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Investigation of multidisciplinary teams in psychiatric and psychotherapeutic care in Hungary. Psychosocial factors of psychiatric care workers during the pandemic

PhD Thesis

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LIST OF ABBREVATIONS

WHO	World Health Organization
HCW	health care workers
CEE	Central-Eastern European
HAPT	Hungarian Association of Psychiatric Trainees
MPT	Hungarian Psychiatric Association (Magyar Pszichiátriai Társaság)
COPSOQII.	The Second Version of the Copenhagen Psychosocial Questionnaire
WPA	World Psychiatric Association
UEMS	European Union of Medical Specialists (Union Européenne des Médecins Spécialistes)
EPA	entrustable professional activities
AAEP	American Association for Emergency Psychiatry
PECs	psychiatric emergency clinicians
APN	advanced practice nurse
US	United States

1. INTRODUCTION

1.1. The concept, place and importance of multidisciplinary teams

At the beginning of the 21st century the healthcare sector was facing new challenges. According to the WHO World Report on Mental Health 2022, the COVID-19 pandemic increased the global prevalence of anxiety and depression by 25% (Lucero-Prisno III et al., 2023; WHO, 2022), and mental health concerns increased after the pandemic with higher prevalence rates than cancer. (World Economic Forum, 2022; Lucero-Prisno III et al., 2023). One study suggests that one of the key public health challenges in 2023 - following the pandemic - will be mental health, alongside malnutrition, climate change and other factors, and that it is important to monitor and manage health risks (Lucero-Prisno III et al., 2023).

Several studies report that health systems need to be strengthened (Lucero-Prisno III et al., 2023; WHO, 2021). In this changing health situation, it has become very important to know exactly who among mental health professionals has what role, task and responsibility. Psychiatry can also use a number of coercive measure in acute care (Decree 60/2004 (VII.6.) of the Ministry of Health, Social Affairs and the Family on the rules for the admission of psychiatric patients to institutions and the coercive measures that may be applied in their care.," 2004.; Act CLIV of 1997 on Health Care, Chapter-X. Treatment and care of psychiatric patients.," 1997), where it is particularly important to clarify exactly whose competence is what. Coordinated psychotherapeutic work also requires clarification of the competence of professionals in their area of responsibility due to patient avoidance mechanisms (e.g. idealization- devaluation, splitting). (Gabbard, 2016). It is in the patient's care interest that work, and team processes are organized.

This led us to want to look at teams in care in domestic psychiatry and psychotherapy, with a primary focus on multidisciplinary teams as known from practice. However, a more thorough review of the literature revealed that there is confusion about what is meant by a multidisciplinary team (Flores-Sandoval et al., 2021; Howard & Potts, 2019; Karol, 2014; Martin et al., 2022; Pelone et al., 2017; Sangaleti et al., 2017; Van Bewer, 2017). When health professionals and researchers do not use and interpret terminology in the same way, it leads to misunderstandings, disagreements, reluctance to collaborate and ineffective teamwork. Standardised definitions related to interprofessional education,

learning, and practice were recently published in the Proposed Lexicon for the Interprofessional Field (Khalili et al., 2022; Martin et al., 2022). Aleysha K. Martin and colleagues, based on the above-mentioned lexicon, their knowledge of the literature and clinical experience, have proposed a standardized approach to the development of clinically based health teams terminology and characteristics (Martin et al., 2022).

We originally started from Foley's definition (Foley, 1990; Lake et al., 2015), which was consistent with the terminology above. According to his interpretation, the primary multidisciplinary teams are those in which one person is responsible for coordinating the team and making decisions; and these are the most common types of teams. Communication in multidisciplinary teams is through the leader, whereas communication between other team members is not significant. According to Lake (2015), in hierarchy-based teams, the leader is expected to provide solutions and answers and the leader is at the same time different from others in character, skills and motivation (Lake et al., 2015). In contrast to multidisciplinary teams, in interdisciplinary teams the leader's primary role is to facilitate communication between team members. In these teams, all team members make important decisions and form collaborations with each other, and communication takes place freely between team members. Transdisciplinary teams are characterised by decisions being taken entirely at the team level, with some roles being delegated and the boundaries of roles being clarified. In summary, multidisciplinary teams are essentially hierarchical and dominated by superior-subordinate relationships, whereas interdisciplinary teams and transdisciplinary teams are based more on reciprocity and less on hierarchy, with the latter also sharing roles within the team. It is important to stress that this is not a value judgement: either structure can be appropriate and effective for a given environment, task or group (Molnár et al., 2020; Molnár et al., 2023).

“Regarding multidisciplinary teams in psychiatry, R. W. Menninger also concluded that in multidisciplinary teams, team members work separately from each other and that, essentially, the non-physician members of the team are in contact with the physician. Menninger considered it important that all participants within the team contribute to the observation of the patient, which is necessary for subsequent therapy and drug adjustment (Haslam-Hopwood, 2003; Menninger, 1998).

R. L. Munich (2000) took a new approach to the concept of team: he considered it important to have closer cooperation within the team, considering Engel's

biopsychosocial approach. In his view, the role of the leader is to ensure appropriate communication and cooperation between team members and also to provide a sense of connection between them. Munich precisely defines the competences: who has what role within the team. According to him, the multidisciplinary team essentially consists of four members: the psychiatrist, the clinician/therapist (who may be a psychologist, social worker, specialist nurse, resident), the nurse and the patient" (Molnár et al., 2020, 358). The psychiatrist who is in close contact with the nurse is primarily responsible for biological treatment, such as prescribing medication, monitoring the patient's condition and managing medical tasks. The nurse also has an important role in the "biological" treatment, and it is also mentioned that the nurse is the one who is also attentive to the "socio-cultural" aspects of the patient. The role of the therapist is decisive in the care of the patient, he is responsible for updating the so-called treatment plan, promoting the patient's interests when necessary, liaising with family members, applying therapeutic interventions and maintaining contact with the patient's 'outside' therapist, and finally monitoring the so-called discharge plan (rehabilitation) (Haslam-Hopwood, 2003; Munich, 2000).

According to Bodrogi, the patient is also a responsible participant in the multidisciplinary team, receiving accurate information and playing an active role in his or her therapy (Bodrogi et al., 2014). The symmetrical relationship between patients and professionals, teamwork is also part of the therapeutic community movement (Harangozó et al., 2008). In therapeutic communities, the emphasis has shifted to coexistence and the group has become the dominant therapeutic modality (Szőnyi & Füredi, 2015). Tom Main (1942) and Maxwell Jones (1953) are credited with the creation of therapeutic communities. According to Zalka, relevant changes in the lives of patients who completed therapy in the therapeutic community were measured. (Zalka, 2018). Within the framework of community psychiatry, an "experiential expert client" reports on the importance of a supportive environment of professionals (e.g. psychiatrist, psychologist, social worker, etc.) (Bulyáki & Harangozó, 2018).

1.2. Definition of competence and introduction of the concept of competence transgression in the context of psychiatric care

Several studies and professional guidelines emphasize the importance of competence among healthcare workers (Belfort et al., 2017; Karami et al., 2017; Rodríguez-Fernández et al., 2021; Döme P, 2021.; Kovács P, 2024; Kurimay T, 2017.; Rihmer Z, 2016.). According to EMMI Regulation 22/2012 (IX.14.), "competence is the knowledge and ability which, if acquired, will enable the candidate to perform certain examinations and interventions with a degree of autonomy as defined in this Regulation, and which the candidate demonstrates by examination before a committee" (EMMI, 2012.).

In some professional guidelines, such as "On the diagnosis and treatment of bipolar affective disorder (2016) (Rihmer Z, 2016.)" or "On the recognition, care and prevention of adult suicidal behaviour (2017) (Rihmer Z, 2017.)" or "Major (unipolar) depressive disorder: diagnostic and therapeutic guidelines" (2021) (Döme P, 2021.), there are proposals on the competence of the care provider (specialist or trainee specialist/resident). The leading professionals mention suicide prevention as one of the neuralgic points in the psychiatric care system, where it may be necessary to involve different organizations and professions (psychiatrist, child psychiatrist, addiction specialist, psychologist, clinical psychologist, social worker), defining their competences (Németh, 2018.). In suicide prevention strategies, it is also important to separate health competences and responsibilities from those of social leadership (Balczár L, 2018).

Although professional competences in psychiatric care have been acknowledged in the literature, the notion of competence transgression has not been studied. In our view, competence transgression refers to clinical situations in which a health worker—such as a doctor, nurse, or other health professional—performs a task or makes a decision that goes beyond his or her qualifications, professional competence, or license to practice. This situation can not only lead to professional misconduct and compromise the safety of patient care but also have ethical and legal consequences (Molnár et al., 2025). The various forms of medical liability apply to specialists and trainee/residents [ethical liability, disciplinary liability, civil liability, liability for misconduct, criminal liability (Sótonyi, 2006). Both the WPA (World Psychiatric Association) and national codes of ethics address the roles and responsibilities of psychiatrists (MPT, 2000; APA, 2013; Appelbaum & Tyano, 2021).

1.3. The situation of mental health professionals during the pandemic

Our research on multidisciplinary teams has been complicated by the outbreak of the COVID-19 pandemic and has led us to consider additional aspects. In order to better understand the teams and the position of each team member in the hierarchy (e.g. doctor, nurse, etc.) and their position, it was necessary to review the current international literature on health workers and mental health professionals during the pandemic.

"A large body of evidence demonstrates the negative impact of COVID-19 exerted over the mental health of health care providers, including physicians, nurses, and allied health care workers. A meta-review published by Chutiyama et al. summarized the results of 40 systematic reviews, including 1828 primary studies, based on data from over 3,200,000 respondents. The authors concluded that increased stress and anxiety levels, burnout, sleep disorders, and various stress-related mental health problems signified a global issue, exhibiting some regional variation (Chutiyami et al., 2022). However, there is a dearth of data from the Central-Eastern European (CEE) region, Poland connoting an exception (Wańkowicz et al., 2020).

No Hungarian study was included in Chutiyami et al.'s meta-review, even though Hungary suffered from one of the highest COVID-related mortality rates in Europe. (Oxford Martin School 2023). Although during the first wave of the epidemic there was no significant excess mortality in Hungary (Kontis et al., 2020), the second wave affected the country severely, and by the third wave, Hungary exhibited one of the worst mortality rates in Europe (Kovács & Vántus, 2022).

The pandemic drew the public's attention to the importance of promoting the mental health and well-being of HCW (Søvold et al., 2021). Alghamdi and colleagues found that the mean stress score of health care workers was even higher than individuals of the general population who had had contact with COVID-infected patients (Alghamdi et al., 2022; de Filippis et al., 2022). The main sources of stress among health care professionals were: lack of effective COVID-19 treatment, worry for their families' and their own health, uncertainty in most areas of daily and professional life related to the rapid spread and the high mortality of the COVID-19 virus,and lack of preparedness to manage the

crisis caused by the pandemic (de Filippis et al., 2022; Hajebi et al., 2022; Rouhbakhsh et al., 2022).

One of the most frequently analyzed indicators in studies during the pandemic was burnout among health workers. There have been numerous studies on the burnout of mental health workers (Snibbe J, 1989; Deary I, 1996; Kumar, 2007; Myers, 2008; Kumar, 2011; Carneiro Monteiro et al., 2021; Chew et al., 2019; Ferrari et al., 2015; Kealy et al., 2016; Maslach & Leiter, 2016; Rejek & Szmigiel, 2016; Yao et al., 2021; Bykov et al., 2022; Wontorczyk et al., 2023). An Australian study reported high levels of burnout among mental health professionals during the pandemic (burnout scores indicated moderate or higher workplace-related burnout for 40.6% of respondents) (Northwood et al., 2021). Other studies focused on the psychosocial factors predicting high burnout" (Molnár et al., 2024, 2). A Polish study of stress and burnout among psychiatrists found the following: "The results indicated that significant predictors of the development of occupational stress for psychiatrists were psychophysical exhaustion and lack of a sense of professional efficacy. Taking holidays (several times a year, pursuing the passions and interests), and having a stable family relationship (marriage or civil partnership) were also prominent among the predictors of stress" (Wontorczyk et al., 2023, 379). "Several additional factors have been associated with burnout, such as shift work, increased job pressure, work-family conflict, and "practice environment satisfaction", while salary satisfaction was a protective factor against burnout (Zhu et al., 2022). According to Sklar et al., changes in working conditions resulting from COVID-19 care have led to increased turnover through burnout (Sklar et al., 2021).

All related studies have a marked emphasis on the importance of offering tailored mental health support for affected health professionals on both the individual and organizational level (Chutiyami et al., 2022). As the World Psychiatric Association delegates this task to the psychiatrists themselves (Stewart & Appelbaum, 2020), the responsibilities of psychiatrists and mental health specialists substantially increased during the pandemic: besides providing for psychiatric patients and attending to COVID-related mental health problems in the general population, they were also expected to support HCW impacted by the emotional burden of COVID care" (Molnár et al., 2024, 2-3). Professionals working in mental health services experienced significant stress during the pandemic

(Limoges et al., 2021), and close contact with COVID-19 patients resulted in higher levels of anxiety and depression among mental health care workers (Kuki et al., 2021). A study in Hungary analyzed the attitudes and initial reactions of one of the psychiatric staff in Budapest during the pandemic outbreak and the authors found that psychiatrists/psychologists who had more knowledge about the virus situation compared to nurses/other professionals were more likely to experience higher levels of anxiety (Csigó & Ritzl, 2021). Mental health professionals who supported frontline workers also reported increased anxiety and increased workload (Billings et al., 2021). A Dutch study of mental health professionals during the first wave of the pandemic found that 50% of participants reported increased stress (in addition to increased workload, sleep disturbance and other mental health problems) (van Doesum et al., 2023).

Inevitably, COVID has severely impacted mental health care practitioners as well both personally and professionally (Yellowlees, 2022). Social distancing measures fundamentally altered mental health care delivery; psychiatric wards were closed or transformed to COVID care units, the hospitalization of psychiatric patients became very challenging. Takács et al. described that access to electroconvulsive treatment was also reduced during the pandemic in Hungary. The authors also reported that most of the psychiatric wards they studied restricted their activities to acute psychiatric care, including those wards that received patients infected with COVID-19 (Takács et al., 2022). Despite the difficulties, telepsychiatry has developed and spread rapidly, and online consultations and therapies have been shown to be effective (Zangani et al, 2022). Réthelyi described that „besides many other initiatives in Hungary, the Department of Psychiatry and Psychotherapy at Semmelweis University organized mental health consultation and support services for university health care workers together with the Institute of Behavioral Sciences and the Department of Clinical Psychology (Réthelyi, 2020, 570)".

"A review by Crocker and colleagues - based on 55 studies, mostly published between 2020 and 2021, examining mental health professionals - found that Key work-related outcomes included increased workload, changed roles, burnout, decreased job satisfaction, telehealth challenges, difficulties with work-life balance, altered job performance, vicarious trauma and increased workplace violence. Personal outcomes

included decreased well-being, increased psychological distress, and psychosocial difficulties. These outcomes differed between inpatient, outpatient, and remote settings" (Crocker et al., 2023, Molnár et al., 2024, 3).

In rethinking health and psychiatric care, it is important to know the psychosocial factors that influence the working environment of health workers and to understand their roles and competences. Lessons on competences and psychosocial factors at work should also be drawn for a possible future pandemic, as psychiatric care will need to adapt quickly to changing circumstances.

1.4. The stages of research

In line with the literature review, our research can be divided into three parts:

1, Qualitative focus group studies (STUDY1)

2, Quantitative (pre-pandemic) questionnaire-based survey (STUDY2)

3, Quantitative questionnaire-based study, also for the pandemic period, and its evaluation. (STUDY3)

In the first phase of our research, we conducted focus group studies to better understand personal intentions and group dynamics. Drawing on the lessons learned from the focus groups (e.g. unclear competences), we planned to conduct a questionnaire survey on a larger sample. Our first questionnaire survey was conducted just before the COVID-19 pandemic, which we were not able to continue at the time. A further questionnaire-based survey was conducted later in the pandemic.

2. OBJECTIVES

AIMS OF THE STUDY

Our research focused on the concept of the multidisciplinary team, leadership, hierarchy, communication, conflicts, competences within the team and competence transgression. We hypothesized that competence transgression is primarily determined by the lack of role clarity.

During the pandemic, which changed the focus of the research, the aim of our study was to assess work-related psychosocial risk factors of COVID care among mental health professionals in Hungary. We investigated the following mental health indicators: stress, burnout and sleeping troubles. Our aim was to analyze their associations with work-related psychosocial factors in relation to participation in COVID care.

Our hypotheses according to the first and second phase of the research:

1.The concept of multidisciplinary teams is not uniform.

2. The perception of hierarchy is positively influenced by the attitude of staff toward management.

3. Unresolved conflicts in a team are destructive to the team.

4. Competences in multidisciplinary teams are not clear.

5. Competence transgression is determined by a lack of role clarity.

Our hypotheses for the third stage of the research:

6, Working in COVID care units is associated with higher levels of work-related psychosocial risk factors.

7, Participation in COVID-19 care is associated with increased levels of stress, burnout, and sleeping troubles among mental health professionals.

8, Nurses are at a higher risk of stress, burnout, and sleeping troubles compared to other health professional groups.

9, Participation in COVID care and the characteristics of the work environment in COVID care are independent predictors of high stress and burnout.

3. METHODS

The methods used in our research are summarized in Table 1.

Table 1. Summary of methods used in the research

	Temporality	Number of participants	Researched topics
Focus group tests			
Focus group 1.	The MPT's 2017 travelling assembly	N=18	1.Hierarchy in the team, leadership
Focus group 2.	The MPT's 2018 travelling assembly	N=16	2.Communication within the team, conflicts
Focus group 3.	The MPT's 2019 travelling assembly	N=16	3.Job-related competences, competence transgression
Questionnaire survey I. (COPSOQII. +own questions)	January-February 2020	N=279	Psychosocial factors at work Hierarchy, competence transgression
Questionnaire survey II. (COPSOQII. +own questions)	November 2021- April 2022	N=268	Psychosocial factors at work during the pandemic Stress, burnout, sleeping troubles, competence transgression

3.1. THE METHOD OF STUDY1

3.1.1. General description of the focus group survey

We started our research by conducting focus group studies in parallel with the literature review (Molnár et al., 2020). A total of 50 participants took part in the exploratory study, who - through convenience sampling at three consecutive annual conferences of the Hungarian Psychiatric Society - volunteered to participate in the interview, agreed to be audio-recorded and to use the audio-recording for research purposes. Our sampling was therefore not based on random selection. This method meets the criteria for exploratory qualitative research, with the obvious limitation that our sample is not representative and cannot be generalized to the whole population of psychiatric care in Hungary. The focus group is a qualitative research method defined as "a research method in which data are generated by subjects communicating in groups about a particular topic" (Vicsek, 2006). The focus group method is therefore an excellent means of exploring unexplored,

sensitive areas, thoughts and feelings. Due to the nature of the research topic, our method is an adequate tool for a first approach to the topic.

Our focus group was heterogeneous, based on the internal composition of the group: participants were of different educational backgrounds, status and age. According to Vicsek (2006), if our research objective is to investigate natural social communication and interaction and to explore how individuals of different status and with different characteristics interact with and influence each other, then a mixed heterogeneous group is appropriate (Vicsek, 2006).

In each session, due to the limited time available (1.5 hours), three pre-selected sub-topics from the already detailed topics related to the functioning of multidisciplinary teams were formerly offered for discussion by the focus group participants. Subsequently, pre-defined moderator questions on the topics most preferred by the participants of the session were used to facilitate the widest possible exploration of the focus sub-topic, naturally bringing into the discussion the participants' associations and experiences relevant to the topic (Taylor et al., 2012).

3.1.2. First focus group (N = 18, the MPT's 2017 Travelling Assembly): Our focus group aimed to explore hierarchy and leadership within teams. The group consisted mostly of psychiatrists, with additional psychiatric trainees, a neurologist, a psychologist, a lawyer, an anthropologist, a sociologist and an art therapist.

3.1.3. Second focus group (N = 16, the MPT's 2018 Travelling Assembly): The focus group aimed to investigate the relationships within the team, communication between team members, conflicts within the team. Again, the composition of the group was inhomogeneous: specialist (psychiatrist and general practitioner), psychiatric resident, specialist nurse, and anthropologist participants were present.

3.1.4. Third focus group (N =16, the MPT's 2019 Travelling Assembly): The focus group addressed the issue of competencies and responsibilities of specialist physicians and both specialist and residency candidates. Participants in the group included psychiatric consultants, department heads, psychiatric residents and policy makers.

