LIBERTY UNIVERSITY

Action Crisis Intervention Response

A Thesis Project Report Submitted to

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Doctor of Ministry

by

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THE DOCTOR OF MINISTRY THESIS PROJECT ABSTRACT
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Establishing a peer-to-peer mental health intervention program for healthcare workers at Henry Mayo Hospital is imperative for addressing stress, anxiety, depression, job burnout, and compassion fatigue. The growing mental health crisis among healthcare workers, leading to a significant number leaving the industry due to lack of support from management, underscores the urgency of this initiative. This action research project emphasizes the need for such a program in conjunction with the established Mental Health First Aid. While the latter provides tools to recognize a mental health crisis, it lacks holistic approaches to aid healthcare workers in immediate crisis mode. The project will provide statistics highlighting the increased mental health problems and lack of support among healthcare industry professionals, further reinforcing the necessity of the program. Additionally, participant data in the research will be measured against national values to ensure accuracy. The research project will employ various data-gathering methods involving participants from Henry Mayo Hospital and an experienced healthcare worker who also serves as an educator at a local nursing school for eight weeks. Ultimately, this action research project aims to pioneer a program for peer-to-peer crisis interventions to alleviate mental health problems stemming from work-related stressors among healthcare workers at Henry Mayo Hospital.

Contents

Illustrations

Abbreviations

BO	*Burnout*
BHU	*Behavioral Health Department*
CBT	*Cognitive Behavioral Therapy*
CDC	*Center for Disease Control*
CF	*Compassion Fatigue*
CS	*Compassion Satisfaction*
DMIN	*Doctor of Ministry*
DNR	*Do Not Resuscitate*
EAP	*Employee Assistance Program*
EMT	*Emergency Medical Technician*
EOL	*End of Life*
ER	*Emergency Room*
GAD	*Generalized Anxiety Disorder*
HCW	*Healthcare Worker*
HIPAA	*Health Insurance Portability and Accountability Act*
HMH	*Henry Mayo Hospital*
ICU	*Intensive Care Unit*
MHFA	*Mental Health First-Aid*
NICU	*Neonatal Intensive Care Unit*
PC	*Palliative Care*
PFA	*Psychological First Aid*
PICU	*Pediatric Intensive Care Unit*

PTSD	*Post Traumatic Stress Disorder*
STS	*Secondary Traumatic Stress*
LUSOD	*Liberty University School of Divinity*
VT	*Vicarious Trauma*
WHO	*World Health Organization*

CHAPTER 1: INTRODUCTION

Introduction

Healthcare professionals are not an exception to the increasing mental health crisis in America. In fact, according to the Centers for Disease Control and Prevention (CDC), 20 million U.S. health workers are at risk for mental health problems. Mental health concerns for nurses, doctors, assistants, and other support staff include stress, burnout, depression, anxiety, substance abuse, and suicidal behavior.[1] The COVID-19 pandemic exacerbated pre-existing elements in the healthcare industry, such as fear, depression, anxiety, and work-related burnout, along with compassion fatigue. In the post-COVID-19 era, the trajectory for healthcare workers facing a mental health challenge is trending upward.[2] Far too often, medical staff may not seek help when feeling depressed, anxious, stressed, or generally overwhelmed, even though acute care facilities and hospitals offer counseling in their perspective Employee Assistance Program (EAP). The arduous task of facilitating a method for counseling appears to be an uphill battle for many healthcare workers. Now, in the post-COVID-19 era, the stress placed on the HCW has created a traumatic effect in the form of PTSD. It is known from studies of past catastrophic events that

[1] CDC|NIOSH, "Newsroom Feature: Healthcare Worker Mental Health," May 2022, https://www.cdc.gov/niosh/newsroom/feature/health-worker-mental-health.

[2] Alice Fattori et al., "Long-Term Trajectory and Risk Factors of HCWs' Mental Health during COVID-19 Pandemic: A 24 Month Longitudinal Cohort Study," *International Journal of Environmental Research and Public Health* 20, no. 5 March 4, 2023: 4586, https://doi.org/10.3390/ijerph20054586.

thoughts and attempts at suicide may occur long after stressful events are over. Statistics from the last two years will provide evidence of how many suicides occurred post-COVID-19.[3]

Furthermore, the CDC has concluded that HCWs are facing a mental health crisis that requires more immediate attention at the onset of symptoms displayed. In addition to the mental health challenges facing healthcare professionals, harassment in the workforce plays on emotional despondency, as well. In the 2023 CDC publication, "HCWs Face a Mental Health Crisis," the CDC reported that healthcare workers experienced more anxiety, depression, and burnout when facing harassment in the workplace.[4] This report did not indicate where the harassment originated, whether it was the surrounding staff or the management. Harassment likely has a root cause that generates a moral affliction on a person.

