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Learning from Health Care Counselors' Perspectives on Health Care Worker Distress: A Qualitative Analysis

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Abstract

Background

Health care provider stress and emotional distress were well documented long before the COVID-19 pandemic, and there is growing data suggesting these have increased in response to the pandemic. The goal of this study was to take advantage of the unique experiences of licensed mental health (MH) clinicians working with health care trainees and clinicians before and during the pandemic to identify how this crisis affected both ongoing as well as new sources of stress. The Healer Education, Assessment and Referral Program (HEAR) provides MH screening, support, and MH referrals to ~19 000 health care students, trainees, staff, and faculty. Since its inception in 2009, the program has been staffed by 4 licensed counseling professionals who have worked both before and since the COVID-19 pandemic.

Methods

Qualitative data obtained from semi-structured, 1-hour interviews and a follow-up 1-hour focus group with 4 HEAR counselors was analyzed using reflexive thematic analysis.

Results

Several preexisting stressors were amplified during the pandemic: financial concerns; long work hours; exposure to the suffering of illness, death, and dying; bullying; discordant values and moral distress; social inequities; individuals' lack of adaptive coping; and individuals' self-concept as a victim. New stressors included: health care demand greater than the work-force numbers and resources; caretaking for ill family/friends; homeschooling of children; social isolation; experiencing the COVID-19 crisis as a war, fire, or storm; fear of personal illness and death, especially before vaccines; and hopes of a cure with vaccines; followed by perceived opportunities for improvement in leadership response to staff concerns.

Conclusion

Authentically responding to staff concerns/ideas, a patient and provider-centered health care culture, grief education and support, and attention to actionable stressors affecting providers' well-being are indicated to meet the amplified and new stressors triggered by the COVID-19 pandemic and sequelae.

Keywords

health care provider; health personnel; health care workers; psychological distress; burnout; professional; depression; stress; COVID-19 pandemic; psychological well-being

Background

Even before the COVID-19 pandemic, high rates of health care worker (HCW) distress, as manifested by second victim phenomena, burnout, substance abuse, depression, and suicide, had drawn national attention and

calls for action.¹⁻⁴ Occupational stressors, such as untenable workload, compassion fatigue, clerical and administrative burden, low autonomy, disconnected values, electronic health records, disengaged leaders, and work-home balance have been implicated as contributors to these stress-related conditions.⁵ Since the

COVID-19 pandemic, HCW distress has intensified, leading to unprecedented levels of emotional stress and despair for health care providers.^{4,6-9} Increased distress is attributed at least in part to the additional burdens created by social isolation, decreased access to community and religious support, barriers to mental health treatment, illness and medical problems, concerns about infection, fear of exposure of family members, sick colleagues, shortages of necessary personal protective equipment, overwhelmed facilities, and regular exposure to death and dying.^{6,10,11}

The University of California San Diego (UCSD) Healer Education, Assessment, and Referral (HEAR) was instituted in 2009 as one academic health system's approach to identifying and modifying health care worker distress.^{12,13} A quantitative descriptive HEAR study, using data from the American Foundation for Suicide Prevention's anonymous, online, Stress and Depression Screening Questionnaire, HCW distress pre- and post-COVID-19 pandemic reported post-pandemic increases in burnout (OR 1.42 (1.20-1.67), $P < .001$) and increases in depressive symptom intensity (OR = 1.27 (1.07-1.50), $P = .05$).^{6,14} Increases were also observed in each of 10 emotional states previously associated with suicide risk: nervous, annoyed, stress, fights, anxiety, lonely, angry, hopeless, desperate, and out of control (ORs 1.28-1.61).⁶ In addition to the quantitative data derived from the screening questionnaire, we realized a more nuanced comparison of changes in HCW distress triggered by COVID-19 was possible by evaluating the multi-dimensional, collective experiences of HEAR's counselors working with HCWs pre- and post-pandemic. Four HEAR mental health counselors, informed by providing emotional and mental health support to UCSD Health students, trainees, staff, and faculty both before and since the pandemic, were in a unique position to understand the changing landscape of emotional challenges brought on by the pandemic.