3.1.5. The aim of our focus groups

Our aim with the initial focus group studies was to better understand group dynamics and personal intentions regarding team functioning. We felt that personal conflicts within the group could be better understood in a qualitative focus group setting, and therefore did

not conduct quantitative measurements in this area in the later stages. Our subsequent questionnaire survey was based on the focal points that stood out for us (e.g. hierarchy, competence).

3.1.6. Ethical considerations. Our survey was approved by the Ethics Committee of the Semmelweis University (SE-TUKEB: 270-/2017).

3.2. THE METHOD OF STUDY2

The study was based on a cross-sectional questionnaire survey of a non-representative sample of Hungarian health care workers working in work teams.

3.2.1. Data recruitment

The study included individuals who worked in the Hungarian psychiatric care. Data collection took place between January and February 2020. During the recruitment process, we contacted the major psychiatric departments in the capital city, Pest County and the major psychiatric departments in the north-east of Hungary. The survey was conducted in a paper-based questionnaire (N=257) and online questionnaire format (N=27), depending on the preference of the subjects. The online questionnaire was made available through a Google Forms interface, which was identical to the paper-pencil version of the questionnaire package.

3.2.2. Measures

The questionnaire consisted of 3 parts: socio-demographic factors; a question on team functioning; and the second version of the Copenhagen Psychosocial Questionnaire II (COPSOQ II). The sociodemographic questionnaire included basic information about the participant (gender, age), place of residence (municipality, county) and employment status. In the questionnaire, respondents were able to provide details of their type of employment (see Appendix A), but these were recoded into 3 occupational categories for data analysis: nurse, doctor (specialist or resident), and another helper.

Our own questions were related to hierarchy, tensions at work and competence transgression. In this study we focused on hierarchy and competence transgression. In our study we used two binary variables, one related to hierarchy and one related to competence transgression.

The last part of the questionnaire included the Hungarian adaptation of the COPSOQ-II, which is designed to measure the psychosocial factors of a workplace. It has been widely used internationally. The questionnaire includes 7 main factors: Demands at work, Work organization and job contents, Interpersonal relations and leadership, Work-individual interface, Values at the workplace, Health and well-being, Offensive behaviour. (see Figure 1) (Nistor et al., 2015; Pejtersen et al., 2010).

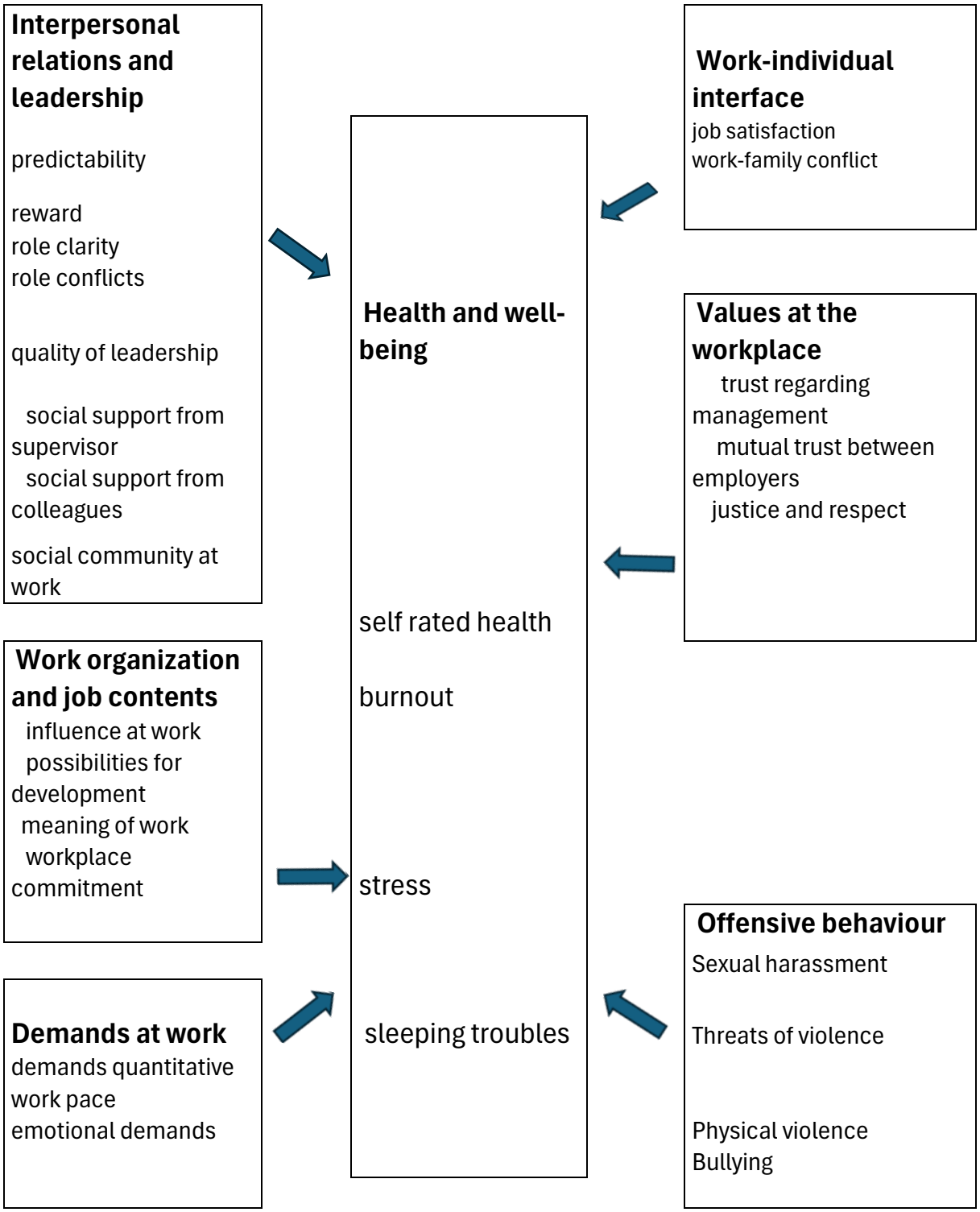

Figure 1. Structure of the Second version of the Copenhagen Psychosocial Questionnaire. In the wake of the Institute of Behavioural Sciences' "Workplace Stress and Stress Management Research Group"

Each main factor contained a number of sub-factors with a variable number of items (see Table 2). The COPSOQ II contained a total of 119 items. We included 23 subscales on psychosocial work environment in our analysis, 3 or 4 items each. Respondents were asked to indicate their responses on a five-point Likert scale for the majority of questions. Some of the questions were related to the participant's job and, accordingly, their personal

experience of their specific job, while another set of questions were related to the workplace as a whole (Nistor et al., 2015; Pejtersen et al., 2010).

Table 2: Main scales and subscales of the Hungarian version of the COPSOQ-II and their reliability based on Cronbach's alpha

Name	Cronbach's Alpha
Quantitative demands	0.763
Work pace	0.869
Emotional demands	0.656
DEMANDS AT WORK (DIM1)	0.830
Influence at work	0.641
Possibilities for development	0.686
Meaning of work	0.736
Workplace Commitment	0.775
WORK ORGANIZATION AND JOB CONTENT (DIM2)	0.872
Predictability	0.656
Reward	0.855
Role clarity	0.719
Role conflicts	0.569
Quality of leadership	0.904
Social support from superiors	0.877
Social support from colleagues	0.727
Workplace commitment	0.668
INTERPERSONAL RELATIONS AND LEADERSHIP (DIM3)	0.899
Job satisfaction	0.835
Work-family conflict	0.816
WORK-INDIVIDUAL INTERFACE (DIM4)	0.452
Trust in management	0.711
Mutual trust between employees	0.568
Justice and respect	0.795
VALUES AT WORKPLACE LEVEL (DIM5)	0.695
Burnout	0.850
Stress	0.855
Sleeping Troubles	0.903
HEALTH AND WELL-BEING (DIM6)	0.936

3.2.3. Statistical analysis

Analyses were conducted by using the IBM SPSS 26.0 software package. Given the length of the test, we performed a post-hoc screening of systematic responses by examining the variance of the last 20 questions of the questionnaire. If the variance of the

responses was below 0.7, the subject's completion was examined, and if a systematic pattern was found (e.g., the last 20 questions were answered with a 1), the subject was excluded from the study (N = 5). A binary logistic regression was applied to the full sample, where the dependent variables were the perceived hierarchy and competence transgression, and the predictors were the COPSOQ-II subscales. This was supplemented by a bootstrap procedure. We did not use variable selection methods on the full sample because we assumed that it would be independent of other COPSOQ-II subscales in which variables would be those significantly associated with perceived hierarchy and competence transgression. Furthermore, in order to examine the differences between those belonging to different occupational categories, the aforementioned binary logistic regression was also performed by group. For the analysis by group, we used stepwise logistic regression. Since we did not have a specific hypothesis for the different job groups, this part of the analysis is exploratory which justifies the variable selection procedure chosen. In reporting the results, both in the figures and in the text, we present the odds ratio with "OR" and the bootstrapped two-sided p-value. (Molnár et al., 2023).

3.2.4. Ethical considerations

Our survey was approved by the Ethics Committee of the Semmelweis University (SE-TUKEB: 270-/2017).

3.3. THE METHOD OF STUDY3

3.3.1. Study design and sample

The first questionnaire survey could not be continued with the immediate outbreak of the COVID-19 pandemic; therefore, another questionnaire survey was conducted later in the pandemic. We conducted a cross-sectional survey during the pandemic between November 15, 2021 and April 15, 2022. The anonymous online questionnaire was made available via Google Forms. Our target group included mental health professionals working in psychiatric and psychotherapeutic care in Hungary.

3.3.2. The data collection process

We employed “targeted sampling”, also known as purposive or judgmental sampling. We utilized online platforms of professional organizations: our call was published on the website and the newsletter of the Hungarian Psychiatric Society, the website of the

Hungarian Chamber of Health Care Professionals, and the Facebook groups of psychologists and the Hungarian Association of Psychiatric Trainees (HAPT). In addition, we contacted most heads of psychiatric wards in Budapest and the rest of the country (by email or phone), and we also wrote letters to relevant hospital directors to encourage participation in the study. Furthermore, we reached out to psychiatric nurses/specialists, psychotherapy inpatient and outpatient services, as well as child- and adolescent psychiatric inpatient and outpatient services. During the data cleaning process, we controlled duplicates; there were none. According to the WHO, in 2020, there were 1170 psychiatrists, 1052 mental health nurses, and 1535 psychologists and 266 other specialized mental health workers (e.g. Occupational Therapists 266) in Hungary, for a total of 4023 mental health professionals (WHO, 2022). Exact response rates could not be calculated due to the sampling method; we could not calculate the exact number of persons reached; however, based on public statistical data, we estimate that approximately 6-7% of health care professionals working at psychiatry care units in Hungary responded to the survey.

3.3.3. Measurements

We also used the Hungarian version of the Copenhagen Psychosocial Questionnaire (COPSOQ II) as the main instrument for data collection. (Nistor et al., 2015; Pejtersen et al., 2010). In our sample, the internal consistency of the subscales was good or acceptable, ranging from 0.656 to 0.916 (see Table 3.). Additionally, we included an item on competence transgression: “In your opinion, to what extent are your overall professional competencies violated during your work?” The response options were: “to a great extent/to a moderate extent/to a small extent/not at all”. Items on sociodemographic and professional background included sex, age, occupation, specialization, years of work experience in specialty, location of workplace (capital or countryside), and whether work was performed in COVID care (see Appendix B).

3.3.4. Statistical analysis

Analyses were conducted by using the IBM SPSS 26.0 software package. Pearson's correlation coefficient was used to determine the associations between work-related psychosocial factors, stress and burnout on the whole sample. As a multivariate analysis

on our full sample, linear regression analysis was performed by using a stepwise method to assess the independent effects of relevant psychosocial factors.

Based on the results of our third focus group (competencies are not clear and this also applies to acute care), we also wanted to know what psychosocial factors are associated with competence transgression in acute psychiatric care. Zero order correlations were used to examine the relationships between the variables (competence transgression, role conflict, role clarity, stress, burnout). In addition to mental state variables, work-related factors were also highlighted in the evaluation of the questionnaire.

We also conducted multivariate regression analysis on a sample of acute psychiatric workers to determine whether the above psychosocial factors are predictors of competence transgression.

3.3.5. Ethical considerations

Our survey was approved by the Ethics Committee of Semmelweis University (SE-TUKEB: 270-1/2017). Participants were informed about the purpose of the study, and their participation was voluntary. Participants gave their consent to take part in the study by completing the anonymous online questionnaire. (Molnár et al., 2024).

4. RESULTS

4.1. THE RESULTS OF STUDY1

4.1.1. Summary of the focus groups

During our focus groups we focused on the following topics: 1. leadership, hierarchy, 2. communication, conflicts, 3. competence. Each focus group had its own focus, but in fact they overlapped. Quotes from our focus groups are shown in Table 3.

The role of leadership, the importance of communication, the presence of informal channels was present in all three groups. The issue of competencies was also prominent in all three groups: in the first group the focus was on leadership competencies and responsibilities, while in the second group it was on competencies between team members, and in the third group particularly on aspects of medical competencies. In all three cases, tensions within the team emerged along each theme (Molnár et al., 2020).

Table 3. Quotes from the focus groups

Hierarchy in the team, leadership
„So, I'd rather the 'hierarchy be rather flat' and rather a big network where things are separated by roles. Everybody should have autonomy, should have a vote, their opinion should be really important, but there should still be one person in summarizing or coordinating that and it shouldn't be shared. For that, one needs to have leadership talent and routine. It is important not to slip into authoritarian behaviour, but to be a humane, good leader.”
„Everyone has their own job and they are responsible for it, but it is the leader's responsibility to lead the team. So, the responsibility of leadership is the leader's and he cannot share it.”
Communication within the team, conflicts
„The nurse is the one who is with the patient 24 hours a day, the doctor is not always there, because he is specializing, doing outpatient care, going to consultations, admitting patients, discharging. She spends a lot of time on the ward, but not always. The nurses are there all the time, practically their relationship with the patients, I think, is probably more continuous. They have a more continuous relationship with the patients, they have a better relationship with the patients. If there are not many patients, obviously the relationship is much more direct, they feel much more at home, they talk to them on the bench...”.
„Tensions were not discussed openly, we just heard about it. For example, in informal settings...”
Job-related competences, competence transgression
„A very high percentage of disputes arise because not all actors in the care process are aware of their legal responsibilities. And then the finger-pointing starts, 'but not me, because you'... The responsibilities need to be very clearly defined.”
„I prepare the worst-case scenario in my mind, that if any dispute arises legally, you cannot say, for example, "the physiotherapist said...". You have made a very important point; the responsibilities are legally installed.”

4.1.2. Results of the first focus group

In our first focus group, a team member who had previously described himself as a multidisciplinary team leader shared his experience with the participants, reporting on his experiences of leadership, how he had tried to achieve diversity by involving different therapists (hypothesized to be a move towards interdisciplinarity). He also shared with the group his experience of trying to protect - in an authoritarian way - therapists with a new approach from their colleagues who had worked there before. In response to this, another group member expressed her tension over the former team leader's perceived authoritarianism in the group setting, which she felt was an idealization of his own work. The issue of dominance in multidisciplinary teams, linked to the person of the leader, and the tensions associated with it, could thus emerge in the group. In terms of informal channels, team members said that they share information in informal places and ways that are of importance beyond the private sphere, both in terms of collegial relationships and patient care.

4.1.3. Results of the second focus group

In the second focus group, rivalry between resident and specialist nurses emerged, such as the phenomenon of who is more competent in terms of patient care within the hospital hierarchy. In addition, the mapping of communication channels in the group quickly revealed the presence and importance of informal channels, in addition to formal communication channels. The existence of informal channels was also reported by the group participants, as well as the creation of sub-groups and the perception that unresolved conflicts can be destructive.

4.1.4. Results of the third focus group

In our third focus group, the issue of competence and responsibility was the main focus of discussion. It became clear that the boundaries of competence were not uniform, with different expectations of the responsibilities and competences of residents, specialist candidates and specialist doctors were different in various departments. Expectations are tailored to the needs of the particular care department, which also vary considerably depending on the patient groups to which they are adapted. There are important differences between the needs and typical problems of acute psychiatric and rehabilitation psychiatric care. In the context of competences, the situation and training of residents was discussed. Participating leaders expressed the need for a comprehensive "psychiatric

specialist competency list" and the idea was also put forward that candidates should acquire competencies during training, after completing certain practical training and passing partial exams. During the review of professional competences, generational differences emerged as tension in the focus group, as experienced managers and residents in the group looked at the same problem from different perspectives. Different perceptions of the situation, ways of working, goals and values make it difficult to use a common language. Finally, but related to the generational differences, the theme of informal channels/subgroups also featured prominently in this focus group.

4.2. THE RESULTS OF STUDY2

Following the focus group surveys, two questionnaire surveys were conducted. The sociodemographic distribution of respondents to the two surveys is presented in Table 4.

Table 4. Comparison of questionnaire survey participants by socio-demographic distribution

	Questionnaire survey I. (N=279) January-February 2020	**Questionnaire survey II. (N=268)** November 2021- April 2022
Gender		
male	52	60
famale	221	208
Occupation		
psychiatrist	27	86
resident	17	37
psychologist	13	47
nurse	198	84
other	21	14
Age		
>31	30	34
31-35	28	48
36-40	22	39
41-45	44	32
46-50	34	37
51-55	45	24
56-60	42	33
60<	14	21
Region		
Budapest	116	125
Countryside	163	143

4.2.1. Participants. The total number of participants in the first questionnaire survey, after excluding systematic respondents, was 279 (mean age=45.7, SD=11.2), of which 221 were women (mean age=47.6, SD=10.4), 52 men (mean age=37.8, SD=0.8) and 6 non-respondents. The youngest participant was 21 and the oldest was 80 years old. The distribution of professions was heterogeneous, with 198 nurses, 44 doctors and 34 other professionals. There were 116 participants from Budapest (41.7%).

4.2.2. Binary logistic regression.

Binary logistic regression was used to examine the relationship between psychosocial factors at work and hierarchy/competence transgression. The ENTER method was used for the analysis on the full sample. The results are presented where the explanatory power of the model (based on the Nagelkerke R-square) exceeds 10%. In the presentation of results, the names of the COPSOQ-II subscales are indicated in capital letters.

4.2.3. Relationship between perceived hierarchy, competence transgression and COPSOQ-II in the full sample

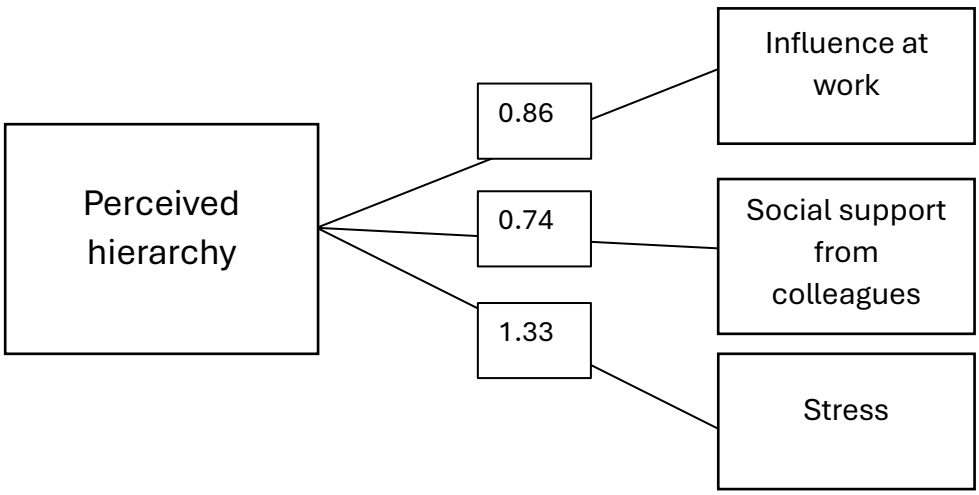

Figure 2.: Relationship of perceived hierarchy to COPSOQ-II subscales in the full sample (the value highlighted in the figure is the odds ratio)

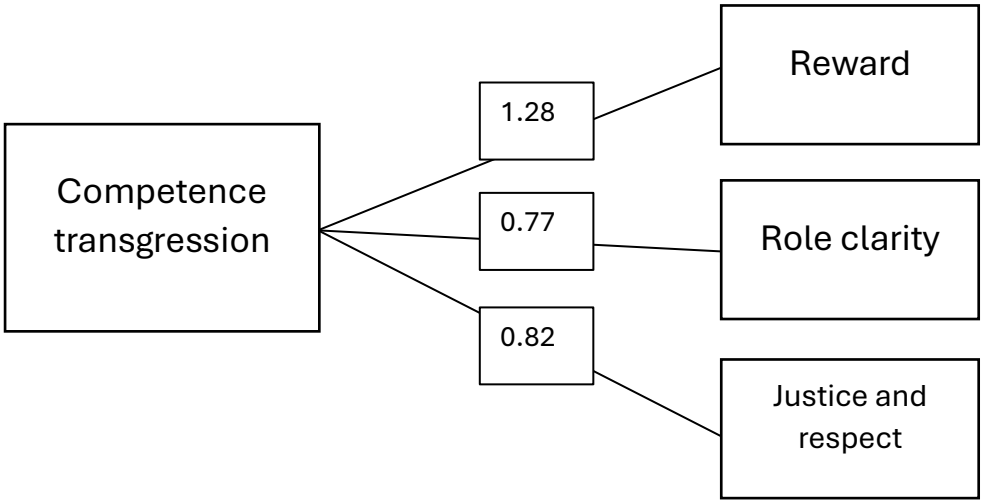

Figure 3: The association of competence transgression with the COPSOQ-II subscales in the total sample (the value highlighted in the figure is the odds ratio)

The model of perceived hierarchy was significant on the full sample (Khi2=64.473, p<0.001, Nagelkerke R2=0.354). Bootstrap simulation was used to find three significant factors.