Personal beliefs and values hold significant importance in the lives of people all over the globe, whether they be religious, cultural, or traditional. Betraying another coworker can conflict with these personal beliefs and likely cause moral injury. Such an act can cause substantial harm to the affected person's mental health. Whether in a hospital or military setting, the consequences of such actions can have a ripple effect that travels through the team. Indirectly, the patient receiving care from the HCW may also be affected by a HCW who is inflicted with a mental health challenge. Moreover, the hospital chaplains have been educated and trained to attend to the needs of patients through counseling, rituals, rites of passage, and support in such situations. It would be beneficial for chaplains to recognize and attend to anyone who falls victim to moral

[3] Kathryn A. Lee and Christopher R. Friese, "Deaths by Suicide Among Nurses: A Rapid Response Call," *Journal of Psychosocial Nursing and Mental Health Services* 59, no. 8 August 2021: 3–4, https://doi.org/10.3928/02793695-20210625-01. 3.

[4] Centers for Disease Control and Prevention, "HCWs Face a Mental Health Crisis," *Vital Signs*, October 24, 2023, https://www.cdc.gov/vitalsigns/health-worker-mental-health, 2018.

injury, patient or HCW, which is inherent to mental health issues in healthcare.[5] Creating an atmosphere where HCWs appear uncaring can negatively affect patients, staff, and, ultimately, every stakeholder. The lack of concern and care for the patient is only sometimes an intentional act. The uncaring and overburdened healthcare professional unintentionally may suffer from compassion fatigue, which not only debilitates their overall work performance but also makes them unable to provide patient care.

While it may not seem significant, experiencing compassion fatigue and burnout can be indicative of a more significant mental health problem. The goal of this action project is to utilize chaplains to increase awareness of mental health issues among HCWs, help them recognize signs and symptoms, provide intervention techniques to other HCWs, and prevent further problems, including those associated with moral injury. The chaplain's role will be essential for the success of this project through training the healthcare professionals in an acute care hospital as part of a peer-to-peer intervention. After all, the hospital chaplain is vital to every acute care hospital in supporting patients through difficult times and providing a range of spiritual services as part of the interdisciplinary care team.[6] Trained chaplains focus on each person with care, respect and dignity and offer comfort to patients and their families during times of crisis, illness, disease, or injury. Chaplains prioritize patients' spiritual and mental health, going beyond the physical symptoms to provide support that the healthcare team may be unable to bestow. Therefore, the chaplain's role in assisting the healthcare team at Henry Mayo Hospital will be necessary. The

[5] Lindsay B. Carey et al., "Moral Injury, Spiritual Care and the Role of Chaplains: An Exploratory Scoping Review of Literature and Resources," *Journal of Religion and Health* 55, no. 4 August 2016: 1218–45, 1220, https://doi.org/10.1007/s10943-016-0231-x.

[6] Laura E. Captari et al., "Supporting Chaplains on the Frontlines of the COVID-19 Pandemic: A Mixed-Method Practice-Based Pilot Intervention Study.," *Psychological Services* 20, no. 1 February 2023: 6–18, https://doi.org/10.1037/ser0000692.7.

ministry context section will illustrate the additional details needed regarding the chaplain's role, Henry Mayo Hospital, and the City of Santa Clarita.

Ministry Context

The previous section highlighted that, in some cases, healthcare professionals suffer from mental health problems. The ministry context for this action research project will now be presented to outline the supporting foundational setting and framework. A mental health crisis is debilitating HCWs across the nation. This ultimately affects the team, the hospital, and the care of patients. The ministry context of this action research project is the HCWs at Henry Mayo Hospital, which is located central to the City of Santa Clarita. Santa Clarita is a city in north Los Angeles County, California. One of the hospitals in the area is Henry Mayo Hospital, founded in 1975 when the town it serves had only one-third of the current 218,103 residents. The City of Santa Clarita is the third largest city in Los Angeles County, following the City of Los Angeles, with four million residents.[7] Including the surrounding rural areas, area hospitals serve a population of 279,645. Of this population, children and youth ages 0–17 comprise 25.7 percent, 18–64 comprise 63.9 percent, and seniors 65 and older represent 10.4 percent.[8] The ethnic background of Santa Clarita is rather diverse at present but has not permanently housed a multiplicity of different ethnicities. Once a town mostly Caucasian or white until the late 1980s, Santa Clarita had become home to many new businesses and corporations, bringing new families to the area. The economic turn brought people worldwide to live, work, and play in the northern Los Angeles County suburb. The current 2023 ethnic statistics are as follows: white, 66.38%; Asian, 10.79%; two or more races, 9.28%; Black or African American, 4.38%; Native American,

[7] "City of Santa Clarita," 2023, https://www.santa-clarita.com.

[8] "Henry Mayo Hospital Statistics and Demographics," 2023, www.zippia.com.

0.82%; and Native Hawaiian or Pacific Islander, 0.32%.[9] The top economic producers in the City of Santa Clarita range from manufacturing to academic institutions. Six Flags Magic Mountain is one of the largest employers, followed by College of the Canyons, California Institute for the Arts, Princess Cruises (headquarters), and Henry Mayo Hospital. Many of the employees of Henry Mayo Hospital reside locally in Santa Clarita or within a short distance in the surrounding communities. Other area hospitals include Olive View Hospital, Northridge Hospital, and Holy Cross, all county-funded acute care hospitals. Each hospital employs HCWs from the Santa Clarita region or the surrounding areas, and it is not uncommon for HCWs to take employment with more than one hospital.