The goal of this study was to understand, from the unique perspective of the HEAR counselors, how specific stressors experienced by HCWs changed or emerged before and during the pandemic. The results of this inquiry could guide individual and institutional preparation for the next public health crisis.¹⁵

Methods

Our research team analyzed qualitative data obtained from semi-structured, 1-hour interviews and a follow-up 1-hour focus group using reflexive thematic analysis.¹⁶ The UCSD Institutional Review Board approved this study (IRB #210137).

Study Participants and Context

The data were comprised of content from counseling interactions with medical students, pharmacy students, medical residents and fellows, nurses, hospital staff, and faculty physicians over a 13-year period. Each of the participants had supported the health care workforce for at least 2 years pre-pandemic and at least 2 years after the pandemic began. The interviews focused on the counselors' experiences and perspectives on health care workforce distress before versus during the pandemic.

The participants' responses were based on their individual and collective experiences drawn from assessing, engaging, supporting, treating, and referring thousands of medical and pharmacy students, residents and fellows, attending physicians and faculty, nurses, and other clinical and non-clinical staff.

Each counselor was interviewed independently in one-on-one interview sessions and again as part of a focus group. The decision to include both individual and focus group interviews was made to enhance the richness of the data.¹⁷ The focus group allowed participants to interact, discuss issues with each other, and facilitated the capture of novel views through the expansion of original thought, clarification, and exploration.

From 2009-2016, HEAR was staffed by 2 counselors who together represented 1 full-time licensed mental health (MH) professional. In 2016, the staff was increased to 2 full-time counselors, and in 2021, in response to increased needs secondary to the COVID-19 pandemic, to 2.5 full time counselors. Four different staff counselors worked with HEAR for at least 2 years before and 2 years after the start of the COVID-19 pandemic. During the 2 years before the pandemic (3/1/18-3/12/20), HEAR counselors assessed 1177 medical students, physician trainees, faculty physicians, and other

health care staff who completed the American Foundation for Suicide Prevention's anonymous, online, Stress and Depression Screening Questionnaire. During the subsequent 2 years (3/13/20–2/28/22) HEAR counselors assessed 1134 UCSD health care workers.⁶

HEAR counselors perform several functions that inform them of the “emotional pulse” of the workforce. First, they manage HEAR's cardinal activity, the Interactive Screening Program (ISP). Developed by the American Foundation for Suicide Prevention, the ISP is a comprehensive method of getting distressed individuals into MH services. The ISP provides a safe and confidential way for individuals to take a brief screening for stress, depression, and other MH conditions, and receive a personal response from a program counselor within the MH system about services available to them. Individuals can communicate anonymously with the program counselor to receive recommendations, feedback, and support for connecting to available MH services.^{14,18}

The ISP questionnaire includes the collection of brief demographic information and items screening for depression, burnout, intense emotional states, alcohol and drug use; disordered eating behaviors; current suicidal thoughts, behaviors, and suicidal plans, past suicide attempts; impairment and current MH treatment. An open-ended question asks about stressors. Since 2009, over 4500 students, house staff, clinical staff, and physician faculty have completed the ISP questionnaire. HEAR counselors review each questionnaire and respond with personalized summaries. For those who score at moderate or high distress, counselors provide an invitation for further dialogue, which may be primarily support, but also may be a referral for further assessment or treatment. The process of referral includes bridge support until an appointment for treatment is kept. This is often referred to as a “warm hand-off.” At the time of our interviews, over 1000 individuals dialogued with HEAR Counselors, resulting in more than 600 referrals.

In addition to the ISP, HEAR counselors respond to referrals or individual requests for support, evaluation, or referral. On average, they meet with the person 1-3 times by phone, computer, or in person. HEAR counselors also

provide interactive educational programs on HCW stress and self-care to requesting units and services. These programs include ample time for participants to air their concerns and grievances. Pre-pandemic, counselors delivered ~10 programs/year; during the pandemic, this rose to 50 programs/year. After critical events in any area of the health care enterprise, HEAR counselors delivered group debriefs for affected students, house staff, clinical staff, and physicians. Since 2016, they averaged 2-4 debriefs/week.

