending on their organizational positions and professional obligations, even though both groups faced limitations in their autonomy and involvement.

#### **Mental health nurses**

The current study found that role ambiguity and limited engagement was a major source of job frustration among mental health nurses. This extends findings of lower competency in performing tasks and absenteeism are signs of frustration where healthcare workers display low engagement in work [10]. As well as, evidences indicated that nurses working in critical care areas such as oncology, experience ethical dilemmas and conflict while practicing their roles and decision-making [31]. This conflict is often created due to a lack of engagement in autonomous nursing roles in patient care resulting in job frustration and burnout. Moreover, lack of involvement in the decision-making process due to devaluing the nursing profession inhibits nurse's enthusiasm to continue with the service [23]. The current sample revealed their intentions of leaving the service if they meet the criteria of early retirement due to the pressure and demands from superiors as well as the social commitments. In addition, unfair task and clinical area allocation as well as task overload contribute negatively to overall job performance in Nigerian tertiary hospitals [61] which was similar to the Oman situation.

The findings of this study are consistent with lack of autonomy and involvement in decision-making, job type [58], organizational reward systems, lack of positive inter-professional and interpersonal relationships with managers [55], lack of support and non-respectful approach [57] as being sources of low self-efficacy. Similarly, ignorance of employee well-being and satisfaction needs is not only damaging to the person but also the entire institution leading to lower efficiency and increased risk of 'medical errors' [69]. Therefore, the sense of confidence in oneself is disturbed ending up with job frustration.

#### **Mental health nursing leaders**

The analysis revealed that mental health nursing leaders have unclear role perceived. This is due to the dual role of mental health nursing leaders being clinical leaders and a manager. Once a nurse has a clear perception of their roles, they create varying means of being engaged effectively in meeting public and institutional demands. This study findings presented lower engagement at decision-making and initiatives at leadership level. In the current study, findings indicated that increased and extra allocated role responsibilities and work pressure without any financial grade promotions are distressing for nurses. To illustrate, nurses are holding higher positions and special tasks i.e. clinical facilitators or ward in-charges without any additional financial allowances or upgrading. This is distressing as there are no differences between them and their subordinates whom they lead.

### **Effort-reward imbalance and recognition**

Participants perceived that the effort put into their responsibilities and the opportunities or recognition they received in return seemed out of proportion to them. Although the perceived disparity varied between mental

health nurses and mental health nursing leaders, this imbalance had an impact on commitment to the organization, motivation, and professional satisfaction.

### **Mental health nurses**

The current study found that effort-reward imbalance was one of the major sources of job frustration among mental health nurses. This extends the effort-reward model, both internal and external factors requiring effort from an employee and external reward expected from the organization which are the basis defining the nurses' frustration [74]. As well as the findings of this study are consistent with the evidences indicating nurse gets frustrated after perceiving that the reward is not received in return for an extensive effort invested [10, 30]. Employee exhaustion and personal life disturbances are a direct outcome of the continuous effort a nurse invests into job responsibilities [42] especially working in the critical care field [22]. To prevent losing the nursing workforce, it is required either to reduce the high investment of effort or develop measures of reward regardless of the vital achievements reported. Likewise, the psychological well-being of healthcare workers in Oman is strongly linked with effort-reward balance which includes leadership support, autonomy, respect, and feedback [53]. This reflects that the effect of insufficient reward may be greater on a personal level targeting self-esteem and self-efficacy where the nurse feels frustrated and demotivated towards standards of practice.

In contrast, the current study findings revealed that the nurses feel internally motivated by doing humane job caring for mentally ill patients. As well as, they expressed the stability and uniformity of salaries among them leading to higher acceptance to task distribution within the clinical areas. This extends to findings of employee self-efficacy is developed through performance achievement, mediated experiences, social persuasion and physiological and emotional states. Lack of acknowledgement from the institution's managers is among the main sources of distress and burnout [61]. However, it is believed that role pressure and slow career promotion are contributing factors to male nurses' burnout [42] which is consistent with the current study findings.