Olive View Medical Center is a hospital in Los Angeles County affiliated with the University of California Los Angeles (UCLA), which was initially established as a sanatorium for tuberculosis in the 1920s. Olive View has expanded over the years to meet the needs of the community and growing populations' needs. Olive View pastoral care chaplains derive from various faiths, and staff chaplains include a Rabbi and Catholic Priest, but other faith communities are available as needed for religious preference. The hospital has 377 beds and serves the international community, providing care to immigrants settling in the Los Angeles region. Olive View's 30-bed behavioral health department caters to many of the county's psychiatric patients. The hospital also has a 51-patient emergency room, an ICU, and several outpatient facilities, including urgent care. These facilities offer employment opportunities to both experienced medical staff and new graduates.[10]

[9] "City of Santa Clarita," 2023, https://www.santa-clarita.com.

[10] Olive View Medical Center, "Who We Are," 2024, https://dhs.lacounty.gov/oliveview/about-us-3/.

Northridge Hospital, located 15 miles southwest of Santa Clarita, is a medical facility with 394 beds. Established in 1955, it offers specialized care units for cancer, cardiology, emergency room, general surgery, stroke center, and pediatric intensive care. The hospital serves the severe pediatric needs of the surrounding cities, including Santa Clarita, and the most critical patients are transported via helicopter. In addition, Northridge Hospital has chaplains who offer spiritual care to patients of different religious faiths, such as Judaism, Christianity, Catholicism, and others. The hospital comprises various specialty units, such as the Medical-Surgical Unit (MSU), Operating Rooms (OR), Pediatric Intensive Care, and Behavioral Health Unit (BHU). Each unit has nurses, doctors, patient care assistants (PCAs), and technicians from various fields of study.[11] Understanding that the staff members might need extra time to process problems is essential. One of the most challenging aspects of nursing is providing care for patients who are nearing the end of their lives, which can be emotionally taxing. These patients might have succumbed to heart disease, genetic abnormalities, cancer, or strokes. Like Northridge Hospital, Henry Mayo operates a renowned stroke center that has earned recognition. Treating stroke patients can be just as risky as treating any trauma patients. The initial treatment is provided by nurses and doctors, who then follow up with the patient throughout their entire stay at the hospital. Healthcare professionals can become emotionally attached to patients and their families, and this emotional attachment can happen in any department, depending on the compassionate nature of the individual.

Palliative Care (PC) is a specialized program offered nationwide, and Henry Mayo Hospital is no exception. The palliative care program provides specialized care to seriously ill and end-of-life patients as well as their family members. The World Health Organization (WHO)

[11] Dignity Health, "Welcome to Northridge Medical Center," 2024, https://www.dignityhealth.org.

defines *palliative care* as an approach that focuses on improving the quality of care for patients and their family members in an acute hospital setting.[12] It is important to note that PC differs from hospice care, specifically designed for terminal patients but generally consists of a team much like the palliative care faction. The team comprises doctors, nurses, social workers, and chaplains, who work together to provide the best care possible. Often, a patient may transition to hospice care at home. Other times, a PC patient may remain in the hospital until their passing. Chaplains are essential to providing spiritual care for patients, their families, and the medical staff. Henry Mayo Hospital (HMH) takes pride in having received certification from the Joint Commission for their palliative care program. HMH has a team of two full-time chaplains, one part-time chaplain, and two per-diem (on-call) chaplains who are always available to attend to the needs of patients, staff, and their families. While hospitals generally employ chaplains as part of the supportive staff to provide spiritual care to patients, HMH also extends services to include staff and their families. The HMH interfaith chaplain department welcomes people from all faiths and will provide outside clergy to meet the patient's spiritual needs.

With more than fifteen hundred employees, the chaplains also try to tend to the religious and spiritual needs of the staff members as much as possible. Given the large number of healthcare employees, it is nearly impossible to provide support to all staff members dealing with anxiety, depression, stress, and other mental health issues. The chaplains may conduct a wellness check on staff who have experienced the loss of a patient or attended to a trauma in the emergency room. Nonetheless, they are always available to provide spiritual support and guidance to those who seek it. HCWs experience tremendous stress in the workforce and in their personal lives outside the hospital's walls. Seeking spiritual guidance or turning to hospital social

[12] Birgitta Wallerstedt et al., "What Is Palliative Care? Perceptions of Healthcare Professionals," *Scandinavian Journal of Caring Sciences* 33, no. 1 March 2019: 77–84, https://doi.org/10.1111/scs.12603.

workers for help is not uncommon, but this is rarely an avenue taken by HCWs. The social workers function predominantly to provide support to patients and their families, such as guidance on available community resources after discharge.