Participants' Influence at work (OR=0.86, p=0.036) and Social support from colleagues (OR=0.74, p=0.006) were negatively related to perception of hierarchy. Stress (OR=1.33, p=0.020), was positively related to perceived hierarchy (see Figure 2.).

The model of competence transgression was significant on the whole sample (Khi2= 78.493, p<0.001, Nagelkerke R2=0.339). Using bootstrap simulation, we found three significant factors. Role clarity (OR=0.77, p=0.002) and Justice and respect (OR=0.82, p=0.001) were negatively associated with competence transgression. Reward (OR=1.28, p=0.010) was positively related to competence transgression (see Figure 3.).

4.2.4. Relationship between perceived hierarchy, competence transgression and COPSOQ-II in professional groups

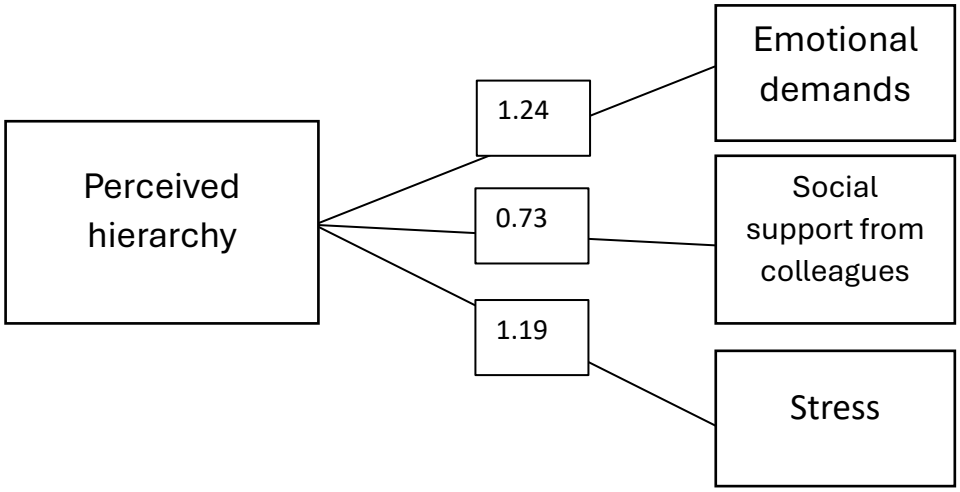

Figure 4.: Relationship between perceived hierarchy and COPSOQ-II subscales for nurses (the value highlighted in the figure is the odds ratio)

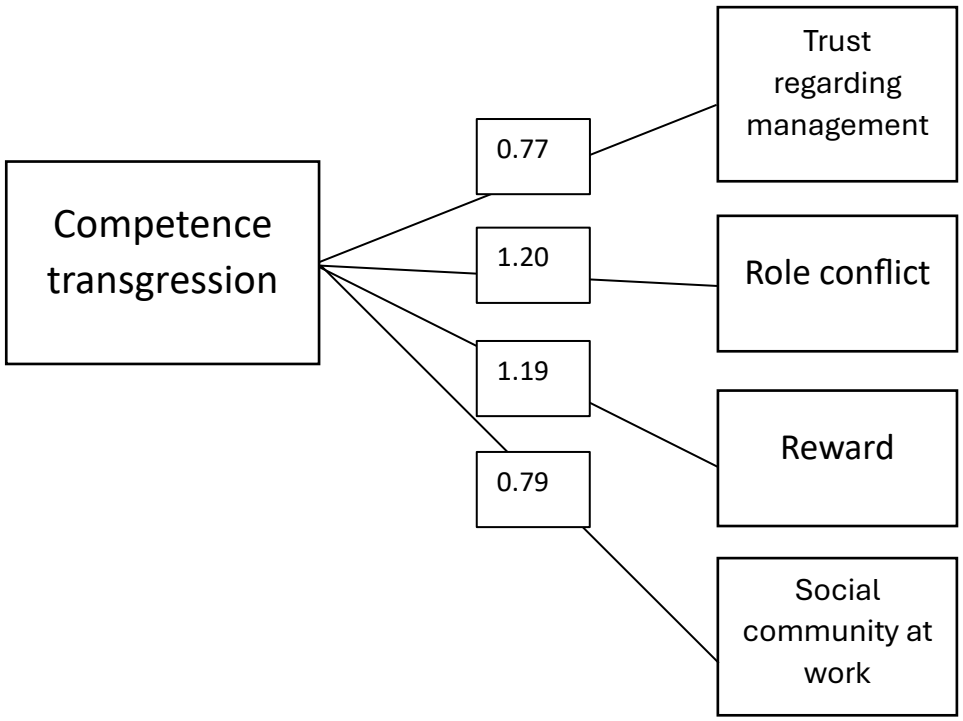

Figure 5.: Relationship of competence transgression with the COPSOQ-II subscales for nurses (the value shown is the odds ratio)

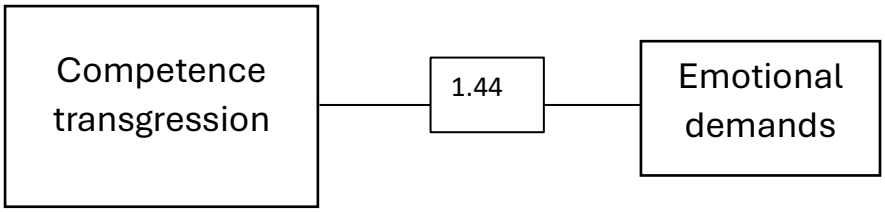

Figure 6.: Relationship of competence transgression with the subscales of the COPSOQ-II for doctors (the value shown is the odds ratio)

The model of perceived hierarchy in the nurses' group (see Figure 4.) was significant (Khi2= 30.985, p=0.000, Nagelkerke R2=0.247,), and three significant predictors were found. In the case of nurses, the Social support from colleagues (OR=0.73, p<0.001) was negatively associated with perception of hierarchy. Emotional demands (OR=1.24, p=0.006) and Stress (OR=1.19, p=0.05) were positively related to perception of hierarchy. The model for physicians was also significant (Khi2= 4.468, p=0.035, Nagelkerke R2=0.160), but no variable was significant.

Both models were significant for competence transgression (nurses: Khi2=40.297, p=0.000, Nagelkerke R2=0.254; physicians: Khi2=11490, p=0.001, Nagelkerke R2=0.313). Nurses' Trust regarding management (OR=0.77, p=0.010) and scores on Social community at work (OR=0.79, p=0.010) were negatively associated with competence transgression. Reward (OR=1.19, p=0.024) and role conflict (OR=1.20, p=0.020) were positively associated with competence transgression (see Figure 5.). There was one significant variable in the physicians' group. Emotional Demands (OR=1.44, p=0.040) was positively associated with competence transgression in the physicians' group (Molnár et al., 2023) (see Figure 6.).

4.3. THE RESULTS OF STUDY3

4.3.1. Sample characteristics

A total of 268 Hungarian persons, 208 women (77.6%) and 60 men (22.4%) completed the online questionnaire. Sample characteristics are shown in Tables 4. and 5.

Regarding occupation, there were 86 physicians (32% of the sample) including one or more specializations, 37 (13.8%) residents in their first to fifth year of specialization training in adult or child psychiatry, 47 psychologists (17.5%), 84 nurses (31.3%), and 14

persons with a degree classified as “other”. Since the latter group was deemed heterogeneous, we excluded them from occupation-based comparison. In terms of specializations: 75 were psychiatrists, 12 were child and adolescent psychiatrists, and 1 was classified as “other”. (Two of these specialists were also board certified in psychiatry and child psychiatry.) Hereafter we refer to these specialists collectively as psychiatrists. Among the physicians in training, 22 were residents (i.e., in the first two years of their training) and 15 were trainees (i.e., in the last three years of their training) in adult psychiatry or in child and adolescent psychiatry specialization training; hereafter we refer to them collectively as psychiatric residents. Among the nurses, 17 were qualified nurses, 52 were specialized nurses, and 15 were assistant nurses. As psychologists were a heterogeneous group, they were not subjected to further categorization.

Overall, 156 respondents (58.21%) participated in COVID care. There were significant group differences concerning occupation: 78% of psychiatric residents, 67% of nurses, and 60% of psychiatrists worked in COVID care, while this proportion was only around 30% for psychologists and “other” professionals. There was a comparable number of respondents working in Budapest (N=125, 46.6%) and in the countryside (N=143, 53.4%); we found no significant regional difference in their involvement in COVID care. In this questionnaire survey, we looked specifically at the number of health professionals who worked in acute psychiatric care and these totalled 105. Of these, 37 were men and 68 were women, as well as 19 nurses, 17 psychologists, 27 residents and 42 psychiatrists. Of these, 77.14% were involved in COVID care.

4.3.2. Comparison of mental health professionals participating and not participating in COVID care in terms of psychosocial factors at work

The comparison of mental health professionals involved in and those not involved in COVID care revealed several differences regarding work-related psychosocial factors (see Table 6.). We found significantly higher mean scores for work pace (59.08 versus 49.78) and role conflicts (55.21 versus 45.93) among those working in COVID care. Those who participated in COVID care had significantly lower scores for influence at work (38.18 versus 51.79), predictability (44.71 versus 57.03), reward (55.82 versus 65.03), role clarity (70.19 versus 75.37), social support from supervisor (59.24 versus 65.55), job satisfaction (54.36 versus 62.84), trust regarding management (55.89 versus

67.86), as well as justice and respect (44.51 versus 54.35). Regarding mental health indicators, only the stress score was significantly higher among COVID care workers (47.96±21.73 compared to 42.35±22.14), while there were no significant differences in burnout and sleeping troubles scores.

Table 5. Demographic characteristics of the sample from the second questionnaire survey

	Sample size	**Participated in COVID care**		Between group difference	
	Total N	N	%	Chi square	Exact Sig. (2-sided)
All respondents	268	156	58.21		
Profession				27.251	<0.001***
psychiatrist	86	52	60.47		
resident	37	29	78.38		
psychologist	47	15	31.91		
nurse	84	56	66.67		
other	14	4	28.57		
Sex				7.27	0.007
Male	60	44	73.33		
Female	208	112	53.85		
Age group				8.822	0.266
<31	34	25	73.53		
31-35	48	27	56.25		
36-40	39	23	58.97		
41-45	32	14	43.75		
46-50	37	24	64.86		
51-55	24	12	50.00		
56-60	33	21	63.64		
>60	21	10	47.62		
Workplace location				2.399	0.121
Budapest	125	79	63.2		
Countryside	143	77	53.85		

Table 6. Psychosocial factors according to COVID care

	Scale internal consistency	Sample total (N=268)		**COVID care (N=156)**		**Not in COVID care (N=112)**		Between Groups ANOVA	
Psychosocial factors at work	Cronbach alfa	Mean	SD	Mean	SD	Mean	SD	F	Sig.
demands quantitative	0.76	44.38	20.63	45.27	18.90	43.14	22.87	0.698	0.404
work pace	0.846	55.19	22.29	59.08	20.00	49.78	24.21	11.816	0.001
emotional demands	0.687	68.07	18.14	68.03	17.53	68.14	19.04	0.002	0.962
influence at work	0.775	43.87	22.59	38.18	19.15	51.79	24.62	25.855	<0.001
possibilities for development	0.656	72.99	17.40	71.55	16.29	75.00	18.74	2.570	0.110
meaning of work	0.828	79.17	19.86	77.83	18.94	81.03	21.02	1.692	0.195
workplace commitment	0.844	61.68	25.64	59.21	24.50	65.12	26.88	3.495	0.063
predictabi-lity	0.748	49.86	25.66	44.71	24.01	57.03	26.25	15.867	<0.001
reward	0.887	59.67	25.55	55.82	25.25	65.03	25.11	8.710	0.003
role clarity	0.802	72.36	20.43	70.19	20.44	75.37	20.12	4.243	0.040
role conflicts	0.715	51.33	19.69	55.21	17.85	45.93	20.90	15.268	<0.001
quality of leadership	0.88	60.87	25.02	57.49	24.82	65.57	24.65	6.944	0.009
social support from supervisor	0.844	61.88	25.00	59.24	26.09	65.55	23.02	4.201	0.041
social support from colleagues	0.744	62.72	20.49	61.59	20.64	64.29	20.27	1.127	0.289
social community at work	0.81	75.28	19.52	75.59	18.19	74.85	21.31	0.092	0.761
job satisfaction	0.75	57.90	20.42	54.36	20.02	62.84	20.02	11.709	0.001
work-family conflict	0.878	47.02	28.98	48.08	28.32	45.54	29.93	0.502	0.479
trust regarding manage-ment	0.781	60.89	22.11	55.89	20.75	67.86	22.15	20.497	<0.001

mutual trust between employees	0.74	63.31	20.77	62.29	19.43	64.73	22.51	0.904	0.343
justice and respect	0.834	48.62	23.57	44.51	22.25	54.35	24.24	11.831	0.001
BURNOUT	0.916	56.09	24.08	**57.81**	23.13	**53.68**	25.26	1.923	**0.167**
STRESS	0.896	45.62	22.04	**47.96**	21.73	**42.35**	22.14	4.263	**0.040**
sleeping troubles	0.867	32.88	24.48	**34.05**	25.54	**31.25**	22.94	0.855	**0.356**
competence transgression	single item	1.97	0.79	2.04	0.78	1.87	0.79	2.763	0.098

4.3.3. Stress, burnout and sleeping troubles scores for each professional group according to whether or not they received COVID care

As a next step, we compared the stress, burnout, and sleeping troubles scores of each professional group in the context of their participation in COVID care (see Table 7.). Only psychiatry specialists exhibited significant differences in stress and burnout scores. Those involved in COVID care had a higher mean stress score (52.16±22.41 versus 38.60 ±19.55; p=0.005) and a higher mean burnout score (58.30±23.54 vs. 47.06±23.40; p=0.033) compared to those not involved in COVID care.

We also compared the professional groups to each other (Table 7.). and found a significant difference (p=0.001) only in sleeping troubles: nurses scored higher (M=41.67, SD=25.73) compared to the other professional groups (psychiatrists: M=31.90, SD=24.48; psychiatry residents: M=26.18, SD=16.66; psychologists: M=25.27, SD=22.04). We found no difference in terms of burnout or stress.

Table 7. Stress, burnout and sleeping troubles among mental health professionals participating and not participating in COVID care Mean scores based on the COPSOQ II questionnaire

	PROFESSION	COVID CARE			ANOVA	
means		NO	YES	Total	F	Sig.
STRESS	**psychiatrist**	38.60	52.16	46.80	**8.306**	**0.005**
	resident	50.78	51.51	51.35	0.006	0.938
	psychologist	46.68	42.92	45.48	0.327	0.570
	nurse	41.74	43.97	43.23	0.203	0.654
	Total	42.95	48.11	46.04	3.443	0.065
	ANOVA between professions				1.245	0.294
BURNOUT	**psychiatrist**	47.06	58.29	53.85	**4.705**	**0.033**
	resident	64.84	56.47	58.28	1.025	0.318
	psychologist	60.55	63.33	61.44	0.123	0.727
	nurse	53.13	56.70	55.51	0.403	0.527
	Total	54.35	57.85	56.45	1.318	0.252
	ANOVA between professions				1.143	0.332
SLEEPING TROUBLES	psychiatrist	29.60	33.41	31.90	0.497	0.483
	resident	32.81	24.35	26.18	1.646	0.208
	psychologist	24.61	26.67	25.27	0.087	0.769
	nurse	41.07	41.96	41.67	0.022	0.882
	Total	31.43	34.17	33.07	0.774	0.380
	ANOVA between professions				**6.597**	**<0.001**

4.3.4. Results of the correlation analysis for the full sample

To investigate the relationship between psychosocial factors and stress/burnout, a correlation analysis was performed on our full sample (Table 8.).

The strongest correlations were found with emotional demands and work-family conflict (emotional demands with stress: r=0.380, with burnout: r=0.376; while work-family conflict with stress: r=0.543, with burnout: r=0.540). Among psychosocial factors, workplace commitment negatively correlated with stress (r=-0.313, p<0.001) and burnout (r=-0.283, p<0.001). Influence at work exhibited a significant correlation with stress (r=-0.2, p=0.001) and burnout (r=-0.212, p<0.001), albeit a markedly weak negative correlation.

Table 8. Correlation between work-related psychosocial factors and mental health indicators (N=268)

	stress		burnout	
	Pearson Correlation (r)	Sign. (p)	Pearson Correlation (r)	Sign. (p)
demands quantitative	0.269**	<0.001	0.292**	<0.001
work pace	0.153*	0.012	0.171**	0.005
emotional demands	**0.380****	**<0.001**	**0.376****	**<0.001**
influence at work	-0.200**	0.001	-0.212**	<0.001
possibilities for development	-0.149*	0.014	-0.097	0.113
meaning of work	-0.235**	<0.001	-0.190**	0.002
workplace commitment	-0.313**	<0.001	-0.283**	<0.001
predictability	-0.250**	<0.001	-0.182**	0.003
reward	-0.231**	<0.001	-0.177**	0.004
role clarity	-0.172**	0.005	-0.144*	0.018
role conflicts	0.275**	<0.001	.0198**	0.001
quality of leadership	-0.190**	0.002	-0.182**	0.003
social support from supervisor	-0.130*	0.033	-0.130*	0.033
social support from colleagues	-0.172**	0.005	-0.092	0.132
social community at work	-0.173**	0.004	-0.095	0.121
job satisfaction	-0.228**	<0.001	-0.243**	<0.001
work-family conflict	**0.543****	**<0.001**	**0.540****	**<0.001**
trust regarding management	-0.132*	0.031	-0.075	0.221
mutual trust between employers	-0.163**	0.008	-0.055	0.371
justice and respect	-0.215**	<0.001	-0.183**	0.003

4.3.5. Results of the regression analysis for the full sample

Lastly, employing multivariate analysis, we tested the predictors of stress and burnout (Table 9.), including all psychosocial work factors: quantitative demands, work pace, influence at work, possibilities for development, meaning of work, predictability, reward, role clarity, role conflicts, quality of leadership, social support from supervisor, social support from colleagues, social community at work, job satisfaction, trust regarding management, mutual trust between employees, justice and respect, work-family conflict, emotional demands, workplace commitment, participation in COVID care, competence transgression, and professional background (nurse, psychologist, psychiatrist, psychiatry trainee, and psychiatry resident). Profession and competence transgression were included in the model as DUMMY variables (0-1 values). These variables were selected as potential factors, and in accordance with the algorithm, non-significant variables were eliminiated by using the stepwise method. This model explained 40.5 % of the variance for stress and 39.8 % for burnout (adjusted R squares: stress 39.6%, burnout 38.9%).

Stress levels were significantly influenced linearly by work-family conflict, emotional demands, competence transgression, and workplace commitment. Whereas the first three had a positive effect on stress, workplace commitment had a negative effect on it (i.e., the more committed one was to their job, the less stress one experienced). Competence transgression exhibited the strongest linear relationship with stress. The degree of burnout was significantly affected by work-family conflict, emotional demands, workplace commitment, and by being a specialist psychiatrist. The last two variables were negatively associated with burnout (i.e., being committed to one's job and being a psychiatrist were associated with lower burnout scores). All other variables related to profession were deselected in the stepwise method.(Molnár et al., 2024).