### **Mental health nursing leaders**

Consistent to Desi's self-determination theory that focuses on human motivation, being in a leadership position, the current study analysis revealed the importance to practice autonomy in a non-threatening environment where sense of competence and belongingness is developed. As a result, confidence in personal competency level is enhanced due to respect and empowerment. Likewise, a greater sense of belonging to the system will be developed among leaders which as a result will enhance work commitment and motivation as the current study result showed that the absence of these three factors or one of them will lead to de-motivation. This is consistent with the believe that the internal sense of motivation is linked with working hours and overall work environment [75].

Additionally, the current study also showed that effort-reward imbalance was a major source of frustration among mental health nursing leaders as illustrated with those who have higher salaries are less satisfied due to having higher qualifications with higher demands. To illustrate, the leaders who have higher salaries with lower qualifications are satisfied with work expectations unlike those who are highly qualified with lower salaries and higher work expectations in the current study findings.

Similar to mental health nurses, mental health nursing leaders in the current study perceived lack of involvement, autonomy, empowerment, disrespect and coercive management are causes of job frustration. This extends finding of a positive relationship between self-efficacy and commitment towards challenging goals [21]. The mental health nursing leaders in this study indicated lower efforts in initiatives and innovative ideas than before.

## Work-life balance and gendered/family expectations

One major source of annoyance among participants was juggling work obligations with personal and family obligations. Age, gender roles, marriage responsibilities, and cultural expectations within the Omani environment all had a significant impact on these experiences.

### Mental health nurses

The current study indicated that work-life imbalance is among the major stressors of healthcare employees which is consistent with evidences [10, 44]. This as well extends findings of the uncontrolled factors may hinder the efforts invested to enhance the work-life balance issues of healthcare workers over time (Shanafelt et al., 2019). Additionally, the lack of stability of work and social demands causes frustration among front-line HCWs. Several socio-demographic factors were found to be strongly linked with the high level of burnout such as married and younger age [70]. To illustrate, experienced female married physicians working in tertiary hospitals whose practice affects negatively their personal lives showed a higher risk of burnout reflected 70% in KSA- a neighboring GCC country- [8]. The fact indicates that the nurses frequently think of leaving work due to their disturbed personal lives [44] among all HCWs. They tend to retire very early, turnover, entirely change their work field and/or remain inactive, depressed and demotivated. Additionally, the work-life equilibrium among clinical practice professionals is significantly lower than that of academic practitioners [26].

Supporting the global evidences, the current findings suggested that mental health nurses especially married females find it stressful to cope up with shift duties and personal life commitments. This is consistent with the fact that certain personal and work-related factors increase the risk of frustration and depression among nurses such as marital status, age and non-shift duties [29]. In contrast to Omani culture regarding work-related factors, nurses prefer regular morning duty to regulate their personal lives. Whereas, male mental health nurses prefer doing shift duties to be away from regulatory and rush hours of regular morning duty. In terms of personal life, the nurses feel pressured with work-life balance where they have limited family support and higher work demands. Stressor in personal life-related issues is proven to be one of the leading sources of frustration among mental health nurses in Oman. As well as their satisfaction with being available on social occasions is always ignored. About the findings, most of the nurses lost their motivation due to the non-rewarding approach and perceived the duty as a source of financial stability only. The frustration among mental health nurses is affected by gender where females are under pressure from family roles while attaining to professional role. The male gender pressure is more about the nursing profession, in general, being stigmatized by society as an unfavorable profession for males. This extends findings of masculinity in the Arab region is socially restricted to expressing emotions whereas stress gets versed inside male nurses even further [24].

This is in contrast with male nurses being satisfied which as well was linked to the fact of doing a humane service job matching their interests and abilities which is consistent with GCC evidences [9]. In Oman, number of males choose nursing as a profession is very low compared to females due to the societal stigma around nursing profession. Therefore, the current findings in Omani sample contradicts the findings of other neighboring GCC country where male nurses show no or limited satisfaction with nursing profession. Whereas, the most concern of mental health nurses who are younger and within the family development period of life are being frustrated to some extent.

This extends findings of nurses perceive feelings of lower empowerment and autonomy, unfair allocation of tasks, reward and compensation are the most prominent factors towards job frustration [9]. Regarding social acceptance, Arab younger generations feel the cultural pressure of early marriage and making a family which is a challenge to cope with work needs in the medical field [59]. These factors were observed in the current sample among Omani mental health nurses working in psychiatric hospital. This indicates that shared cultural beliefs influence individual psychology towards job frustration as a situational factor of the MARS Model in the conceptual framework.