The hospital social workers abstain from providing emotional support to medical staff as per protocol. Nevertheless, they qualify to identify mental health crises and provide appropriate care if a situation should arise. Inevitably, raising awareness about HCWs' mental health is crucial. Unfortunately, few programs train hospital workers to recognize mental health crises among staff. Mental Health First Aid was initially introduced at Henry Mayo Hospital in 2019 as part of an annual training program to meet staff needs. Staff in all departments accoutered more sensitivity training, teaching them how to identify stress, anxiety, depression, and chemical dependency in a coworker or patient. Code Lavender is a nationwide program that aims to establish a team within the hospital to recognize the same symptoms mentioned above. Code Lavender and MHFA focus on providing external resources such as a psychologist and therapist or the company's employee assistance program.

From 2019 to the present year, the need for mental health awareness among staff at Henry Mayo Hospital has increased due to two recent events that created an overwhelming need. In 2019, a high school in Santa Clarita experienced a mass shooting coined "The Saugus High School Shootings," which became national news. Three shooting victims, including the shooter himself, and two students were rushed into Henry Mayo Hospital, creating a storm of media frenzy along with community concern. The chaotic scene had a mental toll on many staff, including nurses, physicians, supporting staff, and administration. The day after the shooting, HMH provided on-site professional counselors to attend to the needs of staff who were directly affected emotionally by the shooting. Unfortunately, many staff went unscheduled to work the day of the shooting, and staff directly impacted by the events from the previous day took

vacation/personal time off after the fact and did not receive counseling. Whether counseling was offered later was not disclosed.

In March 2020, just months after the high school shootings that shocked the city of Santa Clarita, COVID-19 emerged with lockdowns and mask mandates and changed the entire world overnight. HCWs were suddenly on the frontlines of a virus outbreak the likes of which the world had not seen since the Spanish Flu. The COVID-19 pandemic had a tremendous impact on healthcare staff all over the globe. Feelings of fear, anxiety, and stress overcame healthcare workers who were in situations that had negatively impacted their psychological health.[13] Healthcare workers, especially nurses, asserted caution, often not going home to their families if they were treating or attending to the care of COVID-19 patients for fear of transmitting the disease to their loved ones. The normalcy of everyday life changed quickly. In lieu of going home, many of the nurses at HMH stayed in hotels or elsewhere to avoid contact with their families. Fear, anxiety, and the unknown caused a new psychological and emotional phenomenon. Staff, including housekeeping, janitors, administration, and the healthcare team, were impacted tremendously. As with the other departments, the HMH Chaplains had to figure out the quotidian tasks generally done throughout the day and continually adjust. Instead of visiting patients, chaplains would call the rooms directly or use iPads to communicate with those requiring spiritual services.

So much has been learned throughout the past few years as chaplains evolved from the recent pandemic culture, and questions began to surface about how chaplains treat medical staff who display fear, anxiety, depression, burnout, and compassion fatigue. Were HCWs turning to a

[13] Ayhan Tabur et al., "Anxiety, Burnout and Depression, Psychological Well-Being as Predictor of Healthcare Professionals Turnover During the Covid-19 Pandemic: Study in a Pandemic Hospital," *Healthcare MDPI* 10, no. 3 March 2022: 3.

method of self-medicating to allude to the new emotions? The topics of mental health and the ramifications of emotions not being addressed are being apprised in this action project. Being able to not only recognize the suffering of a peer but act in response to the suffering is essential to this project. Unlike Mental Health First Aid, this project will provide the necessary tools to render immediate spiritual care through the pastoral care department, render psychological assistance through avenues that will be defined, and render personal counsel through various means. The next section will emphasize the lack of immediate mental health assistance for healthcare staff and the details surrounding the problem presented.

Problem Presented

The statistics and data collected through research and an overall perspective of area hospitals, including Henry Mayo, were accessible in the ministry context. Hospitals generally utilize programs such as Code Lavender or Mental Health First Aid (MHFA) as part of staff training and sensitivity for those suffering from a mental health crisis. MHFA is a program introduced in 2019 aimed at helping medical staff recognize people who are experiencing mental health problems. Although many staff members receive training in these programs, they fail to give direction on assessing and implementing the procedures to help their peers who are experiencing a personal mental health crisis. MHFA helps with distinguishing what a mental health crisis is, but not how to activate and respond to a crisis intervention appropriately. Activating a mental health emergency among peers can be effective if the staff are adequately trained through regular educational programs offered annually or bi-annually in hospitals such as HMH. Code-Lavender and MHFA programs have been taught in many hospitals nationwide for more than a decade. Essentially, first-aid is only a Band-Aid to help peers with a personal crisis, and most healthcare staff, including nurses, require awareness of Code Lavender’s existence.

The problem lies in the diminished training that only sufficed management goals of annual employee training and education. Annually mandated courses covering topics such as sexual harassment or slips, trips, and falls, among others, are required by management for every employee, and most companies employing hundreds of employees require the same training. It is imperative that hospital staff, through the course training by hospital chaplains, engage in a comprehensive crisis intervention program.