Table 9. Results of regression analysis for stress and burnout (N=268)

STRESS

	B	Beta	t	p value
(Constant)	20.308		3.649	<0.001
work-family conflict	0.32	0.421	8.079	<0.001
workplace commitment	-0.2	-0.232	-4.712	<0.001
emotional demands	0.244	0.201	3.878	<0.001
competence transgression	3.039	0.108	2.181	0.03
R-square	**0.405**			
F test	44.79			
sign. (p)	<0.001			

The variables excluded in the stepwise method are: demands quantitative, work pace, influence at work, possibilities for development, meaning of work, predictability, reward, role clarity, role conflicts, quality of leadership, social support from supervisor, social support from colleagues, social community at work, job satisfaction, trust regarding management, mutual trust between employers, justice and respect, COVID care, nurse, psychologist, psychiatrist, psychiatric trainee, resident.

BURNOUT

	B	Beta	t	p value
(Constant)	33.954		6.377	<0.001
work-family conflict	0.373	0.449	8.554	<0.001
workplace commitment	-0.209	-0.222	-4.607	<0.001
emotional demands	0.294	0.222	4.265	<0.001
psychiatrist	-7.959	-0.155	-3.187	0.002
R-square	**0.398**			
F test	43.524			
sign. (p)	<0.001			

The variables excluded in the stepwise method are: demands quantitative, work pace, influence at work, possibilities for development, meaning of work, predictability, reward, role clarity, role conflicts, quality of leadership, social support from supervisor, social support from colleagues, social community at work, job satisfaction, trust regarding management, mutual trust between employees, justice and respect, COVID care, nurse, psychologist, psychiatry trainee, resident, competence transgression.

4.3.6. Results of correlation and regression analysis for acute psychiatric care workers

Correlations

The relationships between competence transgression, role conflict, role clarity, stress and burnout were investigated.

Table 10 shows that competence transgression did not have a significant correlation with the background variables. That is, date of birth and job position were not clearly associated with competence transgression.

Being a nurse and role clarity showed a weak positive association, while role clarity and being a resident showed a medium-strength negative correlation. Role clarity had a moderate negative correlation with competence transgression. An unclear job role was amplified with an increase in age. Those who worked in COVID care were more likely to find themselves in role conflict. If they experienced a role conflict in their job, these professionals were more likely to violate their boundaries of competence and perceive their job role as less clear.

Burnout and stress go hand in hand and can be inherent to the problems outlined above. The older the colleagues, the more stressed they are daily. This is less common for nurses.

Competence transgression showed a moderately significant association and role clarity a moderately negative association with burnout and stress. In other words, those who are not clear about their job roles or experience role conflict are more likely to experience stress and burnout sooner.

Regression

In our regression model (Table 11), we examine the extent to which the underperformance on the above psychosocial factors predicts competence transgression in our sample of acute care workers. We gradually introduced variables into our model, each one adding a little bit more to the interpretation of our model. Our model 4 provides 28.2% ($R=0.531$; $df= 4$; $F= 9.797$; $p<0.000$) support for the finding that a lack of role clarity, the role conflict, stress, and burnout together predict competence transgression (Molnár et al., 2025).

Table 10. Analysis of Zero- order correlation between variables (n=105)

Variables	Competence transgression	Role clarity	Role conflict	Burnout	Stress
Date of birth	0.090	-0.290**	0.030	0.130	0.205*
Nurse	-0.034	0.248*	-0.113	-0.055	-0.192*
Psychologist	-0.130	0.058	0.224*	0.097	0.010
Resident	0.123	-0.258**	0.035	-0.064	0.020
Psychiatrist	0.015	-0.008	0.225*	0.027	0.126
Participated in COVID care	0.154	-0.115	0.233*	0.068	0.121
Competence transgression	1	-0.387**	0.430**	0.336**	0.308**
Role clarity		1	-0.427**	-0.251**	-0.205*
Role conflict			1	0.209*	0.320**
Burnout				1	0.715**
Stress					1

*p< 0.05; **p< 0.01

Table 11. Standardised Linear Regression Coefficients (n=105)

Model		Unstandardized B	Coefficients Std. Error	Standardized Coefficients Beta	t	Sig.
1	(Constant)	3.135	0.263		11.916	0.000
	Role clarity	-0.016	0.004	-0.387	-4.260	0.000
2	(Constant)	1.973	0.426		4.630	0.000
	Role clarity	-0.010	0.004	-0.249	-2.598	0.011
	Role conflict	0.014	0.004	0.323	3.374	0.001
3	(Constant)	1.460	0.461		3.164	0.002
	Role clarity	-0.008	0.004	-0.205	-2.158	0.033
	Role conflict	0.013	0.004	0.295	3.144	0.002
	Burnout	0.008	0.003	0.223	2.544	0.012
4	(Constant)	1.465	0.464		3.156	0.002
	Role clarity	-0.008	0.004	-0.206	-2.157	0.033
	Role conflict	0.012	0.004	0.290	2.971	0.004
	Burnout	0.007	0.004	0.205	1.664	0.099
	Str_mean	0.001	0.005	0.027	0.212	0.833

a. Dependent Variable: Competence transgression

5. DISCUSSION

5.1. THE CONCEPT OF THE MULTIDISCIPLINARY TEAM AND THE POSITION AND ANALYSIS OF THE HIERARCHY

In our first focus group, information on leadership and hierarchy was gathered and the authoritarian leadership and hierarchy typical of multidisciplinary teams was revealed and discussed. Participants formulated that it is the responsibility of the leader to lead the team and that the responsibility of leadership cannot be shared. According to Martin, the definitions of healthcare teams are not clear, he suggested a precise definition of teams (Martin et al., 2022) and also highlighted the role of the leader in relation to multidisciplinary teams. He further described that team members basically work independently and in consultation with the leader who is the highest ranking professional, usually a doctor. According to Doyle, part of what characterizes multidisciplinary teams is essentially that the leader stands out from the team in terms of charisma, vision, power and authority (Michele Erina Doyle & Mark K Smith, 2001) which is called classical leadership. The leader has an important role in allocating roles and responsibilities within health teams (St. Pierre et al., 2008) and in managing both conflicts (Paganin et al., 2023) and destructive processes (Hámornik, 2013; Levi & Askay, 2020). The team leader is responsible for managing personal conflicts that hinder effective functioning within the team (Bodrogi et al., 2014).

We wondered what role leadership plays in the perception of hierarchy and what other psychosocial factors are involved in it. Our first questionnaire survey showed that where they perceived their team to be less hierarchical, they felt stronger social support from colleagues and greater personal influence at work, and experienced lower levels of stress. For nurses working at lower levels of the hierarchy, emotional demands and stress had a significantly positive effect on the perceptions of hierarchy, whereas social support from colleagues had a negative effect on it. That is, nurses who perceived their team as hierarchical reported higher stress and emotional demands and lower social support. The social support of colleagues also draws our attention to the importance of interpersonal factors in how psychiatric workers experience their work community. Our results suggest that in a superior-subordinate hierarchy, the quality of relationships within the team, which are co-subordinate, appears to be more important. Our interpretation is that the

more supportive a work community is, the less hierarchical their team is perceived to be. We found no significant relationship between perceptions of leadership and hierarchy.
In a Swiss study (Peter et al., 2020), stress levels of healthcare workers at different levels of the hierarchy were examined and it was found that those who worked at higher levels of the hierarchy had more control over their work, while those who did not work in a managerial position (e.g. nurses) were more affected by stress. The psychosocial factors we investigated in the context of hierarchy overlapping with the Karasek-Theorell Job Demand-Control-Support model (Karasek Jr, 1979; Karasek, 1990; Nistor et al., 2015), which is a model for studying workplace stress. According to this model, low social support, low control and high work demands are the "worst combination" for health and stress.

5.2. COMMUNICATION WITHIN THE TEAM, CONFLICTS

In our second focus group, communication and conflict within the team became the focus of attention. A conflict between a resident and a nurse emerged regarding who is more experienced and competent in the assessment and treatment of particular psychiatric patients. Nurses perform an important function within the team but may also perceive their own role as devalued by others (Hámornik, 2013; Long et al., 2003). A Greek study examining conflicts among 200 health care workers described that the majority of participants reported that conflicts occurred at their workplace, regardless of the professional team to which they belonged. Among different professional groups, doctors have reported nurses as the main occupational category with which conflicts are occurring, while nurses and administrators reported mostly doctors as the main source of conflicts. Among hierarchical structures, the majority of participants stated that conflicts occur mainly with the upper hierarchical rank" (Saridi et al., 2021).
“An important lesson from our focus group was the predominance of informal communication channels within the team. Connections within the team are mostly based on personal sympathy. In addition to professional competence and activity, other individual factors (sympathy, trust, solidarity) also influence the way team members relate to each other (Mérei, 1998). Informal channels can lead to ‘split problems’ and hidden conflicts which are conducive to the formation of sub-groups, but they also carry the potential for destructive behaviour which can reduce effectiveness through the

breakdown of integration" (Mérei, 1998; Hámornik, 2013, Molnár et al., 2020, 362). In health care, team conflicts can be constructive if misunderstandings and disagreements about roles and responsibilities can be clarified (Cullati et al., 2019; Jehn, 1994; Tekleab et al., 2009), but they can also reduce trust and performance and lead to poor mental health. The most common consequences of team conflict are a failure to provide timely and patient-centered care and less effective patient care (Cullati et al., 2019; Jerng et al., 2017; Saridi et al., 2021; Weiner & Cole, 2004). Other studies have described how poor communication can increase the potential for medical errors in care (Barrett et al., 2001). Creating an accepting atmosphere within the team allows for staff conflicts to be talked through (Füredi, 1979). Involving an external supervisor can be an improvement in reducing the emotional strain on teamwork (Kurimay, 2017). It is important to discuss tensions in an appropriate space, within a group, in "team supervision" (Szőnyi & Füredi, 2015).

5.3. INVESTIGATING WORK-RELATED COMPETENCES AND COMPETENCE TRANSGRESSIONS

One of the main research topics of our study was competences and competence transgression. We were curious to find out how clear the competence boundaries are in psychiatric care, what psychosocial factors influence competence transgression, what job positions are related to it and what conclusions can be drawn from this.

5.3. 1. Unclear boundaries of competence in psychiatric care

The boundaries of job-related competences are not clear in multidisciplinary teams, which was confirmed by our third focus group study. The importance of this was reviewed in the literature, both for acute and rehabilitation-psychotherapeutic care.

"In psychiatric rehabilitation, it is also important for community care teams providing personal support (case management) to acquire appropriate competences and to define the responsibilities of the specialists working in the team (Liberman, 2010, " (Molnár et al., 2020, 362).). A study regarding community mental health nurses showed that a well-structured work environment with clarified responsibilities and well-defined duties can lead to a fruitful cooperative relationship between healthcare professionals with higher work satisfaction levels that in turn are reflected on the patient's care quality (Goetz et al.,

2018; Saridi et al., 2021). According to the Hungarian professional guideline on psychotherapeutic care in health care, it is important to "define the basic aspects and processes of the activities of psychotherapists working in the field of psychotherapy, as well as the related competences and attitudes in health care" (Kovács P, 2024).

“In general emergency medical care, a hierarchy can clarify decision-making and responsibility in the management of critical situations (St. Pierre et al., 2008). In emergency psychiatric care, it is also important that roles within the team are clear and well-defined, roles and responsibilities are well-defined, and decision-making authority is well-defined (Tringer 2003). With regard to acute psychiatric care, the subsection of the Health Care Act entitled "Institutional treatment of psychiatric patients" mentions the competence of the head of the psychiatric institution to notify the court in the case of emergency treatment, and the specialist of the psychiatric outpatient clinic is mentioned in the case of compulsory treatment in order to initiate the procedure (Act CLIV of 1997 on Health Care, 1997). According to the sub-chapter 'Specific rules on the rights of psychiatric patients' and to Decree 60/2004 of the ESZCsM a restrictive measure may be taken by a doctor (Decree 60/2004 (VII.6.) of the Ministry of Health, Social Affairs and the Family, 2004; Act CLIV of 1997 on Health Care, 1997). A number of ethical-legal-medical aspects must be considered in relation to coercive measures. On the one hand, it should only be used when duly indicated and, above all, the patient's dignity must be respected. On the other hand, failure to use coercive measures would risk causing serious harm to the patient, and in such a case, if the doctor refrains from treatment when it would be in the patient's best interests, he or she is in breach of duty (Bridgman, 2000). Despite the legal provisions, the competence and responsibility of the specialist and non-specialist are not always fully clear in medical practice” (Molnár et al., 2020, 362).

5.3.2. Psychosocial factors affecting competence transgression

Based on our first questionnaire survey, we found that while role clarity was a negative predictor in the full sample, role conflict was a positive predictor of competence transgression in the nurses' subsample. In our second questionnaire survey, looking specifically at acute psychiatric care workers, we found that competence transgression was influenced by role clarity, role conflict, burnout, and stress. While in the first case the effect is negative, in the last three cases it is positive. In other words, the clearer the

job role, the less likely one is to cross competence boundaries. Conversely, if someone experiences conflicting expectations and role conflicts, they are more likely to cross competence boundaries. We also found that the greater the degree of stress and burnout, the more likely the employee is to fail to meet competence boundaries (Molnár et al., 2025).

Piko's study found that role conflict was positively associated with burnout and some of its dimensions among Hungarian health care workers. (Piko, 2006). Chen and colleagues studied burnout among hospital workers in Pakistan and described how a motivational leadership style they found effective reduced burnout through job clarity. If all employees clearly understand their role, this is expected to lead to a lower risk of burnout (Chen et al., 2022). Spännargård et al. (2023) studied 327 Swedish psychotherapists by using the Copenhagen Burnout Inventory questionnaire. The authors found that work-related stress and burnout variables were ultimately predicted by only two variables, perceived competence and working in private practice. Psychotherapists who perceive themselves to have the competence to help patients are likely to experience less anxiety, greater job satisfaction, and lower stress. Therapists in private practice also have greater control over their work roles and tasks, which reduces the potential for stress and burnout (Spännargård et al., 2023).

5.3.3. Investigating the relationship between residents and role clarity

An emphatic finding of this research is that residents working in acute care perceived their job roles to be less clear. In a systematic review, Navines examined resident burnout during the first wave of the pandemic. The author highlighted the importance of clear protocols and hands-on training in protective measures, as well as access to protective equipment, to ensure trust and control, thereby reducing stress levels (Navinés et al., 2024).

In a systematic review, Pinilla described the core entrustable professional activities (EPAs) important in psychiatry. EPAs represent discrete clinical tasks that can be entrusted to trainees in psychiatry. These activities are increasingly being used as educational frameworks in several countries. This systematic review outlined how the concept of EPA-based curricula appears to be increasingly present in psychiatric training. However, the lack of empirical research in this context is an important limitation for

recommendations on educational practice (Pinilla et al., 2020). This review included a German study (Vietz et al., 2019) in which Vietz and colleagues compared competences relevant to psychiatry and surgery. Between 30 and 30 participants from each of the two departments participated in the study through semi-structured interviews. This study concluded that the competencies necessary for conducting a ward round are similar in surgery and psychiatry and correspond to previously reported competencies in internal medicine. According to the study, clinical skills are of greater importance in surgery than in psychiatry. Non-verbal communication was also described more frequently in psychiatry than in surgery, and empathy competencies were more frequently considered to be characteristic of psychiatric residents than of surgery residents.

A comprehensive, systemic overview of the competencies, responsibilities and roles of acute psychiatric care workers is less widely available in international literature (NHS 2007; Chen et al., 2013). The World Psychiatric Association (WPA) General Assembly in Vienna adopted a resolution addressing the responsibilities and roles of psychiatrists during the COVID-19 pandemic (Chen et al., 2013; (Stewart & Appelbaum, 2020). A resolution of the WPA and the European Union of Medical Specialists (UEMS) Psychiatric Section examined the competencies of psychiatric training (UEMS 2009; Belfort et al., 2017). In Hungary, the EMMI Decree 22/2012 (IX.14.) addresses the requirements for the training of psychiatric specialists (EMMI, 2012.). Other studies emphasize the need to further develop and rethink the "health competence framework" (Batt et al., 2020; Lepre et al., 2021). The UEMS and EPA position papers may provide further perspectives in this area (UEMS 2009; Belfort et al., 2017; Brittlebank et al., 2016; Hendrickx et al., 2020).

5.3.4. Investigating the relationship between competence transgression and reward among nurses

A surprising finding of our research was that the reward was a positive predictor of competence transgression among nurses. That is, the more a nurse transgresses her competence boundary, the more she feels acknowledged. Several studies have examined nurses' competence in the literature (Amini et al., 2017; Eita & Alhalawany, 2021; Kalani et al., 2023; Zeydi et al., 2022). According to Eita et al, the goal of psychiatric nurses to become more competent enables them to perform their roles and tasks to a satisfactory

standard (Eita & Alhalawany, 2021). No results on nurses' competence transgression were found in the literature. We know from everyday national practice the phenomenon that in psychiatric wards where there is a high overload and few doctors, nurses can perform tasks that are primarily within medical competence. For example, transferring medication from a fever chart to a new fever chart. In the COVID wards caring for psychiatric patients in the pandemic situation, it has been appreciated that nurses who are experienced in psychiatric care are informed about the patient's condition, how they see the patients, especially where doctors who were not previously working in psychiatric care are working due to their secondment/transfer. In practice, we see that doctors often go to nurses whose work and professionalism is recognized.

In addition to everyday examples, the training of Advenced Practice Nurses (APNs) in health care demonstrates the need for a regulated framework for training "health science professionals with the knowledge to carry out complex, independent work with extended responsibilities in patient care, to think critically according to their specialization and to apply the knowledge acquired in practice" (Semmelweis University, 2024).

A US study on rethinking the competence of health care workers in psychiatry suggests that certain tasks and competencies should be delegated to health care workers with appropriate training and experience in places where there are few or no psychiatrists. The American Association for Emergency Psychiatry (AAEP) has „endorsed the use of independently licensed clinical social workers, clinical psychologists, and licensed mental health counsellors, collectively referred to as psychiatric emergency clinicians (PECs)" (Richmond et al., 2021). According to a French study, advanced practice nurses working in psychiatry experienced very low stigmatization from their colleagues in their working environment (in contrast to other professions in psychiatry) and APNs can play an important role in the improvement of professional health practices, particularly in terms of improved coordination between psychiatric-care and physical-care (Damien et al., 2024). An Israeli study shows the need for APNs working in different fields and there are very few in psychiatry (Zlotnick et al., 2024). The specialization of APN training in Hungary includes a specialization in geriatric specialist nursing (Semmelweis University 2024). Our study highlights the need to rethink the competencies of nurses working in psychiatric care.

5.4. INVESTIGATING THE IMPACT OF PARTICIPATION IN COVID-19 CARE AMONG MENTAL HEALTH PROFESSIONALS

5.4.1. Investigating the relationship between participation in COVID-19 and work-related psychosocial factors among mental health professionals

„We compared work-related psychosocial factors among mental health professionals involved in and those not involved in COVID care during the fourth and fifth waves of the COVID-19 pandemic in Hungary. Similar to what other studies have shown, those involved in COVID care scored their work environment as necessitating a higher work pace and instigating more role conflicts, being less predictable, having less influence on their actual work, less justice and respect, yielding fewer rewards, and also having less trust regarding management and being less satisfied with the leadership (Table 3.)" (Molnár et al., 2024, 7). Prior to the pandemic, a number of studies had already examined the levels of stress and burnout among mental health professionals and their relationship with psychosocial factors. In this context, Rössler drew attention to certain job characteristics such as workload, lack of social support (especially from supervisors/managers), lack of adequate information, role ambiguity or role conflict, and limited autonomy (Rössler, 2012).

5.4.2. Investigating the relationship between COVID-19 treatment participation and stress, burnout and sleeping troubles among mental health professionals.

Participation in COVID care was associated with an increase in stress levels for those working in psychiatric care, but there was no difference in burnout based on whether or not working in COVID care. Participation in COVID care was associated with an increase in stress and burnout levels for psychiatric specialists. "Thus, our study indicates that participation in COVID care does not in itself cause burnout. This was an unexpected result, as according to Chutiyami's meta-review (Chutiyami et al., 2022) and a scoping review by Moitra et al.(Moitra et al., 2021), frontline work is generally a risk factor for stress and burnout among health care workers" (Molnár et al., 2024, 7).

During the first three waves of the pandemic, without effective treatment or prevention, hospitalizations and acute mortality rates reached unprecedented levels. The health care

system was overwhelmed and efforts to separate the infected from the uninfected led to a complete reorganization of the hospital system. There was a shortage not only of protective equipment but also of health care providers, both in acute and COVID care units. This has led to a redeployment of staff, forcing many to perform tasks that they had not done before or that were beyond their competence. Many health workers were infected and many developed severe symptoms requiring hospitalization and chronic post-COVID symptoms. There have also been deaths during the pandemic. There are no official statistics on pandemic-related deaths among Hungarian health workers. However, the Hungarian Medical Chamber has published a list on its website in memory of health workers whose deaths have been attributed to COVID-19 infection basen on the media and various personal sources of information (Hungarian Medical Chamber, 2023)

By contrast, in the fourth and fifth waves of COVID-19 (September-December 2021; January-May 2022), vaccines were available, and mortality associated with the omicron variant was lower. In addition to these positive changes, we know from field experience that fear of infection among mental health professionals has decreased.