## Mental health nursing leaders

Similar to our findings among mental health nurses, mental health nursing leaders conveyed an advantage of having leadership position is to stabilize personal life with regular morning shift. In contrast, the demands for after-duty calls is frustrating where personal life space is invaded. The current study found that work-life balance was a major source of frustration among mental health nursing leaders as well in relation to gender and marital status. This is consistent with the evidence showing that gender and marital status are among the significant factors of job frustration of HCWs in Middle Eastern countries i.e. Turkey [52]. The researchers put special emphasis on the specific elements concerning the personal data of an employee to assess the correlation of these towards job frustration. In terms of age factor among KSA nurses and physicians, the job-related stress level was significantly higher amongst those who were younger than 37 to 40 years [9, 16]. This fact is consistent with current study findings. This is due to the sense of security they have due to entering into the zone of retirement at any time with full pay. It is estimated that those who are above 40 are having more stable family lives and limited expectations at work due to having higher financial grades representing better work-life balance and enhanced self-efficacy.

Moreover, nurses working in shift duties have altered leisure time resulting in altered self-efficacy, depression and lower self-esteem [29]. Whereas, in the current study findings, leaders were concerned that they are disturbed even in their after-work hours or off duties. These internal sources of burnout and frustration require external efforts. These efforts require mainly managerial and institutional levels of attention to minimize the unfavorable outcomes on both personal and organizational levels.

## Leadership, communication and blame culture

Participants' experiences of job frustration were significantly shaped by leadership styles, communication methods, and corporate culture. The results brought to light issues with restricted involvement in decision-making, communication obstacles, and a perceived blame-oriented culture that impacted mental health nurses and mental health nursing leaders at all organizational levels.

The current study found that leadership, communication and blame culture are major sources of job frustration among both groups of participants. This indicates that the organizational and leadership aspects were identified as the external sources of frustration as per the conceptual framework. The nurses highlighted the coercive leadership approach as the main predictor. In addition to this, the excess of policies makes the staff feel lost with possible conflicts with co-workers. About the finding of the current study, the blame culture where the focus of the management is destructive more than constructive. All these findings were consistent with the evidence presented by other scholars in the field.

This is consistent with the fact that indicates the most prominent extrinsic factors affecting healthcare employees' job stress and frustration are organizational and leadership approaches [42]. This includes managers' style of leading the work and human resources by the institutional policies guiding and directing their approach. They are observed to have a critical influence on employee reactions and decisions.

## Mental health nurses

Situational factors in the MARS Model represent environmental factors where it is important to have a harmonious workplace which plays a major role in stress reduction. These factors are out of individual control but are important elements contributing to stress. Researchers stated that the nursing profession has a disturbed image of being not valued enough resulting in poor working conditions among colleagues [23]. It is important to facilitate respectful institutional behaviour among nurses and management to avoid work-related frustration [57]. It is believed that good teamwork, interpersonal relationships with colleagues, management support and engagement in decision-making promotes a positive workplace [27]. The current study findings indicated nursing workforce are the least dignified profession in the hospital with no concern to their ideas, suggestions and reported incidents.

In Oman, it is observed that there is lack of connectivity among policies which are sometimes considered as misleading and causing conflict. For instance, policy related to unchanged discharge and admission for addiction patients. Therefore, incidents might take place where nurses are the one who gets most of the blame as perceived due to lower management support as supported by international evidences [34, 62]. This indicates that mental health nurses are being the weakest point in the chain where the pressure of management falls. Therefore, mental health nurses avoid reporting any incident.

Evidences indicate that leadership approach varies across institutions as well as with individuals [36]. Approximately 76% and 84.1% of senior nurses and junior nurses respectively subjected to intimidation and humiliation in the workplace by their superiors as an illustrative example [61]. This extends findings of most coercive attitudes delivered from senior female nurses towards female junior nurses. Moreover, decisions are taken without involvement is another source of frustration [54, 55]. The victims of the coercive leadership approach tend to adopt the same behaviour in future [61]. The current study findings supported these facts for mental health nurses.