The mental health crisis intervention cannot be a simple Band-Aid that preserves a wound that remains unhealed. Peer-to-peer counsel can provide the necessary tools for the HCW to overcome a crisis. The continued follow-up with the healthcare employee/peer is what makes a difference in the mentoring phase, which provides the exclamation for peer support. The simple stress of a HCW can be addressed and verified, and help can be provided almost immediately through techniques supplied by a trained peer. More complex issues, such as long-term chronic depression, chronic anxiety, and PTSD, require a deeper standard of care for the healthcare professional. The problem at Henry Mayo Hospital is that mental health awareness training has not addressed how staff can engage with a peer suffering from mental health complications.

Purpose Statement

The purpose of this DMIN action research project is to design and implement the "Action Crisis Intervention Response" (ACIR) as an addendum that improves mental health awareness training so staff can initiate, engage, and provide help to peers. The completed intervention design will then be introduced to the chaplains of HMH for implementation, and training will be provided on an ongoing basis with permission from management. As part of the program aimed at helping staff, the goal of this project is to train staff so they can assess the needs of a peer who may be encountering a mental health crisis as the result of the death of a patient, a trauma that

was experienced in their unit or a personal problem that resides from outside the work setting. Inherently, it is through direct action that staff members at Henry Mayo Hospital can quickly assess the situation and act accordingly to neutralize the issue with the designed action crisis intervention. Employees in the healthcare industry often suffer from acute onset mental health crises, which is a well-known fact among hospitals nationwide, according to the statistics provided in the introduction. Hospital employees usually do not seek help until their jobs are at risk or it has become too complex to endure the day's routine tasks collectively. In such cases, human resources may provide them with information or contacts for group counseling or therapy through the employee assistance program (EAP). Unfortunately, this approach is not practical in addressing the immediate unresolved personal mental health needs that some healthcare professionals may have clutched for weeks, months, or years.

It is imperative to construct an environment where healthcare professionals can seek help for mental health issues without fear of stigmatization, discrimination, or retribution. This ACIR approach benefits employees, patients, and the hospital in general by improving the quality of care. The best course of action is promptly addressing any emotional changes in coworkers, as peers are often the first to notice. Creating a safe and neutral environment of trust is especially important for those who work long hours together and build strong friendships over time. Leaders and team supervisors should be aware of any decrease in productivity among their team members. Ignoring personal problems can have a negative impact on patient care, which is why prioritizing mental well-being is essential. This research project aims to support workers who may be experiencing a mental health crisis, focusing on the people who work alongside healthcare professionals, such as other nurses and healthcare staff, who are the first line of defense. Furthermore, some staff must be more transparent and open about a crisis that they may be going through. These and other assumptions will be addressed next.

Basic Assumptions

The purpose of this project was established in the previous section. This subsequent portion will address specific basic assumptions regarding this research development. This project assumes that healthcare professionals participating will not openly admit to having mental health issues, such as depression, anxiety, fear, burnout, or compassion fatigue, due to the emotional impact that such admission may have on them. Secondly, it is expected that some medical staff may choose not to participate in the project due to past experiences with similar programs that failed to provide immediate care to the staff during a crisis. For example, while Mental Health First Aid was presented as a program to help, it did little to address the needs of the staff in times of crisis. As a result, some staff members may perceive this project as a failure before it is even presented. It is worth noting that although medical professionals are often perceived as "thick-skinned," they may not always be in touch with their personal feelings. Therefore, the project assumes that the reality of their emotions may not be accurately presented. To facilitate comprehension of this project's medical and theological aspects, the definitions section will guide the action research project.

Definitions

This action research project is unique to Henry Mayo Hospital and its staff. To avoid ambivalence, this section will specifically define unique terms found in this project. Terms utilized in this project are ministry-related and intertwine throughout, and include pastoral care, chaplain, and interfaith, which are all common to the chaplains. It is essential to ensure that the terms used and their presentation are appropriate and relevant to the context for the reader to grasp the purpose of this action project copiously. Hospital chaplains have the necessary training to use these terms effectively for communication and documentation purposes.

Chaplain. Several ministries employ or volunteer chaplains. A few well-known types of chaplains are military chaplains, hospice chaplains, and hospital chaplains. Hospital chaplaincy plays a big part in this project. Hospital chaplains are sometimes volunteers or, more often, are paid hospital employees. Chaplains serve the patients and staff in the acute hospital setting. The chaplain's role at HMH is to visit patients and their families to provide spiritual support during their stay. Hospital chaplains are licensed or ordained ministers with special training and a theological degree. Chaplains meet with patients at their level of immediate distress, seeking comfort.[14]

Code blue. Hospitals announce different codes through the main intercom or page staff. Code blue is one code the medical staff pays attention to and prompts immediate care to a distressed patient. Mike Magee provides an accurate definition: A code blue, announced over the hospital public address system, alerts staff to the urgent medical needs of a patient. The primary focus is to stabilize the victim or patient with life-saving measures.[15] At HMH, a code blue is a call to action. Medical staff, social workers, and chaplains rush to a patient's bedside, usually in cardiac arrest.