Also since 2016, HEAR counselors have provided ongoing, short-term counseling for over 100 residents and fellows annually. Since 2018, HEAR counselors have offered 1-hour one-on-one prescheduled “opt-out” sessions to touch base, discuss concerns, provide resources, and remove barriers to care for each new resident in requesting training programs.¹⁹ At the time of the study interview, they had conducted about 200 of these meetings for new residents. In 2019, several divisions in the UCSD Department of Medicine requested the same service for faculty physicians. By the time of this data collection, 120 physicians had met with HEAR counselors for these one-on-one “opt-out” sessions.

HEAR counselors also provided quarterly Schwartz Center Round.²⁰ These multidisciplinary conferences provide an opportunity for trainees, staff, and faculty to discuss emotionally trying situations, support each other, and create a sense of community and connection. About 100 trainees, staff, and faculty attended each of these.

Study Team Characteristics

The study team was both multidisciplinary and intergenerational and included an international medical student early career investigator (AH), a psychiatrist clinician educator with expertise in psychotherapy (ND), a nurse scientist with thematic analysis experience (JD), and a distinguished professor of psychiatry (SZ). Three of the team members were trained in reflexive thematic analysis (JD, ND, AH).¹⁶

Interviews

Information was obtained from semi-structured, 1-hour interviews followed on a separate

occasion by a focus group. Iterative reflexive analysis was conducted for both interview and focus group data to review data, identify codes, discuss and name themes, gain consensus on nomenclature, re-enter the data as new meaning or ideas were identified, and report-writing.¹⁶

Data were collected from January to February 2022. The study’s key goal was to answer the question: How have stressors on HCWs changed since the onset of the pandemic? Specific questions for the interviews were agreed upon by 2 members of the research team (JD,

AH) and relevance to achieve the study goal confirmed by a third (SZ). (**Table 1**) There was 1 interviewer for all five sessions (AH), who was supervised and trained by an experienced qualitative researcher (JD). All interview data were recorded via audio and transcripts were generated. Analysis was conducted first by 2 authors independently (AH, ND), then together, then validated by 2 other experienced members of the research team (JD, SZ).

Interview content included assessments of sources, manifestations, and intensity of respondents’ distress as well as examples of

Table 1. Interview Guide

Meetings were recorded and downloaded. Transcripts of the meetings were filed with answers to the following questions.

Individual Therapist Interview Questions

- We are exploring how things have changed with your role as a HEAR therapist across 3 different time-spans: before COVID, during COVID (April 2020 – June 2020), and now in this period of the chronic pandemic.
- When did you start working with the HEAR team?
- For 2 therapists: You left and came back; can you give me an idea about what periods of time you served the HEAR team as a therapist?
- Please tell me about your role as a HEAR therapist. What is your typical day like? What are your responsibilities?
- Have there been changes in what you are hearing from health care workers pre-pandemic vs. the beginning of the pandemic versus now in the chronic stage of pandemic?
- I understand you serve faculty, trainees, and hospital staff. That is a broad range of people. Have the needs of these groups changed over time?
- Are there any differences between the concerns of faculty, trainees, and hospital staff?
- Have you noticed any difference in the way people have been accessing your services over time? Please comment on ISP versus direct calls versus follow-up from debriefs.
- Given what you have experienced has there been a change in the sources of distress over time?
- Given what you have experienced has there been a change in the intensity of distress over time?
- Have you noticed any changes in adaptive or maladaptive coping strategies?
- What has it been like to serve as a therapist for the HEAR program?
- Has this changed because of the acute or chronic pandemic?
- What are your greatest stressors as a HEAR therapist?
- What have been your most rewarding moments? What keeps you going?
- You must be exposed to a lot of negativity from health care workers in crisis. How do you personally handle the stress of the job?
- What advice do you have for others?
- If you had a magic wand and could change anything about the work you do, what would that be?
- What advice do you have for others doing this type of work?
- What advice do you have for health care leaders regarding deploying services like the HEAR program?
- Is there anything else that I didn’t ask that you would like to share?
- There will also be a group focus group, please think about that.