Another unexpected finding was that among the professional groups, only psychiatrists were found to be associated with an increase in stress and burnout scores when participating in COVID care. To our knowledge, this is the first study to focus on the mental health of mental health professionals, comparing different subgroups working in similar settings, comparing those who participated in COVID care and those who did not. “In a Croatian study (Jokić-Begić et al., 2020), comparing psychiatrists with other specialists, they found that physicians working in other specialties had higher anxiety scores on the COVID-19 Anxiety Scale (CAS); furthermore, psychiatrists were also more prone to abuse drugs and sedatives compared to other specialists (the frequency of using sedatives was 1.6% among physicians and 2.8% among psychiatrists)” (Molnár et al., 2024, 8).

Our study focused mainly on doctors and nurses working in psychiatric care in Hungary. Psychologists were affected by the pandemic in a very different way: while some of them also had a nursing role in COVID care, others (also) worked in safer private practice; therefore a more complex approach and survey would have been needed to examine them in their different roles. „Studies concerning psychologists and therapists have chiefly

focused on the practice of teleconsultation and support for health workers (Békés et al., 2020; Billings et al., 2021; Phillips et al., 2021), whereas in our study 31.9% of psychologists (15 persons) reported direct 'bedside' involvement in COVID care, a grouping of psychologists absent in relevant literature. No significant differences were found between psychologists' stress and burnout scores according to whether they worked in COVID care or not. The low number of psychologist participants also makes us cautious about comparing data" (Molnár et al, 2024, 8).

Our study also showed that, at the lower levels of the hierarchy, there was no significant difference in stress and burnout between COVID and non-COVID workers (e.g. medical trainees, nurses). Their options and choices are essentially limited by their professional position. We also know from experience that the competences, responsibilities and autonomy of psychiatrists working at the bedside of COVID patients have changed significantly during the pandemic. COVID care has been difficult for specialists, psychiatry residents, nurses and other staff involved, but the responsibility for making decisions has been primarily that of the specialists. „We know that in practice there have been psychiatric patients who, because of their underlying psychiatric illness (e.g., paranoid schizophrenia) and somatic complaints (e.g., shortness of breath, weakness), were admitted to psychiatric wards that had been converted into COVID care units. However, there were also psychiatric patients who were admitted with mild symptoms, which became more severe in the course of their illness and required somatic care (e.g., monitoring of vital signs, administration of oxygen or specific drugs). In the presence or threat of respiratory complaints (e.g., alcohol-induced delirium), psychiatrists also had to carefully consider the provision of certain psychiatric drugs (e.g., benzodiazepines) to patients due to their respiratory depressant effects. These professional decisions and responsibilities may have been difficult for psychiatric specialists, and the current epidemiological situation may have induced chronic uncertainty, leading to a perceived loss of control" (Molnár et al., 2024, 8-9).

5.4.3. Comparison between occupational groups on stress, burnout and sleeping troubles

„We found significant differences only for sleeping troubles when comparing nurses with other professional groups involved in psychiatric care. While previous review articles

have concluded that being a nurse during the pandemic is a risk factor for mental health problems (Chutiyami et al., 2022; Moitra et al., 2021), our results showed no significant difference in stress and burnout between nurses and other mental health professionals. In our study, stress and burnout scores for each professional group (see Table 7.) exhibited similar values, which may have been due to unpredictability and insecurity affecting all professions (secondments were necessary regardless of professional status). Of our sample of psychiatric workers, 58.2% was directly involved in COVID care. According to another Hungarian study (Spányik et al., 2022), unpredictability was higher among non-physician health care workers compared to physicians, but no significant difference was found between physicians and non-physicians in terms of stress and burnout" (Molnár et al. 2024, 9).

According to a review and meta-analysis by Macaron, who compared burnout in doctors and nurses during the pandemic based on 14 studies, he found that the risk of burnout was similar in both groups (Macaron et al., 2023). Results of Kunz et al. were similar, showing similar levels of stress and burnout between nurses and doctors before the pandemic (Kunz et al., 2021) According to Budzynska, who studied healthcare workers in Poland during the long-lasting COVID-19 pandemic, she found that there was no significant difference between the perceived levels of stress and burnout, mental health, between doctors and nurses (Budzyńska & Moryś, 2023). According to Vita, the professional role of the nurse is a significant predictor of higher levels of psychological distress compared to other occupational positions, including both the impact of traumatic events and depression and anxiety symptoms (Vita et al., 2023). Several meta-analysis studies have highlighted that nurses, due to their closer and longer contact with patients and thus higher risk of infection and high levels of work-related stress, are more vulnerable (Luo et al., 2020; Saragih et al., 2021; Vita et al., 2023). The greater psychological impact in nurses may also be related to greater exposure to patients' complication and events related to their death, higher perception of risk and to the initial lack of protective devices (Kunz et al., 2021; Preti et al., 2020; Vita et al., 2023), leading to a greater concern regarding the risk of contracting and spread ing the infection.

„Prior studies conducted during the pandemic have emphasized that being a physician is a risk factor for burnout (Rapisarda et al., 2020; Ruiz-Fernández et al., 2020; Zhu et al., 2022). According to Li (Li, 2020; Zhu et al., 2022), nurses consider their work a

development opportunity, which has a protective effect against burnout. Lasalvia et al. (Lasalvia et al., 2009; Umene-Nakano et al., 2013) state that the burnout of psychiatrists in mental health teams is the highest, however, our study did not confirm this claim.

A study from Saudi Arabia(Alkhamees et al., 2021) investigated burnout among psychiatry residents during the pandemic, which described a lower prevalence (27.3%) compared to a pre-pandemic systematic review (33.7%) (Chan et al., 2019), which was explained by a reduction in their duties during the outbreak" (Molnár et al., 2024, 8). Navinés' systematic review and meta-analysis of resident burnout during the first wave found that the estimated pooled prevalence of burnout was 40%. Burnout was associated with psychiatry history. There were no diferences by gender, civil status, children in-charge, year of residency, or time exposure to COVID (Navinés et al., 2024). Agrawal studied US residents who had worked in psychiatric care during the first wave and described how half of the sample reported high burnout, with a mental composite summary score of 40.7. Among junior residents, the mental composite summary score was significantly lower during COVID than before the pandemic, which was associated with lower autonomy, increased insecurity and more difficult working conditions (Agrawal et al., 2023). A recent study in Hungary, which looked at burnout among doctors in the county of Győr-Moson-Sopron during the pandemic, found that residents and junior doctors (25-35 year olds) were the most affected by burnout, which they attributed to anxiety due to the professional insecurity of junior doctors, vulnerability due to hierarchical positions, overwork, lack of professional and collegial support, and they also suggested a generational gap as a source of stress (Balog et al., 2024).

According to an Italian study among health workers, psychologists also experienced excessive work stress and burnout during the pandemic (Crescenzo et al., 2022; Crescenzo et al., 2021), while another study states that psychologists who are effective in helping others are less effective in taking care of themselves and need to remedy this (Rokach & Boulazreg, 2022). An Austrian study comparing clinical psychologists with the general population found that depression, anxiety, moderate/high stress symptoms were higher in the general population, whereas no difference was found for insomnia. This was explained by their better socioeconomic status, fewer economic challenges, easier coping with stressful situations, and the fact that most of them, being in private practice, have greater autonomy (Humer et al., 2023). Regarding Austrian

psychotherapists, Schafflerwrites that "essential resources encompassed social connections, mindfulness, work satisfaction, and internal processes. Notably, psychotherapists demonstrating good well-being were older, more physically active, had a lower proportion of females, were employed in private practices rather than in institutionalized settings, had more years of professional experience and treated more patients weekly than their counterparts with poor well-being. Furthermore, they exhibited greater optimism, health focus, and satisfaction with their coping methods" (Schaffler et al., 2023).

„Regarding sleep quality, in our study, nurses scored significantly higher on the sleeping troubles subscale than psychiatrists, psychiatry residents, and psychologists. We explain this with the well-known negative effect of shift work on sleep quality. However, the literature again is divided on this subject: according to Cabeza et al.'s study in Columbia, during the first waves of the COVID-19 pandemic, psychiatrists and psychologists had more sleeping troubles than nurses, albeit this difference was not significant (Cabeza et al., 2022). In the review and meta-analysis of Salari et al. (Salari et al., 2020), the prevalence of sleep disorders during COVID-19 was higher among physicians as well. An African study (Oderinde et al., 2021) asserted that 23.9% of psychiatric workers were affected by sleep problems but found no significant association with professional position" (Molnár et al, 2024, 9).

5.4.4. Psychosocial factors affecting stress and burnout among mental health professionals

Emotional demands, work-family conflict, workplace commitment, competence transgression have a moderating role in the development of stress. Emotional demands, work-family conflict, workplace commitment, being a psychiatrist have a moderating role in the development of burnout.

"Our study also revealed that participation in COVID care alone did not cause stress or burnout. According to Pappa et al. (Pappa et al., 2021), concerns about the impact of COVID-19 on society and feeling pressured and uncomfortable at work contributed to burnout among mental health workers. Congruently, Rapisarda et al. (Rapisarda et al., 2020) states that close contact with COVID patients also constituted a risk factor for

burnout" (Molnár et al., 2024, 9). Rahmat, who studied psychosocial factors in Indonesian psychiatric nurses, described that nurses who interact with patients more than five times each shift typically experience significant levels of stress and anxiety has a signifcant relationship with the contact frequency (Rahmat et al., 2023). Macaron found that „frontline workers were at higher risk of experiencing burnout compared to their second-line worker colleagues. They also experienced higher mean scores for emotional exhaustion and depersonalization. Aside from fear of getting infected or spreading the infection to their loved ones, frontline HCW became the target of stigmatization in their communities, with people viewing this group as a possible cause of virus transmission (Macaron et al., 2023; Taylor et al., 2020). Frontline workers also experienced increased workload coupled with the unique demands of a novel pandemic and reported elevated levels of psychological outcomes such as depression, post-traumatic disorder, and anxiety (Billings et al., 2021; Macaron et al., 2023)."

A new study suggests that COVID-19 may not have damaged the mental health of most people to the extent that previous research has suggested. This systematic review examined the 'general mental health' factor before and during COVID in the general population; no changes in terms of mental health were found based on 94,411 unique titles and abstracts including 137 unique studies from 134 cohorts (Sun et al., 2023). Based on Navines systematic review and metanalysis, direct care of COVID-19 patients by residents was not a risk factor for resident burnout (Navinés et al., 2024). According to Budzynska, working in a COVID-19 ward did not differentiate health workers in terms of perceived stress, burnout or mental health (Budzyńska & Moryś, 2023).

„In our study, competence transgression had a moderating role only for stress, but not for burnout. Kagan et al. (Kagan et al., 2021)) examined mental health nurses/nurse managers, claiming that many suffered from burnout and were overwhelmed by their new tasks and responsibilities, yet experienced high levels of satisfaction with their managerial performance because they viewed the extension of their nursing competence as a positive outcome (Bambi, 2020; Kagan et al., 2021).

Workplace commitment was also found to have a moderating and negative effect on both stress and burnout; that is, the more committed one is to one's job, the less stress or burnout one experiences. Among health care workers, stress and burnout have been

described as negatively influencing the development of organizational commitment (Dasgupta, 2016; Kuusio et al., 2010; Laschinger et al., 1999; Rodríguez-Fernández et al., 2021). It has also been reported that among nurses, professional competence did not show any effect on the development of organizational commitment (Karami et al., 2017; Rodríguez-Fernández et al., 2021).

Emotional demands and work-family conflict had a moderating role in both stress and burnout. Martinez et al., who also worked with a version of the COPSOQ questionnaire during the first wave of COVID, described that health care workers reported worse health outcomes and higher exposure to psychosocial risks than the general salaried population. In addition to the high work demands and work pace, emotional demands were also high in health care workers, and frontline workers were more exposed to these psychosocial risks (Martínez et al., 2022).

In our study, influence at work was selected out as a non-significant variable by using the stepwise method. We also know from the pre-pandemic literature that for psychiatrists and mental health professionals, professional autonomy is essential for their mental health, job satisfaction, and for avoiding burnout (Fothergill et al., 2004; O'Connor et al., 2018; Schulz, 1988). Wu's study found (Wu, 2020) that low burnout scores among COVID care workers were associated with greater professional control and access to more information. Ogütlü et al. (Öğütlü et al., 2021) conducted research among Turkish psychiatrists, most of whom reported moderate or high levels of stress related to the COVID-19 pandemic, and the majority of them also experienced moderate or high levels of work- and patient-related burnout, as well as lower levels of personal burnout. The latter was explained by the respondents' confidence in their ability to manage the COVID-19 crisis themselves, which, according to the authors, indicates personal resilience and an internal locus of control.

Our results are in accordance with other findings stating that work-family conflict is related to burnout and stress. Kameg et al. surveyed mental health nurses (Kameg et al., 2021), 64% of whom reported that the demands of their job often disrupted their family life; overall burnout scores remained moderate. This was explained by the fact that participants were generally able to cope effectively with the demands of the job, thus reducing burnout. Family life was a protective factor for caregivers during the COVID-

19 pandemic, and family was an external source of support that mitigated burnout (Goh, 2020)" (Molnár et al., 2024, 9-10).

5.5. Limitations

Our cross-sectional studies provided a snapshot of both team functioning and the psychosocial factors that characterize teams among mental health professionals… however, this did not allow for a longitudinal study to explore causal relationships. Our questionnaires were targeted at a wide range of professionals working in psychiatric-psychotherapeutic care in Hungary, yet, as the number of respondents was relatively small, our surveys cannot be considered representative. The pandemic made the survey difficult: the first questionnaire survey could not be continued due to the outbreak of the pandemic. The second questionnaire survey was active over a 5-month period, as data collection went less efficiently as we hoped. During this period, COVID was active and there was no change in the regulation of COVID care or in the functioning of psychiatric care units. Although we sent several reminders via our previously used recruitment channels, we had to close the survey at a lower sample size. Based on personal information, the most common reasons for not completing the questionnaire were "we are already too busy and overwhelmed" and "I am not interested in any surveys". We can draw limited conclusions regarding the specific stress of the psychologists, as some of them provided teleconsultations and others were directly involved in COVID care "at the bedside", or both. Another limitation of the studies is that we evaluated stress and burnout based on the COPSOQ II questionnaire subscales, which did not allow us to examine the individual components of burnout. A further limitation of the study is that although our design targeted to investigate multidisciplinary teams in psychiatric and psychotherapeutic care, our results primarily reflect psychiatric care. In the second questionnaire survey, we had a very low sample size from psychotherapeutic care and therefore could not present statistically relevant results. We would have been interested to examine the situation of colleagues with other professional qualifications (e.g. physiotherapist, art therapist, social worker, dietician), but we regret that a significant number of them were not included.

5.6. The main new findings presented in the thesis

1.A large-scale study of psychosocial factors relevant to psychiatric teams in Hungary, using the COPSOQII questionnaire.

2.A study of workplace psychosocial factors of Hungarian acute psychiatric care workers.

3. An examination of Hungarian psychiatric care workers according to whether they participated in COVID care.

4. The concept of "competence transgression" in psychiatric care has, to our knowledge, not been studied before.

5. It would be useful to draw up a "national list of competencies in psychiatry".

6. While previous systematic reviews have concluded that being a nurse during a pandemic is a risk factor for mental health problems, our results, using a domestic sample, showed no significant differences in stress and burnout between nurses and other professional groups.

7 Among the professional groups studied, we found that only among psychiatrists was participation in COVID care associated with an increase in not only stress but also burnout scores.

8. For nurses, competence transgression positively affected their reward, which raises the need to rethink nurses' competence. The APN (Advanced Practice Nurse) training towards psychiatry should be developed.

6. CONCLUSIONS

Our research focused on the following questions:

1. The concept of multidisciplinary teams is not uniform.

The international literature does not have a standardized definition of multidisciplinary teams in healthcare, and therefore the use of standardized terminology and definition is recommended. According to a group of authors, multidisciplinary team is typical: „Multidisciplinary teams comprise professionals from multiple disciplines who work independently and complete discipline-specific assessments and treatments to achieve discipline-specific and clinician-directed patient goals (that might or might not complement the work of other professionals). Each member contributes their unique discipline perspective, and all communication occurs through the highest-ranking member (usually the physician) who directs patient care." (Foley, 1990; Martin et al., 2022).

2. The perception of hierarchy is positively influenced by the attitude of staff towards management.

We could not find a significant correlation between hierarchy and leadership. Our research results showed that where they perceived their team as less hierarchical, they had stronger perceptions of social support from colleagues and of their own influence at work, and lower perceptions of stress. For both nurses and doctors, social support from colleagues played an important role in their perception and interpretation of hierarchy. In addition, for nurses, emotional demands and stress in the perception of hierarchy were separate significant findings, i.e., those who perceived their team as hierarchical reported higher stress and emotional demands"

3. Unresolved conflicts in a team are destructive to the team.

Unresolved conflicts have a destructive effect on the team as a whole. To solve problems, it is recommended to provide staff groups, team supervision with the involvement of an external supervisor.

4. Competences in multidisciplinary teams are not clear.

Competences are not clear in multidisciplinary teams.

While professional competences in psychiatric care have been acknowledged in the literature, the notion of competence transgression has not been studied. In our view,

competence transgression refers to clinical situations in which a health worker—such as a doctor, nurse, or other health professional—performs a task or makes a decision that goes beyond his or her qualifications, professional competence, or license to practice. This situation can not only lead to professional misconduct and compromise the safety of patient care but also have ethical and legal consequences.

5. Competence transgression is determined by a lack of role clarity.

Competence transgression is negatively affected by role claritiy. Residents working in acute psychiatric care do not feel clear about their job role. On the basis of the existing, useful EMMI Regulation 22/2012 (IX.14.), it is worth considering the professional recommendations of the World Psychiatric Association and the European Union of Medical Specialists and creating a list of "psychiatric specialist competences".

The reward was a positive predictor of competence transgression among nurses. That is, the more a nurse transgresses her competence boundary, the more she feels acknowledged. Our study highlights the need to rethink the competences of nurses working in psychiatric care and to develop the training of APNs (Advanced Practice Nurses) towards psychiatry.

6. Working in COVID care units is associated with higher levels of work-related psychosocial risk factors.

We found significantly higher mean scores for work pace and role conflicts among those working in COVID care. Those who participated in COVID care had significantly lower scores for influence at work, predictability, reward, role clarity, social support from supervisor, job satisfaction, trust regarding management, as well as justice and respect.

7. Participation in COVID-19 care is associated with increased levels of stress, burnout, and sleeping troubles among mental health professionals.

Regarding mental health indicators, only the stress score was significantly higher among COVID care workers, while there were no significant differences in burnout and sleeping troubles scores. Only among psychiatrists did we find that their participation in COVID care was associated with an increase in stress and burnout scores.

8. Nurses are at a higher risk of stress, burnout, and sleeping troubles compared to other professional health groups.

While previous review articles have concluded that being a nurse during the pandemic is a risk factor for mental health problems, our results showed no significant difference in

stress and burnout between nurses and other mental health professionals. Regarding sleep quality, in our study, nurses scored significantly higher on the sleeping troubles subscale than psychiatrists, psychiatry residents, and psychologists.

9. Participation in COVID care and the characteristics of the work environment in COVID care are independent predictors of high stress and burnout.

Participation in COVID care alone did not cause either stress or burnout. Stress levels were significantly influenced linearly by work-family conflict, emotional demands, competence transgression, and workplace commitment. Whereas the first three had a positive effect on stress, workplace commitment had a negative effect (i.e., the more committed one was to one's job, the less stress one experienced). Competence transgression exhibited the strongest linear relationship with stress. The degree of burnout was significantly affected by work-family conflict, emotional demands, workplace commitment, and by being a psychiatry specialist. The last two variables were negatively associated with burnout (i.e., being committed to one's job and being a psychiatrist were associated with lower burnout scores).

Assessment and knowledge of psychosocial factors in the workplace can provide a basis for reforming and rethinking psychiatric care in the face of new challenges.

7. SUMMARY

Introduction. We have studied psychiatric multidisciplinary teams and their psychosocial factors in Hungary before the pandemic outbreak and in the subsequent waves of the pandemic.

