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Emotional Wellbeing and The Healthcare Workforce: A Review

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Abstract

Healthcare systems have long recognized the impact of adverse health events on patients and families, and in recent years have gone further to identify the resulting emotional strains on the healthcare workforce. This attention to emotional health, which has been described as the overall state of one's emotions and the ability to manage and adapt to stressors, is also referred to as "emotional wellness" or "wellbeing." As this concept of wellness expands and evolves in the midst of the COVID-19 pandemic into a priority on the wellbeing of those in the helping professions, the current review explores the existing literature on the impact of compassion fatigue, compassion satisfaction, and their relationship to occupational burnout, with the conclusion that the emotional wellness of healthcare stakeholders and the health of an organization itself are not mutually exclusive. A review of these identified areas of occupational wellness is conducted, as well as a summary of findings emphasizing its significant implications for the healthcare workforce moving forward, both in relation to tangible costs to the healthcare industry and its reach to the bedside in the form of reported patient experience.

Introduction

Adverse events in healthcare settings have been defined as "an injury that was caused by medical management (rather than the underlying disease) and that prolonged the hospitalization, produced a disability at the time of discharge, or both" (Brennan et al., p. 370)[1]. The devastating impact of such events for patients and their families cannot be overstated, and has been an important and longstanding area of regulatory research and policy[2]. In turn, the resulting emotional strain of such events on the healthcare workforce and the systems within which they occur continues to be investigated in the existing literature, with organizational support evidenced through the proliferation of employee wellness programs. As this issue of wellness expands and becomes a priority within traditional healthcare organizations and the community-at-large, the subject of workforce wellness has gained increasing attention in the last several years.

Amplified by our shared experiences during the COVID-19 pandemic, organizations have been compelled to expand their conceptual frame to incorporate the impact of compassion fatigue and its relationship to occupational burnout, with the conclusion that the emotional wellness of healthcare stakeholders and the health of an organization itself are not mutually exclusive. To facilitate and sustain this dyad moving forward, familiarity with these identified areas of emotional wellness, together with its impact on the "health of healthcare", would serve as a meaningful step towards informing

organizations as to strategies, polices, and procedures to address the evolving needs of an ever-changing healthcare landscape.

Compassion Fatigue

The concept of compassion fatigue was introduced into the healthcare lexicon nearly thirty years ago[3,4] in attempts to define the cumulative emotional impact of both direct and indirect exposure to patient trauma. The term has since been used interchangeably in the literature with secondary traumatic stress and vicarious traumatization, yet with slight variations in interpretation that nevertheless focus on compassion fatigue as the multilayered impact of helping others: emotionally, psychologically, and physically. The features consistent with compassion fatigue can mirror those of a post-traumatic stress disorder - itself defined as the result of direct exposure to a traumatic experience - to such an extent that the term secondary post-traumatic stress disorder is sometimes considered to describe the impact of secondary (or indirect) trauma exposure. Features include the following: an avoidance of stimuli (physical and/or emotional); hypervigilance; emotional numbing or inability to empathize; difficulties with concentration/attention; appetite and/or sleep disturbance; physical fatigue/ailments; irritability and lability of mood[5,6].

The prevalence of compassion fatigue has historically been studied primarily amongst those working in the therapeutic professions[7,8,9], and law enforcement[10,11,12] with its real and often underappreciated impact on other roles also explored in recent years, such as jurors and spoken-language interpreters[13,14,15]. Yet with the arrival of COVID-19, recent studies have turned this lens towards the medical workforce with even more sobering results. A systemic review conducted by Vizheh and colleagues[16] found the prevalence of self-reported anxiety, depression, and stress among healthcare workers exponentially increase since the start of the COVID-19 pandemic, with the highest levels of emotional distress identified among nurses, female workers, frontline healthcare workers, younger medical staff, and workers in areas with higher infection rates. A 2021 study[17] similarly found increased rates of depression and Post-Traumatic Stress Disorder among healthcare professionals since COVID-19, with nearly 25% showing signs of PTSD and nearly 50% signs of alcohol use disorder.