Compassionate care. Regarding interfaith, compassionate care can be considered different in other religions and faiths. Compassion is derived from the Latin word *compati*, meaning to suffer with someone. Compassion is defined differently in other cultural contexts. Compassion arises when others suffer. Compassion is an emotion, motivation, and

[14] Lawrence E. Holst, *Hospital Ministry: The Role of the Chaplain Today* (Eugene, Or.: Wipf & Stock, 2006), 8.

[15] Mike Magee, *Code Blue: Inside America's Medical Industrial Complex*, First edition (New York: Atlantic Monthly Press, 2019), 1.

multidimensional construct.[16] The chaplains at HMH provide compassionate care to families who have lost a loved one and patients who need an empathetic listener.

Compassion fatigue (CF). Compassion fatigue is defined relatively quickly, and Wendell Waters provides a definitive, descriptive definition of CF as stress resulting from helping others (patients), which causes trauma in the healthcare provider.[17] Often related to burnout, the healthcare provider with CF becomes withdrawn and displays feelings of powerlessness. Through the COVID-19 pandemic, many nurses were victims of compassion fatigue, and they were less attentive to patients and lacked empathy. Trauma nurses and doctors are likely to exhibit compassion fatigue before a nurse who tends to the lower level of patients' needs.

Compassion satisfaction (CS). Unlike compassion fatigue, compassion satisfaction is the polar opposite. CS refers to the amount of pleasure someone finds in their work by helping others. Defined in the Pro-QOL assessment, CS is the positive consequence of helping behavior. CS is the pleasure one derives from helping, positive feelings for colleagues, and good feelings resulting from the ability to assist others and contribute.[18] Depending on the amount of time a HCW has on the job or the departments they have worked in, CS is plausible.

Empathy. Not to be confused with sympathy, empathy is understanding what someone is saying or going through. According to Kirsten A. Smith et al., *empathy* is defined in healthcare as a medical professional, such as a nurse, doctor, or surgeon, putting themselves in the patient's

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[16] Agnes M. F. Wong, *The Art and Science of Compassion, a Primer: Reflections of a Physician-Chaplain* (New York, NY: Oxford University Press, 2021), 5.

[17] Wendell Waters, "A Qualitative Study of Relationships Between Compassion Fatigue and Burnout to Turnover Intention in Alabama Trauma Center Nurses" Liberty University, 2021, 15.

[18] B. H. Stamm, "ProQOL: Professional Quality of Life" *The Center for Victims of Torture*, 2016.

position to acknowledge their feelings, concerns, and expectations.[19] The skill of empathy for the healthcare professional can carry over to the doctors' and nurses' peers.

Emotional intelligence quotient. Healthcare professionals require a higher level of emotional intelligence than most professions. EI was introduced by Peter Salovey and John D. Meyer in 1990. They define EI as the ability to accurately perceive, evaluate, and express emotions and the ability to manage emotions to promote emotional and intellectual growth.[20] All of these interpersonal qualities are vital for HCWs to not only regulate their own emotions but also be sensitive to others.

Employee assistance program. EAPs, originally developed in the 1940s in response to the misuse of alcohol that created a work productivity problem, are programs used by companies and corporations to refer employees for mental health care.[21] Licensed therapists, counselors, and psychologists are the primary resources for the EAP. The EAP offers various services to the workforce, including counseling assessments, short-term consultation, and referrals for stress, emotional health, family and relationships, substance use and misuse, and workplace concerns.[22]

Fetal demise. This term refers to a complicated medical condition commonly known as a stillborn fetus. There are medical conditions as well as hereditary conditions that can lead to a fetal demise. The United States Center for Health Statistics defines *fetal demise* as a fetal death

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[19] K. A. Smith et al., "Improving Empathy in Healthcare Consultations-a Secondary Analysis of Interventions," *J Gen Intern Med* 35, no. 10 July 14, 2020, https://doi.org/10.1007/s11606-020-05994-w.

[20] Rosaria Di Lorenzo et al., "Emotional Intelligence, Empathy and Alexithymia: A Cross-Sectional Survey on Emotional Competence in a Group of Nursing Students," *Acta Bio Medica Atenei Parmensis* 90, no. 4-S March 28, 2019: 32–43, https://doi.org/10.23750/abm.v90i4-S.8273.

[21] James Kinney, "Why Most Employee Assistance Programs Don't Work," *Forbes Magazine*, July 26, 2022.

[22] "Employee Assistance Program (EAP)" U.S. Department of Health and Human Safety, 2022, https://www.hhs.gov/sites/default/files/psc-foh-eap-factsheet_508.pdf.

as the delivery showing no signs of life in the infant.[23] Labor and Delivery nurses may experience a fetal demise more often than in the emergency room or other urgent treatment departments. A fetal demise can be emotionally taxing on the patient as well as the medical staff.