In addition, in the current study findings, it was reported intimidation and humiliation are most common feelings perceived by nurses from their superiors, where mental health nurses try to find out ways to escape or otherwise accept without arguing believing that their voices will never be heard. Mental health nurses in the current study analysis expressed devaluing suggestions, lack of acknowledgement, unfair distribution of tasks and lack of freedom to express feelings of frustration.

The current study found that in psychiatric fields, lack of organizational and leadership support is the common factor affecting directly the nurses' motivation being consistent with global evidences [7, 47, 76]. This extends findings of the lack of managerial support, disturbed colleague support also contributes to burnout and distress [23].

In this study, mental health nurses indicated interest in the mental health practice which may support higher self-efficacy. However, the group of nurses who were transferred from medical hospital to mental hospital presented regret due to perceived coercive management and lack of advocacy for nurses. They intended to be absent from work specially when their requests are not met in allocating shift schedule plans. Globally, nurses' migration from developing countries is due to distress and emotional breakdown resulting from managerial bullying [61]. In Oman, nurses prefer to face these challenges by silence behaviour, acceptance and escape through turnover or retirement. This is because of having good financial support which can be as compensation and a reason to tolerate occupational stress. However, it has negative impact on the quality of work by losing the experts due to job dissatisfaction.

### **Mental health nursing leaders**

The current study found that mental health nursing leaders mostly expressed the gap in the channel of communication, approach and accessibility to the top management. As a result, silence behaviour could be due to a personal or work environment factors where an employee perceives a lack of self-worth and self-efficacy consistent to global evidences [35].

In addition, workplace culture plays a significant role in encouraging to report and speak up about healthcare workers by introducing a non-blame approach (Edress et al. 2017). To illustrate, nursing staff in psychiatric settings are always blamed for any incident that takes place [7]. The mental health nursing leaders face the same issue with the top management even if things went right but blame always takes place for small unsuccessful attempts. Therefore, mental health nursing leaders avoid being active in decision making. Additionally, mental health nursing leaders rationalize their act as being forced to carry out the decision from top management trying to save their position. Mental health nursing leaders expressed devaluing suggestions, lack of acknowledgement, unfair distribution of tasks and lack of freedom to express feelings of frustration in the current study findings.

The current study findings supported this fact without the intention to leave the job because of the good salary and fear to start from zero elsewhere. In addition, leaders mostly expressed the gap in the channel of communication, approach and accessibility to the top management. On the other aspect, as per the current finding's analysis,

the leaders struggle to find covering staff to the team affected by sudden absenteeism of mental health nurses due to the same reasons.

In the current study findings, mental health nursing leaders expressed disturbed self-efficacy due to lack of empowerment and trust from top management. In this study, leaders indicated interest in the mental health practice which may support higher self-efficacy. However, the group of mental health nursing leaders who were transferred from medical hospital to mental hospital presented regret due to perceived coercive management and lack of advocacy for nurses.

### **Job insecurity among expatriate nurses**

Particularly among foreign participants who felt apprehensive about long-term job stability and future chances, employment security appeared as a major concern. Although this problem was less common among Omani nurses, it had an indirect impact on mental health nursing leaders who had to handle the ensuing staff issues and workforce challenges. For expatriate nurses in Oman, job insecurity is the main concern where they are in dilemma of leaving to an unknown place elsewhere or waiting for sudden termination. Both of which are affecting their financial stability and personal life. In Oman, it is aimed to create job opportunities for Omani citizens (Omanization) by the sudden termination of foreign workers causing them a lack of stability and insecurity.

### **Mental health nurses**

The current study found that job insecurity among expatriate nurses was a major source of frustration among mental health nurses. As part of insecurity, the foreign workforce faces a serious employment issue with the policy of localization in GCC [46]. In KSA – a neighbouring GCC -, expatriate nurses are found with higher frustration due to limited positional promotions or work-related benefits and opportunities which are mostly spared for natives [5]. In Oman, the case is similar to other GCC countries as well where expatriate nurses feel insecure due to limited opportunities and sudden terminations. In Oman, expatriate nursing staff are at risk of sudden termination which is causing lack of stability and security. In addition to this, they will intend to plan for transfer to a better place with greater sense of job security. This extends findings of causing loss of experts and lower quality of care provision [5]. Whereas, the Omani nurses feel insecure in terms of being moved any time from their comfort zone to cover a shortage somewhere else without prior notification. A matter of fact, nurses are obligated to be ready for taking over the work as indicated specially with sudden shortage due to unexpected absenteeism [5].