Methods: Focus groups were held in 2017, 2018 and 2019 at the MPT's travelling assemblies (N=17). Based on them, a cross-sectional questionnaire survey was conducted among Hungarian mental health professionals (N=279) between January and February 2020, with the main question being how perceived hierarchy and competence transgression are generally related to psychosocial factors of the COPSOQ-II questionnaire. We republished our updated questionnaire to Hungarian mental health professionals, between November 2021 and April 2022 (N=268). In addition to stress, burnout and sleeping troubles, we also examined psychosocial factors at work.

Results. International literature does not have a uniform definition of multidisciplinary teams in health care. We found no significant association between hierarchy in teams and leadership. Competencies are not clear in multidisciplinary teams. There was a medium-strength negative significant correlation between acute care residents and role clarity ($r=-0.258$, $p<0.01$). Although there is ample literature on professional competences in psychiatric care, the concept of competence transgression has not been explored to our knowledge. In our study prior to the pandemic outbreak, reward (OR=1.19, p=0.024) positively influenced competence transgression among nurses. Among those involved in COVID care, only the stress score was higher (47.96 vs. 42.35) in the total sample; however, among psychiatrists, both stress (52.16 vs. 38.60) and burnout scores (58.30 vs. 47.06) were higher. Being in COVID care alone did not cause either stress or burnout.

Conclusions. It may be useful to clarify the concept of multidisciplinary teams and to introduce the concept of competence transgression. It is worth considering the professional recommendations of the World Psychiatric Association and the European Union of Medical Specialists and to draw up a list of "competences for psychiatric specialists". Our study highlights the need to rethink the competences of nurses working in psychiatric care and to improve the training of APNs (Advanced Practice Nurses) towards psychiatry. Further research is needed on stress and burnout testing for mental health professionals.

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Publications related to the thesis:

1, Molnár, L., Szvath, P., Győrffy, Zs., Zana, Á. (2020). A multidiszciplináris teamek vizsgálata a pszichiátriai ellátásban. Három fókuszcsoport tanulságai. Assessment of multidisciplinary teams in psychiatric care – lessons of three focus groups. Lege Artis Medicine (LAM), 30. 357-364. https://doi.org/10.33616/lam.30.031. (Licence number from the journal for use of this publication in a doctoral thesis: L241211FR000000PR.)

2, Molnár, L., Kalotaszegi, S., Gergely, B., Takács, Sz., Zana, Á. (2023). A pszichiátriai munkacsoportok pszichoszociális tényezôinek vizsgálata Magyarországon. A study of psychosocial factors in psychiatric teams in Hungary. Psychiatria Hungarica, 38(3). 218-231.

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Publications not related to the thesis:

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APPENDIX A

The first questionnaire

Questionnaire package for the research entitled *Examination of multidisciplinary teams in psychiatric and psychotherapeutic care*

Thank you for helping us by filling out the questionnaire!

Medical Faculty of Semmelweis University, Institute of Behavioral Sciences
dr. László Molnár. Dr. Ágnes Zana

Sociodemographic questions

I. Which year where you born?

……

II. Your gender:

1. male
2. female

III. Please indicate your highest level of education. You can provide multiple answers!

III a. If you are a nurse/healthcare professional:

1. no healthcare education (e.g. auxiliary nurse)
2. nursing assistant
3. nurse practicing in general healthcare and assistant
4. specialist nurse/assistant
5. practicing nurse
6. nurse trained in a higher education course (e.g. OKJ 54. 55)
7. graduate nurse with BSc
8. graduate nurse with MSc

III/b. If you are a psychologist:

9. psychologist in postgraduate specializing training

10. clinical psychologist
11. child and youth psychologist
12 psychologists with other professional qualifications
13 psychologists and psychotherapists with the specialist qualification in psychotherapy

III/c. If you are a medical doctor:
14. psychiatric resident
15. trainee psychiatrist
16. child and adolescent psychiatric resident
17. trainee of pediatric and adolescent psychiatry
18. specialist psychiatrist
19. child and adolescent psychiatrist
20. neurologist
21. other, non-psychiatric specialist
22. addictologist
23. psychotherapy specialist
24. psychiatric rehabilitation specialist
25. geriatric specialist

III/d. If you have different educational credentials:
26. social assistant v. social worker
27. special education teacher
28. art therapist
29. physiotherapist
30. mental health professional/ mental health assistant
31. patient attendant
32. other degree in higher education
33. other certificate in secondary education
34. other certificate without medical education

IV. What kind of job do you work in? Please indicate an answer.
1. driver

2. middle manager/head of a healthcare ward

3. subordinate work position

V. What type of settlement do you work in full-time?

1. village

2. settlement with a local government

3. smaller town

4. county seat

5. capital

VI. In which county do you work full-time?

1. Budapest	2. Pest county
3. Szabolcs-Szatmár-Bereg County	4. Fejér County
5. Borsod-Abaúj-Zemplén County	6. Komárom-Esztergom County
7. Hajdú-Bihar County	8. Győr-Moson-Sopron County
9. Nógrád County	10. Veszprém County
11. Heves County	12. Vas County
13. Jász-Nagykun-Szolnok County	14. Zala County
15. Békés County	16. Somogy county
17. Csongrád County	18. Tolna County
19. Bács-Kiskun County	20. Baranya County

VII. What kind of healthcare do you currently work in within the workplace surveyed? Please indicate an answer.

1. ward of acute care

2. general psychiatric ward

3. ward of gerontopsychiatry

4. ward of addictology

5. psychiatric rehabilitation

6. ward of psychotherapy

7. day hospital/community care

8. outpatient care with paramedic service

9. specialist patient care facility

10. private practice (psychiatric/psychotherapeutic practice)
11. foundation

VIII. How many people work at the profession-specific care center where you work?
If you work in a healthcare facility:
- then take as a basis the largest organizational unit within it. e.g. psychiatric hospital/ psychiatric clinic/psychiatric center.
- if the above does not apply, please consider the number of employees in the healthcare ward.
If there is no healthcare ward at your workplace, please respond based on the number of healthcare professionals working in your psychiatric and/or psychotherapeutic care service.

1. From 1.1 to 5 individuals
2. From 2.6 to 10 individuals
3. From 3.10 to 20 individuals
4. From 20 to 50 individuals
5. From 5.50 to 100 individuals
6. over 100 individuals

IX. How many years of professional experience do you have in your profession?
1. 0-2
2. 3-5
3. 6-10.
4. 10-20
5. 20-30
6. 30-40
7. More than 40

X. How many jobs do you work in?
1. 1

2. 2

3. 3

4. 4

5. more than four

XI. What type of team do you work in? Please indicate an answer.

1. Besides the patient, the individual team members are primarily in professional cooperation with the medical doctor and there is minimal or no professional dialogue between other team members; furthermore, the team leader alone makes the decisions.

2. There is close professional cooperation between team members, the task of the team leader is to promote cooperation between team members and his/her task is less the decision-making.

3. Going beyond the usual boundaries of specific professional disciplines, there is such close cooperation between team members that they also transfer their own roles to each other by clarifying what roles can be transferred or not.

XII. How much do you think working in a team influences your emotional state?

1. to a large extent

2. moderately

3. slightly

4. not affected

XIII. Is hierarchy present in your team?

1. yes

2. no

XIV. Does your immediate manager deal with workplace conflicts at work?

1. to a large extent

2. moderately

3. slightly

4. no

XV. Does your immediate manager provide adequate assistance with workplace conflicts at work?

1. to a large extent
2. moderately
3. slightly
4. no

XVI. How typical is it in the team where you work that tensions in the team move along the hierarchy (e.g. a tension strikes on a lower-ranking team member)?

1. to a large extent
2. moderately
3. slightly
4. does not occur

XVII. Who can you contact to handle a complaint about a colleague?

……
……
……
……

XVIII. Do you think your opinion will be considered in relation to patient care by

XVIII/a. the specialist doctors?

1. to a large extent
2. moderately
3. slightly
4. not considered

XVIII/b. trainee specialists, residents? (If you have a workplace where trainee specialists or residents work.)

1. to a large extent
2. moderately

3. slightly
4. not considered

XVIII/c. nurses/other trained workers? (If you have a job in a place where nurses or other trained workers operate.)
1. to a large extent
2. moderately
3. slightly
4. not considered

XVIII/d. psychologists?
1. to a large extent
2. moderately
3. slightly
4. not considered

XVIII/e. other therapists?
1. fully
2. moderately
3. slightly
4. not considered

XIX. How typical is it in the team where you work in that tensions regarding patients in the team are directed at a person who is less able to represent their interests within the team?
1. to a large extent
2. moderately
3. slightly
4. does not occur

XX. How do you think competition between colleagues in similar positions to you in the team you work in affects the overall collaborative work/community?
1. increases the quality of patient care and stimulates the community
2. negatively and disruptively affects the community and joint work
3. increases the quality of patient care but negatively affects the community
4. has no effect on it

XXI. How problematic do you think it is for the operation of the team what has been said about employees in informal spaces (e.g. kitchen, smoking area)?
1. to a large extent
2. moderately
3. slightly
4. no problem

XXII. How much trouble do you think it is if conflicts remain hidden in the team?
1. to a large extent
2. moderately
3. slightly
4. no problem

XXIII. Do you think it is necessary for the immediate manager to address workplace conflicts?
1. to a large extent
2. moderately
3. slightly
4. no

XXIV. Do you think it is necessary for the immediate manager to aid with conflicts in the workplace?
1. to a large extent
2. moderately
3. slightly
4. no

XXV. Do you think team supervision, that is, discussion of difficulties arising within the team is necessary?

1. required
2. not required

XXVI. Is team supervision available at your workplace?

1. yes
2. no

XXVII. In your opinion, considering the practical experience of the team members, on whose perception does the setting of the appropriate medication depend on the most? Put it in order!

1. nurse
2. resident/trainee specialist
3. specialist
4. psychologist/therapist
5. employer/another therapist

XXVIII. In your opinion, considering the practical experience of the team members, the application of restrictive measures (if any) (e.g. patient fixation) on whose perception does really depend on the most within the team? Put it in order!

1. nurse
2. resident/trainee specialist
3. specialist
4. psychologist/therapist

……

……

XXIX. Does it happen in your team that competence boundaries are not clear?

1. yes
2. no

XXX. If you answered yes, can you give an example of competency-related problems in your workplace?

……
……
……
……
……
……
……
……
……
……
……

XXXI. If you participate in psychiatrist specialist training or work with a colleague participating in it:
Do you think that during psychiatrist specialist training it would be necessary for medical doctors participating in the training to have greater decision-making power in specific matters?

1. yes
2. no

XXXII. If you answered yes, can you give an example?

……
……
……
……
……
……

Questionnaire on psychosocial factors at work

This space is for company logo or name

Which department do you work in?	_____
What is your job?	_____

Are you:	☐ Woman	☐ Man
How old are you?	☐ Under 30 years ☐ 30-39 years ☐ 40-49 years ☐ 50-59 years ☐ 60 years or more	

Psychosocial factors at work

The following questions are about your psychosocial work environment and job satisfaction. Some of the questions may fit better to your work than others, but please answer all questions.

	Always	Often	Some-times	Seldom	Never/ hardly ever
Is your work unevenly distributed so it piles up?	☐	☐	☐	☐	☐
Does your work put you in emotionally disturbing situations?	☐	☐	☐	☐	☐
Do you have a large degree of influence concerning your work?	☐	☐	☐	☐	☐
Do you have to work very fast?	☐	☐	☐	☐	☐
Is there a good atmosphere between you and your colleagues?	☐	☐	☐	☐	☐

	Always	Often	Some-times	Seldom	Never/ hardly ever
Do you have to relate to other people's personal problems as part of your work?	☐	☐	☐	☐	☐
Do you have a say in choosing who you work with?	☐	☐	☐	☐	☐
Do you have any influence on what you do at work?	☐	☐	☐	☐	☐
Do you get behind with your work?	☐	☐	☐	☐	☐
Is there good co-operation between the colleagues at work?	☐	☐	☐	☐	☐
How often do you not have time to complete all your work tasks?	☐	☐	☐	☐	☐
Do you have enough time for your work tasks?	☐	☐	☐	☐	☐
Do you feel part of a community at your place of work?	☐	☐	☐	☐	☐
Can you influence the amount of work assigned to you?	☐	☐	☐	☐	☐
How often do you consider looking for work elsewhere?	☐	☐	☐	☐	☐
How often do you get help and support from your colleagues?	☐	☐	☐	☐	☐
How often are your colleagues willing to listen to your problems at work?	☐	☐	☐	☐	☐
How often do your colleagues talk with you about how well you carry out your work?	☐	☐	☐	☐	☐

	To a very large extent	To a large extent	Some-what	To a small extent	To a very small extent
Is it necessary to keep working at a high pace?	☐	☐	☐	☐	☐
Is your work emotionally demanding?	☐	☐	☐	☐	☐
Does your work require you to take the initiative?	☐	☐	☐	☐	☐
Is your work meaningful?	☐	☐	☐	☐	☐
At your place of work, are you informed well in advance concerning for example important decisions, changes, or plans for the future?	☐	☐	☐	☐	☐
Does your work have clear objectives?	☐	☐	☐	☐	☐
Are contradictory demands placed on you at work?	☐	☐	☐	☐	☐
Is your work recognised and appreciated by the management?	☐	☐	☐	☐	☐
Do you feel that the work you do is important?	☐	☐	☐	☐	☐
Would you recommend a good friend to apply for a position at your workplace?	☐	☐	☐	☐	☐
Do you know exactly which areas are your responsibility?	☐	☐	☐	☐	☐
Does the management at your workplace respect you?	☐	☐	☐	☐	☐
Do you get emotionally involved in your work?	☐	☐	☐	☐	☐
Can you use your skills or expertise in your work?	☐	☐	☐	☐	☐
Do you enjoy telling others about your place of work?	☐	☐	☐	☐	☐
Do you receive all the information you need in order to do your work well?	☐	☐	☐	☐	☐

	To a very large extent	To a large extent	Some-what	To a small extent	To a very small extent
Do you do things at work, which are accepted by some people but not by others?	☐	☐	☐	☐	☐
Are you treated fairly at your workplace?	☐	☐	☐	☐	☐
Do you know exactly what is expected of you at work?	☐	☐	☐	☐	☐
Do you sometimes have to do things, which ought to have been done in a different way? (	☐	☐	☐	☐	☐
Do you have the possibility of learning new things through your work?	☐	☐	☐	☐	☐
Do you feel motivated and involved in your work?	☐	☐	☐	☐	☐
Do you sometimes have to do things, which seem to be unnecessary?	☐	☐	☐	☐	☐
Do you work at a high pace throughout the day?	☐	☐	☐	☐	☐
Does your work give you the opportunity to develop your skills?	☐	☐	☐	☐	☐
Do you feel that your place of work is of great importance to you?	☐	☐	☐	☐	☐

Regarding your work in general.

How pleased are you with:

	Very satisfied	Satisfied	Un-satisfied	Very unsatisfied
- your work prospects?	☐	☐	☐	☐
- the physical working conditions?	☐	☐	☐	☐
- the way your abilities are used?	☐	☐	☐	☐
- your job as a whole, everything taken into consideration?	☐	☐	☐	☐

The workplace as a whole

The next questions are not about your own job but about the workplace as a whole.

	To a very large extent	To a large extent	Some-what	To a small extent	To e very small extent
Does the management trust the employees to do their work well?	☐	☐	☐	☐	☐
Can you trust the information that comes from the management?	☐	☐	☐	☐	☐
Are conflicts resolved in a fair way?	☐	☐	☐	☐	☐
Does the management withhold important information from the employees?	☐	☐	☐	☐	☐
Are employees appreciated when they have done a good job?	☐	☐	☐	☐	☐
Do the employees withhold information from each other?	☐	☐	☐	☐	☐
Do the employees withhold information from the management?	☐	☐	☐	☐	☐
Do the employees in general trust each other?	☐	☐	☐	☐	☐
Are all suggestions from employees treated seriously by the management?	☐	☐	☐	☐	☐
Are the employees able to express their views and feelings?	☐	☐	☐	☐	☐
Is the work distributed fairly?	☐	☐	☐	☐	☐

The next questions concern your relationship to your nearest superior.

	Always	Often	Some-times	Seldom	Never/ hardly ever
How often is your nearest superior willing to listen to your problems at work?	☐	☐	☐	☐	☐
How often do you get help and support from your nearest superior?	☐	☐	☐	☐	☐
How often does your nearest superior talk with you about how well you carry out your work?	☐	☐	☐	☐	☐

To what extent would you say that your immediate superior…

	To a very large extent	To a large extent	Some-what	To a small extent	To a very small extent
- makes sure that the individual member of staff has good development opportunities?	☐	☐	☐	☐	☐
- gives high priority to job satisfaction?	☐	☐	☐	☐	☐
- is good at work planning?	☐	☐	☐	☐	☐
- is good at solving conflicts?	☐	☐	☐	☐	☐

Work and private life

The next questions are about the connection between work and private life.

	Yes, often	Yes, some-times	Rarely	No, never
Do you often feel a conflict between your work and your private life, making you want to be in both places at the same time?	☐	☐	☐	☐

	Yes, certainly	Yes, to a certain degree	Yes, but only very little	No, not at all
Do you feel that your work drains so much of your energy that it has a negative effect on your private life?	☐	☐	☐	☐
Do you feel that your work takes so much of your time that it has a negative effect on your private life?	☐	☐	☐	☐
Do your friends or family tell you that you work too much?	☐	☐	☐	☐

If you have more comments on your psychosocial work environment, please write here:

Health and well-being

These questions are about how you have been during the last 4 weeks.

	All the time	A large part of the time	Part of the time	A small part of the time	Not at all
How often have you slept badly and restlessly?	☐	☐	☐	☐	☐
How often have you felt worn out?	☐	☐	☐	☐	☐
How often have you found it hard to go to sleep?	☐	☐	☐	☐	☐
How often have you been physically exhausted?	☐	☐	☐	☐	☐
How often have you been emotionally exhausted?	☐	☐	☐	☐	☐
How often have you woken up too early and not been able to get back to sleep?	☐	☐	☐	☐	☐
How often have you felt tired?	☐	☐	☐	☐	☐
How often have you woken up several times and found it difficult to get back to sleep?	☐	☐	☐	☐	☐
How often have you had problems relaxing?	☐	☐	☐	☐	☐
How often have you been irritable?	☐	☐	☐	☐	☐
How often have you been tense?	☐	☐	☐	☐	☐
How often have you been stressed?	☐	☐	☐	☐	☐

	Excellent	Very good	Good	Fair	Poor
In general, would you say your health is:	☐	☐	☐	☐	☐

Conflicts and offensive behaviours

	Yes, daily	Yes, weekly	Yes, monthly	Yes, a few times	No
Have you been exposed to undesired sexual attention at your workplace during the last 12 months?	☐	☐	☐	☐	☐

	Colleagues	Manager/ superior	Sub-ordinates	Clients/ customers/ patients
If yes, from whom? (You may tick off more than one)	☐	☐	☐	☐

	Yes, daily	Yes, weekly	Yes, monthly	Yes, a few times	No
Have you been exposed to threats of violence at your workplace during the last 12 months?	☐	☐	☐	☐	☐

	Colleagues	Manager/ superior	Sub-ordinates	Clients/ customers/ patients
If yes, from whom? (You may tick off more than one)	☐	☐	☐	☐

	Yes, daily	Yes, weekly	Yes, monthly	Yes, a few times	No
Have you been exposed to physical violence at your workplace during the last 12 months?	☐	☐	☐	☐	☐

	Colleagues	Manager/ superior	Sub-ordinates	Clients/ customers/ patients
If yes, from whom? (You may tick off more than one)	☐	☐	☐	☐

Bullying means that a person repeatedly is exposed to unpleasant or degrading treatment, and that the person finds it difficult to defend himself or herself against it.

	Yes, daily	Yes, weekly	Yes, monthly	Yes, a few times	No
Have you been exposed to bullying at your workplace during the last 12 months?	☐	☐	☐	☐	☐

	Colleagues	Manager/ superior	Sub-ordinates	Clients/ customers/ patients
If yes, from whom? (You may tick off more than one)	☐	☐	☐	☐

There are no further questions.

Thank you for filling out the questionnaire.

Kérdőívcsomag A multidiszciplináris teamek vizsgálata a pszichiátriai és pszichoterápiás ellátásban elnevezésű kutatáshoz
Köszönjük, hogy a kérdőív kitöltésével segíti munkánkat!

Semmelweis Egyetem ÁOK Magatartástudományi Intézet
dr. Molnár László, Dr. Zana Ágnes

Szociodemográfiai kérdések

I. Ön melyik évben született?

……

II. Az Ön neme:

1, férfi

2, nő

III, Kérem a legmagasabb iskolai végzettségét jelölje meg! Több választ is megjelölhet!