Focus Group Interview Questions

- We have all gone through individual thoughts about how being a HEAR therapist has changed over time, and what impact the pandemic has had on this type of work.
- Now we’d like to open it up for group thought...
- Are there things you’ve thought about since our original interview that you’d like to bring up?
- Are there questions we asked previously that you’d like to discuss as a group?
- Are there questions we did not ask previously that you’d like to explore?
- What would you like others to know about doing the special work of treating health care professionals?

adaptive and maladaptive coping strategies. Counselors were also queried regarding their own work-related stress pre- and during COVID-19. Three team members reviewed the transcripts for prevailing themes, focusing on changes in sources and intensity of stress pre- and mid-COVID-19 pandemic using reflexive thematic analysis¹⁶

Analysis: Special Considerations to Prevent Bias and Identify Themes and Codes

The order of analyzing the transcripts was chosen based on previous research of the effect on primacy in evaluating experiences.²¹ To avoid placing undue emphasis on ideas first generated during the review, the initial 2 reviewers used a “shuffled” order as follows. One read the transcripts 3, 4, 1, 2, 5, while another read them 5, 4, 1, 2, 3. A total of 846 lines of transcript data were reviewed.

Two authors conducted the initial inductive thematic analysis (ND, AH). The authors independently read the transcripts multiple times before generating codes. Next, they looked for codes in the data that would address the underlying research question of any changes in the counselors’ observations pre- and post-pandemic. The interview questions included sources of referrals, manifestations of distress, distress intensity, coping mechanisms (both adaptive and maladaptive), and counselor’s stress. A paper trail was maintained with shared documents and notes regarding the analytic process.

The authors met regularly to compare notes and refine the codes. Once these were determined, the next phase identified underlying themes that told a story related to client and counselor stressors and coping pre-pandemic and during the pandemic. These themes and codes were then reviewed with a third team member to verify that there was credibility and trustworthiness of the data codes and themes.²² Finally, the team selected de-identified quotes from the transcripts to represent the 6 themes and affirmed that they represented the themes appropriately; in other words, “rang true.” It was confirmed that the named themes could be understood by a reader when separated from the data. In addition,

member-checking was conducted by having the counselors review a draft of the manuscript to confirm the accuracy of the findings.¹⁶

Results

Table 2 shows the themes and codes for health care provider distress before and during the COVID-19 pandemic. There were 6 themes and 51 codes that told the story of (1) phenomenology of distress, (2) systemic changes due to COVID, (3) amplification of pre-existing stress, (4) development of new sources of stress, (5) manner of coping, and (6) learning from the COVID pandemic.

The phenomenology of distress was based on the codes of burnout, hopelessness, loneliness, anger, anxiety, depression, suicide prevention, and grief. Quotes that depicted this theme can be found in **Table 3**, for example:

People are solution-focused; they want to have this work but when you’re screaming at the top of your lungs, and no one is paying attention to you, it becomes this hopeless abyss for people, right? (5:129-130)

Systemic changes due to COVID included delivery of equipment such as masks and other personal protective equipment (PPE); vaccine/booster delivery; new protocols for eating, screening, sanitizing, etc; telehealth opportunities for outpatient visits, trainings, and meetings; hybrid work options for at-home and in-clinic; advocacy to support MH; individual help-seeking; a higher number of high-need MH clients. See **Table 3** for transcript quotes highlighting this theme, for example:

I think the openness to seeking help is much better. And talking about it amongst their peers, that’s a positive thing I’ve seen. But that also increased the demand for our services so much more...we had to hire more HEAR counselors who were so overwhelmed. We could double our staff and still not be able to meet the need that currently exists. (5:35-38)

There were 2 themes for stressors; amplification of pre-existing stress and development of new sources of stressors. Financial concerns, long work hours, exposure to the suffering of illness, death, and dying, relationship stress, bullying; business model versus health care