As a result, 100% of the foreign workforce considers Omani healthcare settings as a transit to other countries with better facilities as they perceive. This extends to the findings of remaining silent as a response to their job frustration [51].

### **Mental health nursing leaders**

The mental health nursing leaders are less concerned with this issue since they are not targeted with insecurity matters, however, all the quarrels pour to their bucket from the mental health nurses causing them frustration. Additionally, the foreign leaders are having greater concern in regards of the policy of localization in Oman with sudden notification for termination and/or stepping down from position.

### **Adaptation strategies used by mental health nurses and mental health nursing leaders**

Participants described a variety of techniques to sustain psychological wellbeing and professional effectiveness in the face of several organizational and personal pressures. These coping mechanisms included workplace modifications intended to maintain motivation, resilience, and dedication to patient care as well as individual and emotion-focused techniques.

It is found that MARS model is insufficient in explaining the adaptation strategies among nurses. This model focuses primarily on role and practice and neglect other factors such as personal, leadership, culture, work environment and demographic factors (Dalal et al. 2018). Additionally, MARS model may not be applicable across diverse cultures [56]. Therefore, our analysis revealed additional themes in reference to factors affecting job frustration and coping measures.

Therefore, General Adaptation Syndrome (GAS) is known as a natural unspecific reaction to stress [71]. GAS demonstrates three phases which are: the initial alarm reaction, resistance stage and exhaustion stage. In the initial alarm reaction, the attempt would either be fight or flight. This stage is an outcome of the lack of self-determination, motivation, ability to perform tasks and role clarity. This explains nurses' lack of commitment to work hours and frequent irregular leaves [56]. In addition to this, some nurses including mental health nursing leaders will initially try to fight with the challenges and are enthusiastic to make a change. In the resistance stage, the individual tends to adapt or lower the impact of stress once it is understood that there is nothing that can be done after being resistant to the challenges which will eventually lead to job frustration. In the frustration phase, about the reduction of the resistance or failure to fight the situation, the individual will accept the situation which will ultimately lead to burnout. Selye, [71] stated that adaptation is the most significant physiological reaction that matters in one's life.

Evidences indicated that coping with job frustration involves self-understanding and relaxation [55] as nurses may resort to silence when faced with negative attitudes from supervisors [64], contributing to further frustration and lower commitment. Desi's self-determination theory explains well these attempts where an individual's self-efficacy is affected with impaired belongingness, competence and autonomy [66] resulting in demotivation.

Our analysis revealed that the coping techniques vary among personal and professional (role, leadership and workplace environments) related. It is found that professional factors representing in both leadership and workplace environment-oriented strategies are limited in reducing job frustration. Most of the efforts are invested by the person himself towards internal frustration. This is done by silent behaviors, accepting, ignoring, faith in doing good to those who need care, isolation, physical or mental escaping attempts, mindset and working on self-development.

### **Mental health nurses**

The current study found that mental health nurses intended to isolate and accept the stressful facts as coping measures to adapt with the situation. In this study, the regulatory limitations stand as barriers to overcome job frustration. Mental health nurses presented no effort to fight instead they accept the situation. Additionally, self-efficacy is found to be a mediating source of frustration highlighting the nurses' identity where foreign male mental health nurses expressed satisfaction being as a nurse. This is consistent with the evidence of mental health nursing staff presented higher self-efficacy (76%) among other specialties in nursing while providing palliative care [41]. In this study, the mental health nurses indicated interest in the mental health practice which may support higher self-efficacy.