III/a, Ha Ön ápoló/egészségügyi szakdolgozó:

1, nincs egészségügyi végzettsége (pl.segédápoló)

2, ápolási asszisztens

3, általános ápoló és asszisztens

4, szakápoló/szakasszisztens

5, gyakorló ápoló

6, felsőfokú ápoló (pl. OKJ 54, 55)

7, diplomás ápoló Bsc

8, diplomás ápoló Msc

III/b, Ha Ön pszichológus:

9, szakképzésben lévő pszichológus

10, klinikai szakpszichológus

11, gyermek- és ifjúsági szakpszichológus

12, egyéb szakvizsgával rendelkező pszichológus

13, pszichoterápia szakvizsgával is rendelkező pszichológus, pszichoterapeuta

III/c, Ha Ön orvos:

14, pszichiáter-rezidens

15, pszichiáter-szakorvosjelölt

16, gyermek-és ifjúsági pszichiáter rezidens

17, gyermek- ifjúsági pszichiáter szakorvosjelölt

18, pszichiáter szakorvos

19, gyermek- és ifjúsági pszichiáter

20, neurológus

21, egyéb, nem pszichiáter szakorvos

22, addiktológus

23, pszichoterapeuta szakorvos

24, pszichiátriai rehabilitációs szakorvos

25, geriáter szakorvos

III/d, Ha Önnek, az előbbiektől eltérő végzettsége van:

26, szociális asszisztens v. szociális munkás

27, gyógypedagógus

28, művészetterapeuta

29, gyógytornász

30, mentálhigiénés szakember/ mentálhigiénés asszisztens

31, betegkísérő

32, egyéb diploma

33, egyéb középfokú végzettség

34, egyéb, egészségügyi végzettség nélkül

IV. Ön milyen munkakörben dolgozik? Kérem egy választ jelöljön meg!

1, vezető

2, középvezető/részlegvezető

3, beosztott

V. Ön főállásban, milyen típusú településen dolgozik?

1, falu

2, község

3, kisebb város

4, megyeszékhely

5, főváros

VI. Ön főállásban melyik megyében dolgozik?

1, Budapest	2, Pest megye
3, Szabolcs-Szatmár-Bereg megye	4, Fejér megye
5, Borsod-Abaúj-Zemplén megye	6, Komárom-Esztergom megye
7, Hajú-Bihar megye	8, Győr-Moson-Sopron megye
9, Nógrád megye	10, Veszprém megye
11, Heves megye	12, Vas megye
13, Jász-Nagykun-Szolnok megye	14, Zala megye
15, Békés megye	16, Somogy megye
17, Csongrád megye	18, Tolna megye
19, Bács-Kiskun megye	20, Baranya megye

VII. Ön jelenleg - a felmérésbe bevont munkahelyén belül- milyen ellátásban dolgozik? Kérem egy választ jelöljön meg!

1, akut osztály

2, általános pszichiátriai osztály

3, gerontopszichiátriai osztály

4, addiktológiai osztály

5, pszichiátriai rehabilitáció

6, pszichoterápiás osztály

7, nappali kórház/közösségi ellátás

8, mentős ambulancia

9, szakrendelés

10, magánrendelés (pszichiátriai/pszichoterápiás rendelés)

11, alapítvány

VIII. Hányan dolgoznak a szakmaspecifikus ellátó helyen, ahol Ön dolgozik?

Ha Ön osztályos ellátásban dolgozik:

- akkor azon belül a legnagyobb szervezeti egységet vegye alapul pl. pszichiátriai szakkórház/ pszichiátriai klinika/ pszichiátriai centrum.
- ha az előbbiek nem állnak fenn, akkor kérem az osztályon dolgozók létszámát vegye figyelembe!

Ha az Ön munkahelyén nincs osztályos ellátás, a pszichiátriai és/vagy pszichoterápiás rendelésem dolgozók létszáma alapján válaszoljon!

1, 1-5 fő között

2, 6-10 fő között

3, 10-20 fő között

4, 20-50 fő között

5, 50-100 fő között

6, 100 felett

IX. Hány éves szakmai tapasztalata van a saját szakmájában?

1, 0-2

2, 3-5

3, 6-10,

4, 10-20

5, 20-30

6, 30-40

7, 40-nél több

X. Hány munkahelyen dolgozik?

1, 1

2, 2

3, 3

4, 4

5, négynél több

XI. Ön milyen típusú teamben dolgozik? Kérem egy választ jelöljön meg!

1, az egyes teamtagok a páciens mellett elsősorban az orvossal állnak szakmai együttműködésben és a más teamtagok között minimális szakmai párbeszéd van vagy nincs is továbbá a vezető egy személyben hoz döntéseket

2, a teamtagok között szoros szakmai együttműködés van, a team vezetőjének feladata, hogy elősegítse a teamtagok közötti együttműködést és kevésbé a döntéshozás a feladata

3, a teamtagok között, átlépve a megszokott diszciplináris határokat, olyan szoros együttműködés van, hogy a saját szerepeiket is átadják egymásnak, tisztázva, hogy milyen szerepek adhatóak át vagy sem

XII. Ön szerint a teamben való munka mennyire befolyásolja az Ön érzelmi állapotát?

1, nagy mértékben

2, közepes mértékben

3, kismértékben

4, nem befolyásolja

XIII. Az Ön teamjében jelen van-e a hierarchia?

1, igen

2, nem

XIV. Az Ön munkahelyén a közvetlen vezetője foglalkozik-e a munkahelyi konfliktusokkal?

1, nagymértékben

2, közepes mértékben

3, kismértékben

4, nem

XV. Az Ön munkahelyén a közvetlen vezetője ad-e megfelelő segítséget a munkahelyi konfliktusokkal kapcsolatban?

1, nagymértékben

2, közepes mértékben

3, kismértékben

4, nem

XVI. Mennyire jellemző abban a teamben, ahol Ön dolgozik, hogy a teamben kialakuló feszültségek a hierarchia mentén mozognak (pl. egy alacsonyabb beosztású teamtagon csapódik le egy feszültség)?

1, nagymértékben

2, közepes mértékben

3, kismértékben

4, nem fordul elő

XVII. Ön kihez fordulhat panaszkezeléssel, ami egyik munkatársával kapcsolatos?

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……..

……

……..

XVIII. Ön szerint a páciens ellátásával kapcsolatban, figyelembe veszik-e az Ön véleményét

XVIII/a, a szakorvosok?

1, nagymértékben

2, közepes mértékben

3, kismértékben

4, nem veszik figyelembe

XVIII/b, szakorvosjelöltek, rezidensek? (Ha olyan munkahelye van, ahol dolgoznak szakorvosjelöltek, rezidensek.)

1, nagymértékben

2, közepes mértékben

3, kismértékben

4, nem veszik figyelembe

XVIII/c, nővérek/szakdolgozók? (Ha olyan helyen munkahelye van, ahol dolgoznak nővérek illetve szakdolgozók.)

1, nagymértékben

2, közepes mértékben

3, kismértékben

4, nem veszik figyelembe

XVIII/d, pszichológusok?

1, nagymértékben

2, közepes mértékben

3, kismértékben

4, nem veszik figyelembe

XVIII/e, más terapeuták?
1, teljes mértékben
2, közepes mértékben
3, kismértékben
4, nem veszik figyelembe

XIX. Mennyire jellemző abban a teamben, ahol Ön dolgozik, hogy a teamben jelentkező, páciensekkel kapcsolatos feszültségek egy olyan személyre irányulnak, aki kevésbé tudja az érdekeit képviselni a teamen belül?
1, nagymértékben
2, közepes mértékben
3, kismértékben
4, nem fordul elő

XX. Ön szerint, abban a teamben, ahol Ön dolgozik, az Önnel hasonló pozícióban lévő kollégák közötti versengés összességében hogyan befolyásolja a közös munkát/a közösséget?
1, növeli a betegellátás színvonalát és a közösségre is serkentően hat
2, negatívan, bomlasztóan hat a közösségre, a közös munkára
3, növeli a betegellátás színvonalát, de a közösségre negatívan hat
4, nincs rá hatása

XXI. Ön szerint mennyire jelent gondot a team működését tekintve, az informális terekben (pl. konyhában, dohányzóban) a munkatársakkal kapcsolatban elhangzottak?

1, nagymértékben
2, közepes mértékben
3, kismértékben
4, nem jelent gondot

XXII. Ön szerint mennyire jelent gondot, ha a teamben a konfliktusok rejtve maradnak?
1, nagymértékben
2, közepes mértékben
3, kismértékben
4, nem jelent gondot

XXIII. Ön szerint szükséges-e, hogy a közvetlen vezető foglalkozzon-e a munkahelyi konfliktusokkal?
1, nagymértékben
2, közepes mértékben
3, kismértékben
4, nem
XXIV. Ön szerint szükséges-e, hogy a közvetlen vezető segítséget adjon a munkahelyi konfliktusokkal kapcsolatban?
1, nagymértékben
2, közepes mértékben
3, kismértékben
4, nem

XXV. Ön szerint szükséges-e a team-szupervízió, azaz a teamben lévő nehézségek átbeszélésére szükséges megbeszélés?
1, szükséges
2, nem szükséges

XXVI. Az Ön munkahelyén elérhető team-szupervízió?
1, igen
2, nem

XXVII. Ön szerint a teamben, a teamtagok gyakorlati tapasztalatát figyelembe véve, kinek az észlelésén múlik leginkább az adekvát gyógyszeres kezelés beállítása? Tegye sorrendbe!
1, nővér

2, rezidens/szakorvosjelölt

3, szakorvos

4, pszichológus/terapeuta

5, foglalkoztató/egyéb terapeuta

……
…

XXVIII. Ön szerint, a teamben, a teamtagok gyakorlati tapasztalatát is figyelembe véve, valójában kinek az észlelésén múlik leginkább a korlátozó intézkedések (pl.rögzítés) alkalmazása (ha vannak ilyenek)? Tegye sorrendbe!

1, nővér

2, rezidens/szakorvosjelölt

3, szakorvos

4, pszichológus/terapeuta

……
…..

XXIX. Az Ön teamjében előfordul-e az, hogy a kompetenciahatárok nem egyértelműek?

1, igen

2, nem

XXX. Ha igennel válaszolt, tudna-e példát mondani arra, hogy az ön munkahelyén milyen kompetencia-problémák állnak fenn?

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XXXI. Ha Ön pszichiáter-szakképzésben vesz részt vagy dolgozik szakképzésben lévő kollégával:
Ön szerint a pszichiáter szakképzés alatt szükséges lenne-e, hogy a képzésben résztvevő orvosok nagyobb döntési hatáskörrel rendelkezzenek, meghatározott kérdésekben?
1, igen
2, nem

XXXII. Ha igennel válaszolt, tudna példát mondani?
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COPSOQII.

	Mindig	Gyakran	Időnként	Ritkán	Soha/ szinte soha
Jellemző-e az Ön munkájára, hogy egyenlőtlenül van elosztva, ezért az elvégzendő feladatok felhalmozódnak?	☐	☐	☐	☐	☐
Kerül-e Ön munkája folytán olyan helyzetekbe, melyek érzelmileg zavaróak, felkavaróak?	☐	☐	☐	☐	☐
Jelentős mértékben képes-e Ön befolyásolni a munkáját?	☐	☐	☐	☐	☐
Nagyon gyorsan kell Önnek dolgoznia?	☐	☐	☐	☐	☐
Jó-e a légkör Ön és a munkatársai között?	☐	☐	☐	☐	☐

	Mindig	Gyakran	Időnként	Ritkán	Soha/ szinte soha
Munkája részeként kell-e foglalkoznia más emberek személyes problémáival?	☐	☐	☐	☐	☐
Van-e Önnek beleszólása abba, hogy kivel dolgozik együtt?	☐	☐	☐	☐	☐
Van-e Önnek befolyása arra, hogy milyen munkát végez?	☐	☐	☐	☐	☐
Elő szokott-e fordulni, hogy elmaradásai vannak a munkájával?	☐	☐	☐	☐	☐
Jó-e az együttműködés a munkavégzés során a munkatársak között?	☐	☐	☐	☐	☐
Milyen gyakran fordul elő, hogy nincs ideje minden feladatának elvégzésére?	☐	☐	☐	☐	☐
Jut-e elég ideje feladatainak elvégzésére?	☐	☐	☐	☐	☐
A munkahelyi közösség részének érzi-e magát?	☐	☐	☐	☐	☐
Tudja-e befolyásolni, hogy mennyi munkát kell elvégeznie?	☐	☐	☐	☐	☐
Milyen gyakran gondolkodik azon, hogy másik munkahelyet kellene keresnie?	☐	☐	☐	☐	☐
Milyen gyakran kap segítséget és támogatást munkatársaitól?	☐	☐	☐	☐	☐
Milyen gyakran hajlandók munkatársai meghallgatni a munkával kapcsolatos problémáit?	☐	☐	☐	☐	☐
Milyen gyakran beszélik meg a munkatársai Önnel, hogy mennyire végzi jól a munkáját?	☐	☐	☐	☐	☐

	Nagon nagy mérték-ben	Nagy mérték-ben	Valamely est	Kis mérték-ben	Nagyon kis mértékben
Gyors tempóban kell-e dolgoznia?	☐	☐	☐	☐	☐
Érzelmileg megterhelő-e Önnek a munkája?	☐	☐	☐	☐	☐
Munkája kíván-e Öntől kezdeményezőkészséget?	☐	☐	☐	☐	☐
Értelmes munkát végez-e?	☐	☐	☐	☐	☐
Jó előre értesítik-e Önt a munkahelyén a fontosabb döntésekről, változásokról vagy jövőbeni tervekről?	☐	☐	☐	☐	☐
Világosak a célkitűzések az Ön munkájában?	☐	☐	☐	☐	☐
Meg kell-e felelnie egymással ellentétes elvárásoknak a munkájában?	☐	☐	☐	☐	☐
Elismeri-e és értékeli-e a vezetőség az Ön munkáját?	☐	☐	☐	☐	☐
Fontosnak érzi-e a munkát, amit végez?	☐	☐	☐	☐	☐
Ajánlaná-e egy jó barátjának, hogy az Ön munkahelyén vállaljon állást?	☐	☐	☐	☐	☐
Tudja-e pontosan, hogy mely területek tartoznak az Ön felelősségi körébe?	☐	☐	☐	☐	☐
Elismeri-e, tiszteli-e Önt a vezetőség a munkahelyén?	☐	☐	☐	☐	☐
Érzelmileg bevonódik-e Ön a munkájába?	☐	☐	☐	☐	☐
Tudja-e hasznosítani képességeit vagy szakértelmét a munkája során?	☐	☐	☐	☐	☐
Örömmel mesél-e másoknak a munkahelyéről?	☐	☐	☐	☐	☐

Megkap-e minden szükséges információt ahhoz, hogy jól tudja végezni munkáját?	☐	☐	☐	☐	☐

	Nagon nagy mérték-ben	Nagy mérték-ben	Valamelyest	Kis mérték-ben	Nagyon kis mértékben
Szokott-e olyan dolgokat csinálni a munkája során, amit egyesek elfogadnak, mások viszont nem?	☐	☐	☐	☐	☐
Igazságosan bánnak-e Önnel a munkahelyén?	☐	☐	☐	☐	☐
Tudja-e, hogy pontosan mit várnak el Öntől a munkájában?	☐	☐	☐	☐	☐
Kell-e tennie időnként olyan dolgokat, amelyeket igazából másként kellene csinálni?	☐	☐	☐	☐	☐
Van-e lehetősége a munkája révén új dolgokat tanulni?	☐	☐	☐	☐	☐
Érdekli, motiválja-e Önt a munkája?	☐	☐	☐	☐	☐
Kell-e időnként olyan dolgokat csinálnia, amik fölöslegesnek tűnnek?	☐	☐	☐	☐	☐
Egész nap nagyon tempósan kell-e dolgoznia?	☐	☐	☐	☐	☐
Nyújt-e lehetőséget a munkája arra, hogy fejlessze készségeit, tudását?	☐	☐	☐	☐	☐
Úgy érzi-e, hogy a munkahelye nagyon fontos az Ön számára?	☐	☐	☐	☐	☐

Általánosságban a munkájával kapcsolatban mennyire elégedett Ön:

	Nagyon elégedett	Elégedett	Elégedet-len	Nagyon elégedetlen
- a munkájában rejlő kilátásokkal ?	☐	☐	☐	☐

- a fizikai munkakörülményekkel?	☐	☐	☐	☐
- ahogy a képességeit hasznosítják?	☐	☐	☐	☐
- a munkájával egészében véve, mindent beleszámítva?	☐	☐	☐	☐

A munkahely egészében véve

A következő kérdések nem az Ön munkájára, hanem a munkahely egészére vonatkoznak.

	Nagyon nagy mérték-ben	Nagy mérték-ben	Valamely est	Kis mérték-ben	Nagyon kis mértékben
A vezetőség bízik-e abban, hogy az alkalmazottak jól végzik a munkájukat?	☐	☐	☐	☐	☐
Megbízhat-e az információkban, amelyek a vezetőségtől származnak?	☐	☐	☐	☐	☐
A konfliktusokat igazságosan oldják-e meg?	☐	☐	☐	☐	☐
Visszatart-e a vezetőség fontos információkat az alkalmazottaktól?	☐	☐	☐	☐	☐
Részesülnek-e elismerésben az alkalmazottak, ha jó munkát végeztek?	☐	☐	☐	☐	☐
Visszatartanak-e információkat az alkalmazottak egymás elől?	☐	☐	☐	☐	☐
Visszatartanak-e az alkalmazottak információkat a vezetőség elől?	☐	☐	☐	☐	☐
Általában megbíznak-e egymásban az alkalmazottak?	☐	☐	☐	☐	☐
Komolyan veszi-e a vezetőség az alkalmazottak összes javaslatát?	☐	☐	☐	☐	☐
Kifejezhetik-e az alkalmazottak véleményüket, érzéseiket?	☐	☐	☐	☐	☐
Igazságosan van-e a munka elosztva?	☐	☐	☐	☐	☐

A következő kérdések a közvetlen felettesével való kapcsolatára vonatkoznak

	Mindig	Gyakran	Néha	Ritkán	Soha/ szinte soha
Milyen gyakran hajlandó közvetlen felettese meghallgatni munkával kapcsolatos problémáit?	☐	☐	☐	☐	☐
Milyen gyakran kap segítséget és támogatást közvetlen felettesétől?	☐	☐	☐	☐	☐
Milyen gyakran beszél Önnel közvetlen felettese arról, hogy mennyire végzi jól a munkáját?	☐	☐	☐	☐	☐

Ön szerint közvetlen felettese mennyire:

	Nagyon nagymért ékben	Nagy mérték-ben	Valamely -est	Kis mérték-ben	Nagyon kis mértékben
- biztosít az egyes munkatársak számára megfelelő fejlődési lehetőségeket?	☐	☐	☐	☐	☐
- tulajdonít nagy fontosságot a munkahelyi elégedettségnek?	☐	☐	☐	☐	☐
- tervezi meg jól a munkát?	☐	☐	☐	☐	☐
- oldja meg jól a konfliktusokat?	☐	☐	☐	☐	☐

Munka és magánélet

A következő kérdések a munka és a magánélet kapcsolatára vonatkoznak.

	Igen, gyakran	Igen, időnként	Ritkán	Nem, soha
Gyakran érez-e konfliktust a munkája és a magánélete között, egyszerre akarva mindkét helyen lenni?	☐	☐	☐	☐

	Igen, teljes mértékben	Igen, bizonyos mértékig	Igen, de csak kissé	Egyáltalán nem
Úgy érzi-e, hogy munkája olyan sok <u>energiát</u> vesz el, hogy az negatív hatással van a magánéletére?	☐	☐	☐	☐
Úgy érzi-e, hogy munkája olyan sok <u>idejét</u> veszi el, hogy az negatív hatással van a magánéletére?	☐	☐	☐	☐
Mondogatják-e Önnek a barátai vagy a családja, hogy túl sokat dolgozik?	☐	☐	☐	☐

Ha további megjegyzései vannak a munkahelyi környezet pszichológiai és társas jellemzőivel kapcsolatban, kérjük ide írja le őket:

Egészség és jóllét

A következő kérdések arra vonatkoznak, hogy Ön hogyan érezte magát az utóbbi 4 hétben.