Burnout

Yet long before compassion fatigue was introduced into the language of the workforce, there was the concept of occupational "burnout". First introduced by psychologist Herbert Freudenberger[18,19] in the mid-1970s, Dr. Freudenberger's seminal work explored the emotional and physical consequences of those employed in the "helping" professions - physicians, nurses, psychologists, social workers, law enforcement, etc. Unlike compassion fatigue or secondary traumatic stress, which stem from indirect exposure to trauma, occupational stress is associated directly with one's work environment and institutional-related stressors. Some familiar occupational stressors include the well known culprits of salary, scheduling, caseload, deadlines, and limited resources. The course of burnout is gradual and cumulative, occurring either independent from compassion fatigue or stemming from such, and has become an increasing priority in the midst of the COVID-19 pandemic[20,21].

The syndrome of burnout or institutional fatigue has continued to be the focus of research, most notably in the work of psychologist Christina Maslach[22,23], who published the first and most widely used instrument for assessment of burnout, the Maslach Burnout Inventory (MBI)[24]. Initially designed for use with individuals employed in the helping professions, it has been psychometrically validated for use among a wide variety of occupations. Relatedly, one of the most significant developments in relation to workforce wellness occurred in 2019, when the World Health Organization (WHO) included Burnout in the 11th Revision of the International Classification of Diseases (ICD-11) as an occupational phenomenon[25,26]:

"syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed... characterized by three dimensions... (a) feelings of energy depletion or exhaustion, (b) increased mental distance from one's job or feelings of negativism or cynicism related to one's job, (c) reduced professional efficacy"

This identification of the consequences of burnout serves multiple important functions - distinguishing this phenomenon from other experiences such as depression or anxiety; destigmatizing the adverse emotional and physiological impact of organizational systems; recognizing its prevalence across the occupational landscape and providing systems an opportunity to focus its resources on addressing this now legitimized public health issue[27].

Compassion Satisfaction

A review of the elements of wellness would be incomplete without recognition of the other side of the coin: the important role compassion satisfaction plays in mitigating the risks of compassion fatigue and burnout. Not

all those in the helping professions experience compassion fatigue, nor is the experience the same with every provider, and it is the degree to which one experiences satisfaction from working within these systems that can serve as a meaningful buffer to the cumulative impact of such. Studies have identified the significance of feeling fulfilled from the work of caregiving, together with the resulting altruistic rewards and sense of efficacy and competence in one's role as a helping professional[28,29]. Additional variables that have been found to bolster compassion satisfaction among the healthcare workforce include the availability of programming that supports wellness and resiliency, spreads awareness, and reinforces preventative measures; opportunities for professional growth; professional recognition (either formally or in the form of positive feedback about one's performance) and an organizational culture experienced as compassionate - essentially the inverse of contributors to burnout[30,31,32,33].

To facilitate identification of these workforce elements, a number of self-assessments have also been created and tailored for those employed in the helping professions[34]. The most widely used and accepted such measure is the Professional Quality of Life Scale (ProQOL)[35,36]. An empirically reliable and validated screening measure that explores the positive and negative aspects of caregiving, the ProQOL is a 30-item questionnaire that asks responders to identify how often they have experienced a list of feelings over the preceding thirty (30) days on a 1-5 Likert Scale, with responses falling within the three domains of Compassion Fatigue, Burnout and Compassion Satisfaction.