Table 2. Themes and Codes for Health care Provider Distress Before and Since COVID-19

Themes	Codes
Phenomenology of distress	Burnout (exhausted, fatigued, over-whelmed) Hopelessness Loneliness Anger Anxiety Depression Suicide prevention Grief
Systemic changes due to COVID-19	Delivery of equipment (masks, other PPE) Vaccines/booster delivery Implied new protocols (eating, screening, sanitizing) Telehealth (out-patient visits, trainings, meetings) Hybrid work (office at-home, in-clinic) Advocation to support MH Individual help-seeking Higher number of high-need MH clients
Amplification of pre-existing stress	Financial concerns (student loans, competitive pay) Long work hours Exposure to suffering (illness, death, dying) Relationship stress (partner, family, team members) Bullying (backed into a corner) Business model versus health care model Moral distress (power dynamics) Social inequities Individual's lack of adaptive coping pre-pandemic Individual's self-concept as a victim
Development of new sources of stress	Health care demand greater than workforce supply Caretaking (online school, ill family/friends, etc) Social isolation (lockdowns of restaurants, theaters, exercise facilities, etc) COVID-19 crisis (analogies to wars, fires, storms) Fear of personal illness and death before vaccines Hope of cure followed by disappointment More absolute death and grieving than pre-COVID-19
Manner of coping	Don't take things personally Know your limits, set boundaries Validate/process emotional life via therapy Learn new emotional regulation strategies Lifestyle changes (exercise, sleep, diet, meditation) Talk more openly about alcohol use Family, pets New hobbies Psychoeducation for depression, anxiety, grief Change job/leave institution (may be a way out from hopelessness) Gratitude towards other health care workers in your team Gratitude of meaningful work within health care Finding meaning in suffering and helping others
Learning from the COVID-19 pandemic	Leadership change (receive feedback, generational differences) Develop patient-centered AND employee-centered care Prioritize MH (salaries, educational loan assistance, more providers) ROI for healthy, sustainable workforce Gratitude for the program: help us to optimize, and other institutions to actualize

Abbreviations: MH = mental health; PPE = personal protective equipment; ROI = return on investment

Table 3. Themes and Quotes for Health care Provider Distress Before and Since COVID-19