HIPAA. The Health Insurance Portability and Accountability Act of 1996 protects patients' identity and health information in healthcare facilities and their entities. Every year, medical staff must participate in a HIPAA refresher course for updated information and laws or comply with local and federal mandates. Congress incorporated into HIPAA provisions that mandated the adoption of Federal privacy protections for individually identifiable health information.[24] The release of a patient's medical records or identifiers by medical staff without the patient's permission is against the law.

Intensive care unit. The intensive care unit, or ICU, is a specialty department for severe and critically ill patients. HMH has an ICU that comprises seventeen individual patient rooms. Some patients may have a 1:1 nurse ratio, and some may have a 2:1 nurse ratio, but not likely a 3:1 ratio. During COVID-19, many critical patients were admitted to the ICU because they were on ventilators. Tim Wenham and Alison Pittard define the ICU as a unit that cares for those who have critical illnesses and or injuries. Patients are either on ventilation, have severe pain from trauma, or are sedated.[25]

Interfaith chaplaincy. Every hospital admits patients of all faiths and backgrounds, and, depending on the geographic location, one faith may dominate above other faiths. *Interfaith*

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[23] Mark M. Maslovich and Lori M. Burke, "Intrauterine Fetal Demise," *Stat Pearls Publishing*, January 2023, https://www.ncbi.nlm.nih.gov/books/NBK557533/.

[24] "HIPPA for Professionals" U.S. Department of Health and Human Services, 2022, https://www.hhs.gov/hipaa/for-professionals/index.html.

[25] Tim Wenham and Alison Pittard, "Intensive Care Unit Environment," *Continuing Education in Anesthesia Critical Care & Pain* 9, no. 6 December 1, 2009: 178–83, https://doi.org/10.1093/bjaceaccp/mkp036.180.

chaplaincy is defined as a spiritual caregiver who provides emotional and spiritual support to all persons of any religion.[26] HMH provides support to Muslims, Catholics, Protestants, and many other faiths. It is vital to demonstrate what Jesus did with the Samaritan woman (John 4:5–30), and it was the love for the person, not their beliefs.

Level–2 trauma center. To understand what a level two trauma center is, it is necessary to define a level one trauma center. The focus for both level one and level two is a geographic area. There are some minor differences between the two. According to the National Inventory of Hospital Trauma Centers, a level-one trauma provides comprehensive trauma care and serves as a regional resource that can provide education and research. A level-two trauma center also provides comprehensive trauma care but serves a large urban area with a less dense population.[27] Both are equal to a degree, and a level-two trauma center is not required to provide education or research. HMH is a level-two trauma center; therefore, this hospital's information is accurate.

Mental health. Mental health can be described in many ways. This term sends a sensitive message to people, often relaying negativity, or emotions. As described and defined by Jodi McCaffrey, mental health is emotional, psychological, and social well-being. Mental health influences how one acts, thinks, feel, gets along with others, handles stress, and makes healthy choices.[28] This action project is highly influenced by the mental health of the medical staff at Henry Mayo Hospital (HMH). Mental health can lead to stress, anxiety, fear, and depression. During the COVID-19 pandemic, many signs of mental health crises, such as fear, anxiety, and high-stress levels, become pronounced.

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[26] Peter Ward Youngblood, "Interfaith Chaplaincy as Interpretive Hospitality," *Religions* 10, no. 3 2019, 3, https://doi.org/10.3390/rel10030226.

[27] Ellen J. MacKenzie et al., "National Inventory of Hospital Trauma Centers," *JAMA* 289, no. 12 March 26, 2003: 1516, https://doi.org/10.1001/jama.289.12.1515.

[28] Jodi McCaffrey, *Mental Health-Signs & Support: A Quick Study Digital Reference Guide*, 1st ed. (Newburyport: Barcharts, Inc., 2020), 1.

Moral injury. Moral values are important to most people, and when violated, there can be lasting emotional and psychological scars. The term was used widely to describe situations by people in the military and has been a term used in healthcare literature since 2018.[29] The emergency room, ICU, labor and delivery are units where healthcare staff may encounter events that cause moral injury. The feelings of guilt, shame, and anger can link a healthcare worker to thoughts of suicide and depression, among other mental health problems. HCWs encounter death and trauma, which have a lasting effect that can be tied to PTSD. Moral injury can affect the values one possesses in terms of ethically correct behavior. If violated, the person can feel the symptoms described above, translating to a mental health issue. Examples are taking part in abortion, taking part in end-of-life measures that do not reflect one's moral compass, or a coworker creating an atmosphere that violates the values of moral standards one possesses.

Palliative care. HMH prides itself on the Palliative Care Department, which comprises doctors, nurses, social workers, and chaplains. This team provides care to families and patients. Palliative care takes place in an acute hospital setting. Palliative care is the total care of patients with life-limiting diseases, who are no longer curable through life-prolonging treatments. Palliative care is derived from the Latin word pallium, a cloak.[30] Palliative care at HMH helps patients with treatments that help subside their pain. In addition, the team helps and supports both the patient and family through the emotional challenges that come with the reality of a terminal illness.