Discussion

The implications for healthcare are significant. In addition to the identified physio-emotional consequences of providing quality patient care, available statistics also highlight the significant organizational impact of workforce wellness on the larger healthcare systems within which healthcare providers operate. A report released by The Joint Commission in 2019[37] summarized a survey revealing that among healthcare systems, a significant patient safety and quality concern is burnout. The near daily media reports predicting an exodus among the healthcare workforce[38,39,40] has also contributed to organizational reassessments of ways to both maximize wellness and mitigate risk of burnout. It has been calculated that physician burnout costs the healthcare industry an estimated $4.6 billion per year, and approximately $7600 per employed physician at the organizational level - even more concerning when these estimates are considered pre COVID-19 figures[41]. This reach also extends to the bedside in the form of patient experience, where patients have been found as less likely to recommend a facility to others in hospitals where nurses regularly work 13+ hours, and further tend to provide lower Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS, a publicly reported survey of patient experiences of hospital care) ratings overall when rating hospitals with longer shifts for nurses[42]. Errors stemming from burnout also carry additional burdens, with some estimates of errors cost approximately $20 billion per year overall and resulting in 100,000 deaths annually[43].

Conclusion

The importance of wellness within healthcare systems has long been recognized. Yet as the longer-term consequences and emotional impact of COVID-19 on the healthcare workforce comes into focus, organizational approaches are evolving to expand beyond the limiting lens of adverse events and beyond traditional human resources programming. In the midst of urgency to stem this tide, the current landscape also brings with it an opportunity to broaden the scope from "wellness" to the more holistic "wellbeing" of the healthcare workforce[44,45], and as studies begin to show the benefits to this approach at both organizational and workforce levels by virtue of increased productivity and retention[46], continuing this trend within healthcare systems is within reach.

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Conflict of Interest

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References

1. Brennan TA, Leape LL, Laird NM, et al. Incidence of Adverse Events and Negligence in Hospitalized Patients: Results of the Harvard Medical Practice Study I. N Engl J Med. 1991; 324(6): 370-376.
2. U.S. Department of Health and Human Services, Office of Inspector General. (n.d.) Adverse Events. 2022. Retrieved from: https://oig.hhs.gov/reportsandpublications/featured-topics/adv erse-events/
3. Joinson C. Coping with compassion fatigue. Nursing, 1992; 22(4), 116-121.
4. Figley CR. Compassion Fatigue as Secondary Traumatic Stress Disorder: An Overview. In Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized, Figley CR, ed. New York: Brunner/Maze. 1995.
5. The International Society for Traumatic Stress Studies. Indirect Traumatization in Professionals Working with Trauma Survivors (for Providers). 2016. Retrieved from: https://is tss. org/ISTSS Main/media/DocumentsnSTSS IndirectTrauma _FNL.pdf

6. Clay RA. Are You Experiencing Compassion Fatigue? American Psychological Association. 2020. https://www.apa.org/ topics/covid-I9 /compassion-fatigue#

7. Cocker F, Joss N. Compassion Fatigue among Healthcare, Emergency and Community Service Workers: A Systematic Review. International Journal of Environmental Research and Public Health. 2016; 13: E618.

8. Adams RE, Boscarino JA, Figley CR. Compassion Fatigue and Psychological Distress Among Social Workers: A Validation Study. Am J Orthopsychiatry. 2006; 76(1): 103-108. doi:10.1037/0002-9432.76.l.103

9. Yodr EA. Compassion Fatigue in Nurses. Applied Nursing Research. 2010; 23(4): 191-7. doi: 10.1016/j.apnr.2008.09.003

10. Bogstrand ST, Skogstad L, Ekeberg 0. The Association Between Alcohol, Medicinal Drug Use and Post-Traumatic Stress Symptoms Among Norwegian Rescue Workers After the 22 July Twin Terror Attacks. Int Emerg Nurs. 2016; (28): 29-33. doi:10.1016/j.ienj.2016.03.003

11. Bourke ML, Craun SW. Coping with Secondary Traumatic Stress: Differences between U.K and U.S Child Exploitation Personnel. Traumatology: An International Journal. 2014; 20(1): 57-64. https://doi.org/10.1037/h0099381

12. Burnett HJ, Wahl K. The Compassion Fatigue and Resilience Connection: A Survey of Resilience, Compassion Fatigue, Burnout, and Compassion Satisfaction Among Trauma Responders. International Journal of Emergency Mental Health and Human Resilience, 2015; (17): 318-326.