Themes	Quotes
Phenomenology of distress	<p>Once COVID came on, it was like across the board, the frustration level went through the roof because everybody was saying before COVID, we were already telling leadership that we want to sit down and have productive conversations to fix the system. (5:99)</p> <p>People are solution-focused; they want to have this work but when you're screaming at the top of your lungs, and no one is paying attention to you, it becomes this hopeless abyss for people, right? (5:129-130)</p> <p>There's a systemic challenge that's not being addressed across the health care system. And we're seeing it manifest in chronic stress burnout, fatigue, depression, anxiety. (3:57-58)</p>
Systemic changes due to COVID-19	<p>The lockdown dealing with the unique stressors that COVID presented. (5:19)</p> <p>I think the openness to seeking help is much better. And talking about it amongst their peers, that's a positive thing I've seen. But that also increased the demand for our services so much more... we had to hire more HEAR counselors who were so overwhelmed. We could double our staff and still not be able to meet the need that currently exists. (5:35-38)</p> <p>We've certainly seen different issues like moral distress, and the [health care] inequities that COVID shone a light on within health care. And how that particularly impacts the health care provider. (4:36-38)</p>
Amplification of pre-existing stress	<p>Same issues were always there [with] COVID [they] were intensified and amplified. We know that our folk were burnt out prior to this. (5:31)</p> <p>It was like, I'm in crisis, this is already too late, we should have had this in place before [the pandemic]. (5:40)</p>
Development of new sources of stress	<p>Nurses talked about shouting into a void. Those nurses were begging the physicians to hear them out saying, "I'm with this patient 12 hours a day, what are we doing?" That was so distressing for so many, particularly early in the pandemic...the moral distress. (5:141-145)</p> <p>What has weighed down on me are some of the really devastating losses that there's not much to say about it, right? Death is inevitable when you're working in health care. The hard part about that is we don't get to slow down and grieve sometimes. [The counselors] can see a huge part of the pandemic trajectory has been grief. So many people with whom I talk will say I'm grieving. Others are circling it and haven't put their finger on it... because for some it might be the very first time in their life that they're articulating, "Oh this is what grief feels like." (3:131-135)</p>
Manner of coping	<p>You need to make sure that your self-care comes first, you need to learn how to say no because there's always going to be people asking you to do more that's beyond your job description, and you just have to say no. You must know your limits. And that's the way you're going to be able to do this and enjoy it and do it for a longer time. (2: 75-77)</p> <p>It's extremely rewarding, and I love working with this population; they were always so grateful for our services and our support. And I found them to be highly motivated, once they reached us, to take our advice to implement tools we shared with them. (2: 42-44)</p> <p>[Many] of the healthy coping mechanisms that people [had] turned to over the years either weren't available for various reasons, or they drifted away from them. And so, we've seen a rise in the maladaptive side of things. (1:69-70)</p>
Learning from the COVID-19 pandemic	<p>We need more therapists, more MH [providers], more of an emphasis and focus on MH across the board. (5:161)</p> <p>Find a way to deploy services like the HEAR program. Do it, find a way to do it. Reallocate funding. If you need to restructure teams, if you need to stand up new systems [do it]. Be open to pursuing this aggressively and making it your number one priority. I truly believe if you take care of your people, they take care of you. (3:151-155)</p> <p>If you don't offer proper services and support, everything falls apart. You're going to lose staff; they're going to burn out. You're going to spend extra money hiring new people who then might burn out as well. And employees who don't feel valued and aren't happy, aren't going to stay. So, purely from a financial point of view, it benefits you to take care of your employees' emotional health and to invest in it. (2:82-84)</p>

Abbreviation: MH = mental health; HEAR = Healer Education, Assessment, and Referral Program

model, moral distress, social inequities, individual's lack of adaptive coping pre-pandemic, and individual's self-concept as a victim emerged as codes for amplification of pre-existing stressors. See **Table 3**, for representative quotes, for example:

Same issues were always there [with] COVID [they] were intensified and amplified. We know that our folk were burnt out prior to this. (5:31)

It was like, I'm in crisis, this is already too late, we should have had this in place before [the pandemic] (5:40)

Development of new sources of stress highlighted a health care demand that was greater than the workforce supply; caretaking for ill family/friends and online schooling of children; social isolation due to lockdowns of restaurants, theaters, exercise facilities; experience of the COVID-19 pandemic as a war, fire, or storm; fear of personal illness and death, especially before vaccines; hope of a cure with vaccines, followed by disappointment; and higher absolute numbers of death and grief than pre-pandemic. See **Table 3** for comments exemplifying this theme, for example:

What has weighed down on me are some of the really devastating losses that there's not much to say about it, right? Death is inevitable when you're working in health care. The hard part about that is we don't get to slow down and grieve sometimes. [The counselors] can see a huge part of the pandemic trajectory has been grief. So many people with whom I talk will say I'm grieving. Others are circling it and haven't put their finger on it...because for some it might be the very first time in their life that they're articulating, "oh this is what grief feels like." (3:131-135)

Manner of coping had the greatest number of codes in our analysis (13 codes). See **Table 2** for the full list of codes which ranged from setting boundaries and finding new hobbies to changing jobs to escape hopelessness, and gratitude for the health care team. See **Table 3** for transcript quotes that described the manner of coping, for example:

It's extremely rewarding, and I love working with this population; they were always so grateful for our services and our support.