### **Mental health nursing leaders**

In the current study, the leaders mostly revealed silence behavior. Whereas, the professional related adaptation measures in our findings focus on self-efforts where the mental health nursing leaders takes the risk by doing good for the patient and service without approval from top management. To further secure employee belongingness and a sense of security in the workplace, leaders are working to enhance the interpersonal relationship with subordinates. Therefore, mental health nursing leaders maintain silence to cope up with job frustration.

This is consistent with the fact that indicates silence behaviour could be due to a personal or work environment where an employee perceives a lack of self-worth and self-efficacy [35]. In contrast, scholars found that silence

behaviour in Omani private institutions is not an indication of frustration rather than an adaptation strategy [35]. In the current sample, it can be estimated that the final stage of frustration among leaders to adapt with silence.

## Limitations

The study has several limitations that should be considered when interpreting the findings. First, the results may not be as applicable to other mental health settings, primary care facilities, or hospitals in different areas or healthcare systems because the study was limited to a single tertiary mental health institution in Oman. Organizational structures, leadership styles, and workforce mix may vary between contexts, which could influence the experience of job frustration among nurses. As a result, care must be taken when extrapolating these results to other situations. Second, The sample is nonetheless context-specific and might not accurately reflect the variety of experiences across all mental health nursing professionals in Oman, despite efforts to assure heterogeneity in participants' viewpoints by including both mental health nurses and mental health nursing leaders. Third, the results, like all qualitative research, are based on participants' subjective descriptions and interpretations of their experiences at a specific moment in time, which may be impacted by recall bias or the state of the workplace at the time. Fourth, the investigation of delicate job circumstances through FGD may have affected how candidly sensitive subjects like organizational culture, workplace conflict, leadership techniques, and communication barriers were discussed. Because of worries about professional connections, secrecy, or possible consequences at work, some participants may have tempered or hidden bad experiences or critical thoughts. The likelihood of social desirability bias and decreased transparency cannot be completely ruled out, despite efforts to create a secure and private atmosphere.

In addition, the usage of English during data gathering is another restriction. Not all participants spoke English as their first language, despite the fact that it is the professional language frequently employed in the study environment. As a result, some participants might not have been able to accurately and deeply convey complicated feelings, experiences, or contextual details in their native tongue. This might have affected certain stories' richness and how meanings were interpreted throughout analysis. Finally, in order to investigate potential factors on job frustration among mental health nurses and mental health nursing leaders, the interview guide was partially guided by the MARS model. The use of a theory-informed interview guide may have altered the course of questioning and influenced the topics expressed by participants, even though the analysis made it possible to identify themes that went beyond the initial framework. As a result, some themes that weren't specifically included in the framework might have gotten more emphasis throughout data collecting than others.

## Implications

### Implications for practice

It is recommended that leaders need to match roles with qualifications and avoid personal partialities among subordinates. Additionally, to enhance efforts to improve employee engagement in decision-making or even prior notification before implementation [53]. Similarly, attempts to criticize actions or behaviors need to be constructive with a reflective and positive reciprocal approach [53]. The weekly departmental meetings should consider psychological debriefing not merely technical work-related issues avoiding one-way commands. Furthermore, a culture of no blame should be emphasized ensuring a secure workplace [62]. In addition, it is recommended to reduce working hours or even introduce flexible working time. It is important to enhance employee self-efficacy by allowing time for practising hobbies and personal life activities. It is suggested to initiate a training program regarding effective coping strategies to have a safe work environment to reduce the level of stress and burnout as well as enhance nursing care [50].

## Implications for policy

Overall, workplace environment-related issues and reciprocal approaches are the backbone of organizations' integrity. Therefore, concerning to mental health hospitals, some policy allegations were highlighted in this study. The scope of practice of nurses working in the mental health field needs revision. To protect the personal lives of individuals from work-related obligations, it is required to design a clear guide to prioritize tasks according to immediacy and urgency as well as after-duty approach. It is essential to set criteria for reward as a system to acknowledge. Likewise, the policymakers need to revise the financial allowances for those who are holding extra responsibilities i.e. management. Moreover, to achieve workload balance, it is indicated to foster a culture of re-allocation of staff from acute wards to rehabilitation wards. Overall, unnecessary policies need to be merged, deleted and clarified. For the expatriate workforce, the national level policy should be in place for prior notification of the possibilities of termination due to Omanization within not less than six months.