13. McQuiston DE, Hooper MD, Brasington AE. Vicarious trauma in the courtroom: Judicial perceptions of juror distress. Judges Journal. 2019; 58(2): 32-35.

14. Lonergan M, Leclerc M, Descamps M, et al. Prevalence and Severity of Trauma and Stressor-Related Symptoms Among Jurors: A Review. Journal of Criminal Justice. 2016; 47: 51-61. https://doi.org/10.1016/j.jcrimjus.2016.07.003

15. Mehus CJ, Becher EH. Secondary Traumatic Stress, Burnout and Compassion Satisfaction in a Sample of Spoken-Language Interpreters. Traumatology. 2016; 22(4): 249-254. https://doi.org/10.1037/trm0000023

16. Vizheh M, Qorbani M, Arzaghi SM, et al. The Mental Health of Healthcare Workers in the Covid-19 Pandemic: A Systemic Review. J Diabetes Metab Disord. 2020; 19(2): 1-12. doi:10.1007/s40200-020-00643-9

17. Hennein R, Mew EJ, Lowe SR. Socio-Ecological Predictors of Mental Health Outcomes Among Healthcare Workers During the COVID-19 Pandemic in the United States. PLoS ONE. 2021; 16(2): e0246602. https://doi.org/10.1371/joumal.pone.0246602

18. Freudenberger H. Staff Burnout. Journal of Social Issues, 1974; 30: 159-65.

19. Freudenberger H, Richelson G. Burnout: How to Beat the High Costs of Success. New York: Bantam Books. 1980.

20. Sasangohar F, Jones SL, Masud FN, et al. Provider Burnout and Fatigue During the COVID-19 Pandemic: Lessons Learned From a High Volume Intensive Care Unit. Anesthesia and Analgesia. 2020; 131(1): 106-111. https://doi.org/10.1213/ANE.0000000000004866

21. Sovold LE, Naslund JA, Kousoulis AA, et al. Prioritizing the Mental Health and Well-Being of Healthcare Workers: An Urgent Global Public Health Priority. Front Public Health. 2021; 9: 679397. doi: 10.3389/fpubh.2021.679397

22. Maslach C, Jackson S. The Measurement of Experienced Burnout. J Occup Behav. 1981; 2: 99-113.

23. Maslach C, Schaufeli W. Historical and Conceptual Development of Burnout. Professional Burnout: Recent Developments in Theory and Research. Washington DC: Taylor & Francis. 1993.

24. Maslach C, Jackson SE, Leiter MP. Maslach Burnout Inventory Manual. Palo Alto, CA: Consulting Psychologists Press. 1996.

25. World Health Organization. International Statistical Classification of Diseases and Related Health Problems (11th ed.). 2019.

26. World Health Organization. Burn-out an "Occupational Phenomenon": International Classification of Diseases. 2019. Retrieved from: https://www .who.in t/news/item/28-05-2019-bum-out-an-occupational-phenomenonintemational-classification-of-diseases

27. Brindley PG, Olusanya S, Wong A, et al. Psychological 'Burnout' in Healthcare Professionals: Updating our Understanding, and Not Making it Worse. Journal of the Intensive Care Society. 2019; 20(4): 358-362. doi:10. l 177/1751143719842794

28. Rossi A, Cetrano G, Pertile R, et al. Burnout, Compassion Fatigue and Compassion Satisfaction Among Staff in Community-Based Mental Health Services. Psychiatry Research. 2012; 200(2-3): 933-8. doi: 10.1016/j.psychres.2012.07.029

29. Sprang G, Clark JJ, Whitt-Woosley A. Compassion Fatigue, Compassion Satisfaction, and Burnout: Factors Impacting a Professional's Quality of Life. Journal of Loss and Trauma. 2007; 12: 259-280.