And I found them to be highly motivated, once they reached us, to take our advice to implement tools we shared with them. (2:42-44)

[Many] of the healthy coping mechanisms that people [had] turned to over the years either weren't available for various reasons or they drifted away from them. And so, we've seen a rise in the maladaptive side of things. (1:69-70)

The final theme was learning from the COVID-19 pandemic. Codes described leadership change (receiving feedback and generational differences), developing patient-centered AND employee-centered care, prioritizing MH (number of providers, salaries, loan forgiveness), return on investment for a healthy, sustainable workforce, gratitude for the HEAR program and suggestions to optimize the program at this site, while actualizing at other institutions, see **Table 3** for comments exemplifying this theme, for example:

We need more therapists, more MH [providers], more of an emphasis and focus on MH across the board. (5:161)

If you don't offer proper services and support, everything falls apart. You're going to lose staff; they're going to burn out. You're going to spend extra money hiring new people who then might burn out as well. And employees who don't feel valued and aren't happy, aren't going to stay. So, purely from a financial point of view, it benefits you to take care of your employees' emotional health and to invest in it. (2:82-84)

Table 4 provides the counselors' consensus regarding their recommendations for health institutions to enhance workforce well-being, MH, and engagement.

Discussion

In this study, we capitalized on a reflexive thematic analysis design to learn from experienced MH clinicians who provided MH care for the health care students and workforce both pre- and post-COVID-19 pandemic. Our study directly addresses a significant 2-pronged gap in the literature. First, how to better inform health care systems on actionable items that support wellness and retain HCWs. Second,

Table 4. Institutional Recommendations

New findings:
<ul style="list-style-type: none"> • The Healer Education, Assessment, and Referral (HEAR) program therapists revealed that many of the stressors since the pandemic were exacerbations of pre-existing stressors evident pre-pandemic. • Since the pandemic, health care workers adopted individual adaptive coping, which included help-seeking behaviors, setting firm boundaries, and knowing their limits. • Therapists benefitted from the practice of gratitude and finding meaning in suffering.
Impact on health care in the future:
<ul style="list-style-type: none"> • Health care that is patient- AND employee-centered can create a healthy, sustainable workforce. • Employees want to feel heard and see themselves at the leadership table during a crisis. <ul style="list-style-type: none"> ◦ Preserve two-way communication and shared decision-making in crisis situations. ◦ Consider diversifying decision-making groups in the "command center" to include representation across generations. • Provide leadership tools to enhance leaders' ability to gather staff perspectives from the front line regarding what action plans are working versus not (using techniques other than surveys). • Proactively prioritize mental health (MH) and wellness for health care workers. <ul style="list-style-type: none"> ◦ Budget adequate resources for screening and referral. ◦ Anticipate increased MH needs (costs) during crisis situations such as a pandemic. Return on investment in decreased turnover and engagement will outweigh the initial costs. ◦ Anticipate that needs will lag past normalizing conditions in public health. ◦ Anticipate that traumatized staff will need long-term support. ◦ Implement a death, dying, and grief education program for health care providers that can be delivered using telehealth/video. Grief may take the form of responding to loss of routine as well as exposure to death. ◦ Assure that there is capacity internally for referrals to psychiatry/MH resources to meet the demand. <ul style="list-style-type: none"> • Monitor time to appointment from referral; need to refer externally if no availability. • Increase the number of providers as indicated by need. • MH counselors <ul style="list-style-type: none"> ◦ Can use the themes identified (phenomenology of distress, systemic changes due to COVID-19, amplification of pre-existing stress, development of new sources of stress, manner of coping, and learning from the COVID pandemic) to effectively intervene and assist health care workers who are struggling with their emotional fitness and mental well-being. ◦ Can bolster resiliency by reflecting on the gratitude of others for their service and finding meaning in suffering.

how we can better prepare for the next, unexpected health care crisis. The strategy of using personalized interviews and reflexive thematic analysis provides much-needed, nuanced, and individualized information that can often be missed in purely quantitative studies. This technique can be replicated for the purposes of organizational learning and performance improvement within an individual health care setting. Furthermore, the themes and codes can guide future interventions and dissemination to a wide variety of health care systems.

Our results provide a coherent and compelling narrative of health care provider distress before and during the pandemic. The phenomenology of distress highlights the ongoing need for health systems to address burnout, depression, anxiety, and suicide prevention. These findings support national initiatives for health care executives to adopt programs for burnout and suicide prevention posed by professional and regulatory agencies.^{5,23,24} Systemic changes due to COVID-19 describe the academic health system's response to a true crisis in health care

and the individual provider's efforts to adapt and comply with organizational requests.