## Implications for future research

Further research should be conducted to highlight adaptation strategies and study in depth the individual factors of job frustration by determining its level using a validated scale. In addition, further studies on leadership communication in mental health settings, exploration of expatriate nurse job insecurity in GCC context and comparative studies across specialities or countries are indicated. The findings will further guide research direction as not to merely rely on a theoretical base of understanding in managing issues but also the experiences of people within the scene. The findings were aligned with the concepts supported by MARS Model. However, additional factors were found to be important in Oman's culture having great influence to job frustration.

## Conclusion

Indeed, the present study explored key factors contributing to job frustration in mental health nursing settings in Oman using a mixed-method approach. In Oman, mental health nurses face serious issues of job frustration due to lack of role clarity and engagement, imbalances in work-life and effort-rewards and low self-efficacy. The common rewarding fact mentioned by both groups of participants was that doing a humane job and learning art of dealing with people. It is observed that nurse leaders are concerned with maintaining good interpersonal relationship with colleagues which explains the mental health nurse's lower frustration towards leadership and work environment. The additional situation factors mainly focus on a defective leadership approach, obligatory and blame culture as well as insecurity. This study indicated that both groups of nurses in varying levels face reciprocal communication issues with top management as a blocking wall to get their voices heard. Furthermore, the pressure of societal barriers is fueling job frustration. The mental health nurses' adaptation measures are poured in personal level whereas the limited indication for coping among mental health nursing leaders was needed in relation towards professional related concerning role perceptions and most are required in leadership and workplace environment levels. The findings of this study indicate that job frustration is not primarily linked to psychiatric nursing practice itself, but rather to organizational and leadership-related factors.

### Abbreviations

|       |                                                          |
|-------|----------------------------------------------------------|
| COREQ | Consolidated Criteria for Reporting Qualitative Research |
| FGDs  | Focus Group Discussions                                  |
| GAS   | General Adaptation Syndrome                              |
| GCC   | Gulf Corporate Council                                   |
| HCWs  | Health Care Workers                                      |

|        |                                           |
|--------|-------------------------------------------|
| ICU    | Intensive Care Unit                       |
| JF     | Job Frustration                           |
| KSA    | Kingdome of Saudi Arabia                  |
| MHNLP  | Mental Health Nursing Leaders Participant |
| MHNP   | Mental health nurse Participant           |
| MHNs   | Mental Health Nurses                      |
| MoH    | Ministry of Health                        |
| OJFQ   | Omani Job Frustration Questionnaire       |
| UNIMAS | Universiti Malaysia Sarawak               |

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**Data availability** No datasets were generated or analysed during the current study.

## Declarations

**Ethical approval** Prior ethical approval was obtained from the University Malaysia Sarawak (UNIMAS) Medical Research Ethics Committee (No.: FME/22/65) and the Research Approval Committee at MOH in Oman (No. Moh/CSR/22/25809). The study was conducted in accordance with the principles of the Declaration of Helsinki. Informed consent was obtained from all participants prior to data collection.

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## Authors and Affiliations

**Asiya Mohamed Al Zadjali<sup>1</sup> · Yoke Yong Chen<sup>1</sup>  · Keng Sheng Chew<sup>1</sup> ·  
Rekaya Vincent Balang<sup>1</sup> · Hamida Hamed Al Harthi<sup>2</sup> · Md Mizanur Rahman<sup>1</sup> ·  
Ling Choo Chiew<sup>1</sup>**

✉ Yoke Yong Chen  
yychen@unimas.my

Asiya Mohamed Al Zadjali  
asiya0alzadjali@gmail.com

Keng Sheng Chew  
kschew@unimas.my

Rekaya Vincent Balang  
vbrekaya@unimas.my

Hamida Hamed Al Harthi  
hamidaalharthy@yahoo.com

Md Mizanur Rahman  
rmmizanur@unimas.my

Ling Choo Chiew  
lingchoo29@gmail.com

<sup>1</sup> Faculty of Medicine and Health Sciences, University Malaysia Sarawak, Kuching, Malaysia

<sup>2</sup> Mental Health Nursing Program Coordinator, Higher Institute of Health Specialties, Muscat, Oman