	Állandóan	Az idő nagy részében	Az idő egy részében	Az idő kis részében	Egyáltalán nem
Milyen gyakran aludt rosszul, nyugtalanul?	☐	☐	☐	☐	☐
Milyen gyakran érezte magát kimerültnek?	☐	☐	☐	☐	☐
Milyen gyakran volt nehézsége az elalvással?	☐	☐	☐	☐	☐
Milyen gyakran érezte magát fizikailag kimerültnek?	☐	☐	☐	☐	☐
Milyen gyakran érezte magát érzelmileg kimerültnek?	☐	☐	☐	☐	☐
Milyen gyakran fordult elő, hogy túl korán felébredt, és nem tudott visszaaludni?	☐	☐	☐	☐	☐
Milyen gyakran érezte magát fáradtnak?	☐	☐	☐	☐	☐
Milyen gyakran fordult elő, hogy többször is felébredt és nehezen aludt vissza?	☐	☐	☐	☐	☐
Milyen gyakran fordult elő, hogy nem tudott lazítani?	☐	☐	☐	☐	☐
Milyen gyakran volt ingerlékeny?	☐	☐	☐	☐	☐
Milyen gyakran érezte magát feszültnek, idegesnek?	☐	☐	☐	☐	☐
Milyen gyakran érezte magát stresszesnek?	☐	☐	☐	☐	☐

Kitűnő	Nagyon jó	Jó	Tűrhető	Rossz

Összességében hogyan jellemezné Ön az egészségi állapotát?	☐	☐	☐	☐	☐

Konfliktusok és erőszakos magatartásformák

	Igen, napi rendszerességgel	Igen, heti rendszerességgel	Igen, havi rendszerességgel	Igen, néhány alkalommal	Nem
Ki volt-e Ön téve a munkahelyén nem kívánatos szexuális érdeklődésnek az elmúlt 12 hónapban?	☐	☐	☐	☐	☐

	Munkatárs	Vezető/ Felettes	Beosztott	Ügyfél/ Vásárló/ Páciens
Ha igen, kinek a részéről? (Több választ is megjelölhet!)	☐	☐	☐	☐

	Igen, napi rendszerességgel	Igen, heti rendszerességgel	Igen, havi rendszerességgel	Igen, néhány alkalommal	Nem
Ki volt Ön téve a munkahelyén erőszakkal való fenyegetésnek az elmúlt 12 hónapban?	☐	☐	☐	☐	☐

	Munkatárs	Vezető/ Felettes	Beosztott	Ügyfél/ Vásárló/ Páciens
Ha igen, kinek a részéről (Több választ is megjelölhet!)	☐	☐	☐	☐

	Igen, napi rendszerességgel	Igen, heti rendszerességgel	Igen, havi rendszerességgel	Igen, néhány alkalommal	Nem
Ki volt-e Ön téve a munkahelyén fizikai bántalmazásnak az elmúlt 12 hónapban?	☐	☐	☐	☐	☐

	Munkatárs	Vezető/ Felettes	Beosztott	Ügyfél/ Vásárló/ Páciens

Ha igen, kinek a részéről (Több választ is megjelölhet!)	☐	☐	☐	☐

”Szekálás” alatt azt értjük, ha valakit rendszeresen kényelmetlen vagy megalázó helyzetbe kényszerítenek, és az illető úgy érzi, nehéz vagy lehetetlen ettől megvédenie magát.

	Igen, napi rend-szeres-séggel	Igen, heti rend-szeres-séggel	Igen, havi rend-szeres-séggel	Igen, néhány alkalom-mal	Nem
Ki volt-e Ön téve a munkahelyén, ”szekálásnak“ az elmúlt 12 hónapban?	☐	☐	☐	☐	☐

	Munka-társ	Vezető/ Felettes	Beosztott	Ügyfél/ Vásárló/ Páciens
Ha igen, kinek a részéről (Több választ is megjelölhet!)	☐	☐	☐	☐

Köszönjük, hogy kitöltötte a kérdőívet!

APPENDIX B

- The second questionnaire

Questionnaire package for the research entitled *Examination of multidisciplinary teams in psychiatric and psychotherapeutic care*

Thank you for helping us by filling out the questionnaire!

Medical Faculty of Semmelweis University, Institute of Behavioral Sciences
dr. László Molnár, Dr. Ágnes Zana

Sociodemographic questions

1. What year were you born?

……

2. Your gender:

man

woman

3. Please indicate your highest level of education! You can mark multiple answers!

3/a. If you are a nurse/healthcare professional, choose the right qualification, if not, move on to the next point.

no healthcare education (e.g. auxiliary nurse)

nursing assistant

nurse practicing in general healthcare and assistant

nurse/assistant

practicing nurse

nurse trained in a higher education course (e.g. OKJ 54, 55)

graduate nurse with BSc

graduate nurse with MSc

3/b. If you are a psychologist, choose the right qualification, if not, move on to the next point!

psychologist in postgraduate specializing training

clinical psychologist

child and youth psychologist

psychologist with other professional qualification

psychologist and psychotherapist with the specialist qualification in psychotherapy

3/c. If you are a medical doctor, choose the right qualification, if not, move on to the next point.

psychiatric resident

trainee of psychiatry

child and adolescent psychiatric resident

trainee of pediatric and adolescent psychiatry

specialist psychiatrist

child and adolescent psychiatrist

neurologist

other, non-psychiatric specialist

addiction specialist

psychotherapy specialist

psychiatric rehabilitation specialist

geriatric specialist

forensic psychiatrist

3/d If you have a different position/educational credential:

social assistant v. social worker

special education teacher

art therapist

physiotherapist

mental health professional/ mental health assistant

patient attendant

other degrees in higher education

have other secondary education certificate

other certificate, working without healthcare education

4. Are you on duty at the workplace involved in the investigation?

yes

no

4/b. If you are not in service, describe how you work in the healthcare (personal contributor/self-employed, contributor, etc.).

5. What role do you work in? Please indicate an answer.

1. driver
2. middle manager/head of a healthcare ward
3. subordinate work position

6. What type of municipality do you work in full-time?

1. village
2. settlement with a local government
3. smaller town
4. county seat
5. capital

7. In which county do you work full-time?

VI. In which county do you work full-time?

1. Budapest	2. Pest county
3. Szabolcs-Szatmár-Bereg County	4. Fejér County
5. Borsod-Abaúj-Zemplén County	6. Komárom-Esztergom County
7. Hajdú-Bihar County	8. Győr-Moson-Sopron County
9. Nógrád County	10. Veszprém County
11. Heves County	12. Vas County
13. Jász-Nagykun-Szolnok County	14. Zala County
15. Békés County	16. Somogy county
17. Csongrád County	18. Tolna County
19. Bács-Kiskun County	20. Baranya County

8. What kind of healthcare do you currently work in within the workplace surveyed? Please indicate an answer.

ward of acute care

general psychiatric ward

ward of Gerontopsychiatry

ward of child and adolescent psychiatry

ward of addictions

psychiatric rehabilitation

ward of psychotherapy

day hospital

outpatient care with paramedic service

specialist medical provider/ psychiatric caregiver

child and adolescent psychiatric provider/caregiver

forensic psychiatric care

COVID psychiatric care

private practice (psychiatric/psychotherapeutic practice)

foundation

other

9. *How many people work in the psychiatric (and/or psychotherapeutic) care you work in?*

From 1.1 to 5 individuals

From 2.6 to 10 individuals

From 3.10 to 20 individuals

4.From 20 to 50 individuals

From 5.50 to 100 individuals

6, over 100

10. How many years of professional experience do you have in your profession?

……..

11. How many jobs do you work at?

1. 1

2. 2

3. 3

4. 4

5, more than four

12. What type of team do you work in? Please indicate an answer.

a. Besides the patient, the individual team members are primarily in professional cooperation with the medical doctor and there is minimal or no professional dialogue between the other team members. The team leader alone makes the decisions.

b. There is close professional cooperation between team members, the task of the team leader is to promote cooperation between team members and his/her task is less the decision-making.

c. Going beyond the usual boundaries of specific professional disciplines, team members cooperate so closely that they transfer their own roles to each other, clarifying what roles can be transferred or not.

13. Is hierarchy present in your team?

1. yes

2. no

14. Is team supervision available at your workplace, i.e. a meeting necessary to discuss difficulties in the team?

1, yes

2, no

15. Have you worked/are you working in COVID care during the pandemic?

yes

no

16. To what extent do you think your mental well-being may be affected by the factors below if you are in COVID care?

very little, little, somewhat, greatly, very large

a. predictability, predictability

b. professional recognition

c. acquisition of new competences

c. financial recognition

d. support from the supervisor

e. support from staff

f. climate of trust

g. family allowances

QUESTIONS PERTAINING RECOGNITION

1.How professionally recognized-appreciated do you feel overall (based on your professional competence and experience) within your work community?

Greatly

Moderately

Slightly

Not at all

2. How satisfied are you with your position and professional advancement?

Greatly

Moderately

Slightly

Not at all

3. How financially recognized do you feel within your work community?

Greatly

Moderately

Slightly

Not at all

4. How much do you feel valued within your workplace community based on your personality, attitude and behavior?

Greatly

Moderately

Slightly

Not at all

5. What would make you feel more recognized within your work community? Write down exactly what you mean!

QUESTIONS PERTATINIG COMPETENCY

1.How well do you know exactly what your responsibilities are?

Greatly

Moderately

Slightly

Not at all

2. Are there clear boundaries of competence in your work community?

1, yes

2, no

3. Whose vision in your workplace community is most likely to determine the adecvate medication? Put it in order!

1, nurse

2, resident/trainee specialist

3, specialist

4, psychologist/therapist

5, occupational therapist/other therapist

……

4. On whose experience and perception does the application of restrictive measures (e.g. patient fixation) (if any) depend most on within your workplace community? Put it in order!

1, nurse

2, resident/trainee specialist

3, specialist

4, psychologist/therapist

……..

5/a. If you meet a patient in need of acute care or exhibiting "imminent threatening behavior", will your competence be compromised?

yes

no

5/b. If so, how?

6/a. If you are involved in psychiatric rehabilitation/psychotherapy, will your competence be compromised?

yes

no

6/b. If so, how?

7. To what extent do you think your competencies at work are compromised overall?

Greatly

Moderately

Slightly

Not at all

8. If your competencies at work are compromised, in what exactly?

9. If your competencies at work are compromised, will you receive appropriate professional help/supervision?

yes

no

10. If your competencies at work are compromised (e.g. doing the work of a colleague of higher status), do you feel more recognized?

yes

no

I can't judge.

11. If you participate in psychiatrist specialist training or work with a colleague participating in it:

Do you think that during the psychiatrist training, it would be necessary for doctors participating in the training to have greater decision-making power in specific matters?

1. yes

2. no

12. If you answered yes, can you give an example?

……
……
……

……
……
……

……
……
……

For the English version of the COPSOQ II questionnaire linked to the second questionnaire, see pages 94-104, and for the Hungarian version, see pages 116-128.

Kérdőívcsomag A multidiszciplináris teamek vizsgálata a pszichiátriai és pszichoterápiás ellátásban elnevezésű kutatáshoz
Köszönjük, hogy a kérdőív kitöltésével segíti munkánkat!

Semmelweis Egyetem ÁOK Magatartástudományi Intézet
dr. Molnár László, Dr. Zana Ágnes

Szociodemográfiai kérdések

1.. Ön melyik évben született?

……

2. Az Ön neme:

férfi

nő

3., Kérem a legmagasabb iskolai végzettségét jelölje meg! Több választ is megjelölhet!

3/a, Ha Ön ápoló/egészségügyi szakdolgozó válassza ki a megfelelő végzettséget, ha nem, lépjen tovább a következő pontra!

nincs egészségügyi végzettsége (pl.segédápoló)

ápolási asszisztens

általános ápoló és asszisztens

szakápoló/szakasszisztens

gyakorló ápoló

felsőfokú ápoló (pl. OKJ 54, 55)

diplomás ápoló Bsc

diplomás ápoló Msc

3/b, Ha Ön pszichológus válassza ki a megfelelő végzettséget, ha nem, lépjen tovább a következő pontra!

szakképzésben lévő pszichológus

klinikai szakpszichológus

gyermek- és ifjúsági szakpszichológus

egyéb szakvizsgával rendelkező pszichológus

pszichoterápia szakvizsgával is rendelkező pszichológus, pszichoterapeuta

3/c, Ha Ön orvos válassza ki a megfelelő végzettséget, ha nem, lépjen tovább a következő pontra!

pszichiáter-rezidens

pszichiáter-szakorvosjelölt

gyermek-és ifjúsági pszichiáter rezidens

gyermek- ifjúsági pszichiáter szakorvosjelölt

pszichiáter szakorvos

gyermek- és ifjúsági pszichiáter

neurológus

egyéb, nem pszichiáter szakorvos

addiktológus

pszichoterapeuta szakorvos

pszichiátriai rehabilitációs szakorvos

geriáter szakorvos

igazságügyi pszichiáter

3/d, Ha Önnek, az előbbiektől eltérő munkaköre/végzettsége van:

szociális asszisztens v. szociális munkás

gyógypedagógus

művészetterapeuta

gyógytornász

mentálhigiénés szakember/ mentálhigiénés asszisztens

betegkísérő

egyéb diplomával rendelkezik

egyéb középfokú végzettsége van

egyéb, egészségügyi végzettség nélkül dolgozik

4. A vizsgálatba bevont munkahelyén Ön szolgálati jogviszonyban végzi munkáját?

igen

nem

4/b. Ha nincs szolgálati jogviszonyban, írja le milyen formában dolgozik az ellátásban (személyes közreműködő/vállalkozó, közreműködő stb.)!

5. Ön milyen munkakörben dolgozik? Kérem egy választ jelöljön meg!

1, vezető

2, középvezető/részlegvezető

3, beosztott

6. Ön főállásban, milyen típusú településen dolgozik?

1, falu

2, község

3, kisebb város

4, megyeszékhely

5, főváros

7.. Ön főállásban melyik megyében dolgozik?

1, Budapest	2, Pest megye
3, Szabolcs-Szatmár-Bereg megye	4, Fejér megye
5, Borsod-Abaúj-Zemplén megye	6, Komárom-Esztergom megye
7, Hajú-Bihar megye	8, Győr-Moson-Sopron megye
9, Nógrád megye	10, Veszprém megye
11, Heves megye	12, Vas megye
13, Jász-Nagykun-Szolnok megye	14, Zala megye
15, Békés megye	16, Somogy megye
17, Csongrád megye	18, Tolna megye
19, Bács-Kiskun megye	20, Baranya megye

8. Ön jelenleg - a felmérésbe bevont munkahelyén belül- milyen ellátásban dolgozik? Kérem egy választ jelöljön meg!

akut osztály

általános pszichiátriai osztály

gerontopszichiátriai osztály

gyermek- és ifjúságpszichiátriai osztály

addiktológiai osztály

pszichiátriai rehabilitáció

pszichoterápiás osztály
nappali kórház
mentős ambulancia
szakrendelés/ pszichiátriai gondozó
gyermek- és ifjúságpszichiátriai szakrendelés/gondozó
igazságügyi pszichiátriai ellátás
COVID-pszichiátriai ellátás
magánrendelés (pszichiátriai/pszichoterápiás rendelés)
alapítvány
egyéb

9. *Hányan dolgoznak összesen a vizsgálatba bevont pszichiátriai (és/vagy pszichoterápiás) ellátásban, ahol Ön dolgozik?*

1, 1-5 fő között
2, 6-10 fő között
3, 10-20 fő között
4, 20-50 fő között
5, 50-100 fő között
6, 100 felett

10. Hány éves szakmai tapasztalata van a saját szakmájában?

….

11. Hány munkahelyen dolgozik?

1, 1
2, 2
3, 3
4, 4
5, négynél több

12. Ön milyen típusú teamben dolgozik? Kérem egy választ jelöljön meg!

a, Az egyes teamtagok a páciens mellett elsősorban az orvossal állnak szakmai együttműködésben és a többi teamtag között minimális szakmai párbeszéd van vagy nincs is. A vezető egy személyben hoz döntéseket.

b, A teamtagok között szoros szakmai együttműködés van, a team vezetőjének feladata, hogy elősegítse a teamtagok közötti együttműködést és kevésbé a döntéshozás a feladata.
c, A teamtagok között, átlépve a megszokott diszciplináris határokat, olyan szoros együttműködés van, hogy a saját szerepeiket is átadják egymásnak, tisztázva, hogy milyen szerepek adhatóak át vagy sem.

13. Az Ön teamjében jelen van-e a hierarchia?

1, igen

2, nem

14. Az Ön munkahelyén elérhető team-szupervízió, azaz a teamben lévő nehézségek átbeszélésére szükséges megbeszélés?

1, igen

2, nem

15. A pandémia alatt dolgozott-e/dolgozik-e covid-ellátásban?

igen

nem

16. Ön szerint a mentális jólétét milyen mértékben befolyásolhatják a lentebbi tényezők, ha covid-ellátásban vesz részt?

nagyon kis mértékben, kismértékben, valamelyest, nagymértékben, nagyon nagy mértékben

a, előreláthatóság, tervezhetőség

b, szakmai elismerés

c, új kompetenciák szerzése

c, anyagi elismerés

d, támogatás a felettestől

e, támogatás a munkatársaktól

f, bizalmi légkör

g, családi támogatás

ELISMERÉSSEL KAPCSOLATOS KÉRDÉSEK

1.Ön mennyire érzi magát összességében szakmailag (szakmai hozzáértése, tapasztalata alapján) elismerve munkahelyi közösségén belül?

Nagymértékben

Közepes mértékben

Kismértékben

Egyáltalán nem

2. Ön mennyire elégedett a pozíciójával, szakmai előrejutásával?

Nagymértékben

Közepes mértékben

Kismértékben

Egyáltalán nem

3. Ön mennyire érzi magát anyagilag elismerve munkahelyi közösségén belül?

Nagymértékben

Közepes mértékben

Kismértékben

Egyáltalán nem

4. Ön mennyire érzi azt, hogy munkahelyi közösségén belül személyisége, hozzáállása, viselkedése alapján megbecsülik?

Nagymértékben

Közepes mértékben

Kismértékben

Egyáltalán nem

5. Ön mitől érezné magát jobban elismerve munkahelyi közösségén belül? Írja le pontosan, hogy mire gondol!

KOMPETENCIÁVAL KAPCSOLATOS KÉRDÉSEK

1.Mennyire ismeri pontosan, hogy mi az Ön felelősségi köre?

Nagymértékben

Közepes mértékben

Kismértékben

Egyáltalán nem

2. Az Ön munkahelyi közösségén belül előfordul-e az, hogy a kompetenciahatárok nem egyértelműek?

1, igen

2, nem

3. Az ön munkahelyi közösségén belül kinek a meglátásán múlik leginkább az adekvát gyógyszeres kezelés beállítása? Tegye sorrendbe!

1, nővér

2, rezidens/szakorvosjelölt

3, szakorvos

4, pszichológus/terapeuta

5, foglalkoztató/egyéb terapeuta

……

4. Az ön munkahelyi közösségén belül kinek a tapasztalatán, meglátásán múlik leginkább a korlátozó intézkedések (pl.rögzítés) alkalmazása (ha vannak ilyenek)? Tegye sorrendbe!

1, nővér

2, rezidens/szakorvosjelölt

3, szakorvos

4, pszichológus/terapeuta

……..

5/a.. Ha Ön találkozik akut ellátást igénylő illetve ”közvetlen veszélyeztető magatartást” mutató pácienssel, sérül-e az Ön kompetenciája?

igen

nem

5/b. Ha igen, hogyan?

6/a. Ha Ön pszichiátriai rehabilitációban/pszichoterápiában vesz részt, sérül-e a kompetenciája?

igen

nem

6/b. Ha igen, hogyan?

7. Ön szerint összességében mennyire sérülnek a munkahelyi kompetenciái?

Nagymértékben

Közepes mértékben

Kismértékben

Egyáltalán nem

8. Ha sérülnek a munkahelyi kompetenciái, pontosan miben?

9. Ha a munkahelyi kompetenciái sérülnek, kap-e megfelelő szakmai segítséget/szupervíziót?

igen

nem

10. Ha a munkahelyi kompetenciái sérülnek (pl. magasabb státuszú kollégája munkáját végzi el), elismertebbnek érzi magát?

igen

nem

nem tudom megítélni

11.. Ha Ön pszichiáter-szakképzésben vesz részt vagy dolgozik szakképzésben lévő kollégával:

Ön szerint a pszichiáter szakképzés alatt szükséges lenne-e, hogy a képzésben résztvevő orvosok nagyobb döntési hatáskörrel rendelkezzenek, meghatározott kérdésekben?

1, igen

2, nem

12. Ha igennel válaszolt, tudna példát mondani?

……
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……..

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A második kérdőívhez kapcsolódó COPSOQ II. kérdőív angol nyelvű változata a 94-104. közötti oldalakon, a magyar nyelvű változata pedig a 116-128. közötti oldalakon olvashatóak.