These institutional and individual responses to COVID-19 are further delineated in the themes of amplification of pre-existing stress and development of new sources of stress. In particular, the codes of "individual's lack of adaptive coping" and "individual's self-concept as a victim" can guide MH counselors to effectively intervene, based on the recent literature, and assist providers who are struggling.²⁵ Counselors can compassionately highlight behaviors and feelings they observe such as complaining, avoiding responsibility, feeling powerless or hopeless. Then a counselor can ask, "What would you do, if you had the power to do something?" The next step is to help the client imagine possible ways to take responsibility to achieve their goal(s) based on their unique perspectives and strengths. We posit that the benefit of employees taking responsibility for making meaningful improvements can best be actualized within an organizational mindset of corporate social responsibility, where leaders listen authentically to the ideas proposed by employees and take action based upon their input.²⁶ In this manner, leaders have the opportunity to support the mental health of the workforce and encourage bolstered individual autonomy, known to be positively associated with worker MH.⁵

Furthermore, in manner of coping, multiple codes described adaptive strategies that can inform counselors and clients moving forward. This qualitative data supports setting boundaries, knowing your limits, adopting therapeutic lifestyle changes (sleep, exercise, diet, meditation), seeking therapy for emotional regulation, psychoeducation for MH issues (depression, anxiety, grief, etc), practicing gratitude for others, finding meaning in suffering, and helping others to improve coping.^{27,28} However, individual actions to build resiliency are insufficient alone and require organizational efforts to reduce stressors that are the root cause of these issues.⁹

The codes of "health care demand is greater than work supply" and "more absolute death and grieving due to COVID-19" can guide health care leaders to make fundamental changes in their workforce priorities. Proactive grief

education and support are indicated to guide the workforce through the changes imposed in their home/work lives by the pandemic, as well as the increased exposure to death.^{29,30} Grief support could be offered on a large scale as part of a holistic wellness program.³¹ Counselors trained in discerning different types of grief and loss are shown to promote HCW well-being during the pandemic by guiding them toward finding their own strengths and abilities thereby amplifying HCW resilience. As an example, a recent early-stage innovation report from Australia during the pandemic described a blended care approach utilizing digital (websites and apps), telehealth, and in-person MH services.³² Implementing a robust peer-to-peer support program might be another way to mitigate the work and loss-related stresses, enhance HCW resilience and feelings of belonging and connection before these stresses escalate into more chronic and severe MH challenges.³³ Importantly, grief management can be seen as a suicide prevention activity as unmanaged grief has been associated with death by suicide among nurses during the COVID-19 pandemic.³⁴

The final theme of learning from the COVID-19 pandemic delivered suggestions to further respond and adapt to both health care financial AND provider priorities. Frustrations regarding feeling "voiceless" warrant increased 2-way communication between leadership and frontline workers to prevent feelings of organizational betrayal.³⁵ The code of "learn new emotional regulation strategies" can guide counselors and health systems to develop emotional fitness training programs that have shown promise in other first-responder workforces.³⁶

Limitations

This project has limitations as it was a single-site analysis using non-experimental qualitative methods. Further qualitative and quantitative analyses are needed from multiple health systems to confirm how to optimally respond to our patients and care providers during public health disasters such as the COVID-19 pandemic.

Conclusion

In summary, the results of this qualitative study support the process of listening to therapists who work with health care professionals as a

strategy to detect actionable shifting trends of root causes of distress in the workplace. Recommendations emanating from the counselors' individual and collective experience include developing a health care approach that is patient- and provider-centered to build a healthy, sustainable workforce; advocating for a more receptive and intergenerational leadership; prioritizing mental health and emotional fitness for all; and encouraging gratitude between team members. Surely, this investment in human capital and the well-being of the workforce will resonate with both health care's business and healing models.

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Conflicts of Interest

The authors declare no conflicts of interest.

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