30. Zhang Y, Zhang C, Han X, et al. Determinants of Compassion Satisfaction, Compassion Fatigue and Bum-Out in Nursing. Medicine. 2018; 97: 26(e11086).

31. Kelly L, Runge J, Spencer C. Predictors of Compassion Fatigue and Compassion Satisfaction in Acute Care Nurses. Journal of Nursing Scholarship. 2015; 47(6): 522- 528.

32. Yildmm N, Co kun H, Polat S. The Relationship Between Psychological Capital and the Occupational Psychologic Risks of Nurses: The Mediation Role of Compassion Satisfaction.Journal o f Nursing Scholarship. 2021; 53: 115-125. https:l/ doi.org/10 .1111/ jn u.12607

33. Hunsaker S, Chen HC, Maughan D, et al. Factors That Influence the Development of Compassion Fatigue, Burnout, and Compassion Satisfaction in Emergency Department Nurses. Journal of Nursing Scholarship. 2015; 47: 186-194. https://doi.or g/10.1111/jnu.12122

34. Bride BE, Radey M, Figley CR. Measuring Compassion Fatigue. Clin Soc Work J. 2007; 35: 155-163. doi: 10.1007/s10615-007-0091-7

35. Stamm BH. Professional Quality of Life: Compassion Satisfaction and Fatigue Subscales. R-IV (ProQOL). 2005.

36. Stamm BH. The Concise ProQOL Manual (2nd Ed). 2010. Pocatello, ID: ProQOL.org.

37. The Joint Commission. Quick Safety: Developing Resilience to Combat Nurse Burnout. 2019.

38. McClelland WS, Giusto A, Williamson T. The Healthcare Exodus Is an Untreated Trauma Crisis. 2022. Slate.com. https://slate.com/teclmo_log_y/2022/03/healthcare-workers-bumout-trauma-soldiers.html

39. Plescia M. If 1 in 5 Healthcare Workers Have Quit, Where have they Gone? Becker's Hospital Review. 2022. https://www.beckershospitalreview.com/workforce/if-l-in-5-healthcare-workers-havequit-where-have-they-gone

40. Yong E. Why Health-Care Workers are Quitting in Droves. The Atlantic. 2021. https://www.theatlantic.com/health/archive/202l/1l/the-mass-exodus-of-americas-health-care-workers/620713/

41. Han S, Shanafelt TD, Sinsky CA, et al. Estimating the Attributable Cost of Physician Burnout in the United States. Annals of Internal Medicine. 2019; 170(11): 784-790. https://doi.org/10.7326/Ml 8-1422

42. Stimpfel AW, Sloane DM, Aiken LH. The Longer the Shifts for Hospital Nurses, the Higher the Levels of Burnout and Patient Dissatisfaction. Health Affairs (Project Hope). 2012; 31(11): 2501-2509. https://doi.org/10.1377/hlthaff.2011.1377

43. Rodziewicz TL, Houseman B, Hipskind JE. Medical Error Reduction and Prevention [Updated 2022 Jan 4]. In StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2022. Available from: https://www.ncbi.nlm.nih.gov/books/NBK4 99956/

44. Miller S. Wellness Programs Show Modest Benefits, as Efforts Pivot to 'Well-Being'. Society for Human Resource Management. 2020. https://www.shrm.org/resourcesandtools/hr-to pics/benefits/pages/we1lness-programsshow-modest-benefits-as-efforts-pivot-to-well-being.aspx

45. DeLoatch P. From Wellness to Well-Being: The Evolution of Employer Health Initiatives. HR Dive. 2019. Retrieved from: https://www.hrdive.co/news/from-wellness-to-well-being-the-evolution-of-employerhealth-initiatives/561591/

46. Krekel C, Ward G, De Neve J. Employee Wellbeing, Productivity and Firm Performance Labor: Personnel Economics eJournal. Said Business School WP. 2019. http://dx.doi.org/l0.2l3 9/ssm.3356581