Pastoral care. Each time a chaplain interacts with a patient or their family members, there may be a ministry need. Pastoral care can be added to the spiritual needs of medical staff

[29] Martha Hostetter and Sarah Klein, "Responding to Burnout and Moral Injury Among Clinicians," *The Commonwealth Fund*, August 17, 2023, https://doi.org/10.26099/k72x-t469.

[30] Robert Twycross, *Introducing Palliative Care*, 4th ed. (Radcliffe Medical Press, 2003), 2.

and patients. Pastoral care encompasses more active listening than counsel. Dr. John Patton provides an in-depth understanding of pastoral care. Pastoral care is the action of a community of faith that celebrates God's care by also hearing and remembering those who are, in some way, cut off from the faith community.[31] Patients hospitalized for long periods do not have the opportunity to attend mass or church. Chaplains might read scripture and pray for the patients, but listening comprises most of the visit.

Resilience room. If a healthcare worker feels overwhelmed or stressed, there are designated spaces in the hospital that help with regaining mindful peace. Nurses and doctors are hands-on with trauma and death, which can create anxiety and stress. There are other factors where stress can also be attributed such as outside factors. Woehrle et al. describe the importance of having a resilience space or room for medical staff. Interventions to improve the overall hospital environment through positive resilience can have a lasting impact on personal care. Resilience rooms create a positive space for individuals or groups to find peace and cope with work-related and personal stress. Therapeutic areas for HCWs and staff symbolize an organizational commitment to well-being.[32] Resilience rooms can be unique, quiet spaces with low, dim lights and comfortable seating, a chapel, or an atrium that provides a quiet, peaceful setting.

Vicarious trauma. VT is a psychological phenomenon that causes a permanent cognitive shift in the inner experience and worldview of nurses after prolonged empathetic engagement

[31] John Patton, *Pastoral Care: An Essential Guide*, Abingdon Essential Guides (Nashville: Abingdon Press, 2005), 4.

[32] T. Woehrle, E Marleau, and L. Kitch, "Implementation of a 'Serenity Room,'" *Nursing* 50, no. 10 2020: 59, https://doi.org/10.1097/01.NURSE.0000697160.77297.06.

with a patient's trauma.[33] Although VT can be experienced in other acute hospital departments, the emergency and intensive care departments are more susceptible to VT.

Limitations

The previous section provided accessible definitions for terms used in this project, which will help readers move forward. The following section will evaluate any anticipated limitation that can impact the research. This action research project aims to gather essential data by considering various factors. Participants will be required to attend a sixty-minute class once a week, located at a central location in Henry Mayo Hospital. Hospital personnel, such as nurses and technicians, work different shifts, including overnight shifts, unpredictable days off, and vacation days that may vary. Although gathering data from day and night shifts would be ideal, the study's limitation is getting those who work overnight shifts to participate fully. Due to multiple shifts, gathering healthcare professionals representing various departments on every shift will also be a challenge.

Since the inception of HIPAA, medical staff have trained to be hesitant about giving information about patients, themselves, or coworkers. Therefore, the abstinence of truthful answers from the medical staff or the lack of forthright responses could be problematic, even with the clarity that the information they provide will be protected and not disseminated, and the expectancy of ambiguous responses is foreseeable. Another limitation of this action research project is that it may require more work to obtain honest answers from staff who initially agreed to participate in the study. Many medical staff do not reveal if they have had a mental health crisis or are not fully engaged with trauma patients or death due to their department's nature.

[33] Stephanie Kennedy and Richard Booth, "Vicarious Trauma in Nursing Professionals: A Concept Analysis," *Nursing Forum* 57, no. 5 September 2022: 893, https://doi.org/10.1111/nuf.12734.

Some nurses and HCWs have worked only in units where they provide care to patients transitioning through physical therapy, hence the limited exposure to trauma, grief, or situations that can cause mental health issues. A limitation to conducting personal interviews can be challenging, even though the researcher will reassure the interviewee that all questions will be confidential and will not be released without permission. In healthcare, there tends to be a lack of trust towards those inquiring about personal information.

The researcher's obligation is to build trust and ask questions about the action research project. Although the questions will be personal, the participants might be hesitant to answer all questions thoroughly and honestly. The last limitation involves younger or less experienced staff in their respective field. They, too, may not have seen traumas or a patient's death but have worked with others who have. Coming straight out of school and transitioning to departments such as the ICU or the emergency room, the younger staff members may not want to participate because they are not emotionally equipped to do the job, and participating would make them feel weak.[34] Even though there are some possible limitations, the framework for this action research project will be outlined next in the delimitation section.

Delimitations

There are distinctive limitations that can have a vital impact on this research project, as presented in the prior portion. The objective delimitations surrounding this study will be conferred in this next section. The chaplains at HMH are well-received by management and provide pastoral care to the patients and other spiritual services needed. Moreover, Henry Mayo Hospital has authorized the use of their classrooms, and hospital staff will be recruited to

[34] Barbara A. Heise, Debra K. Wing, and Amy H. R. Hullinger, "My Patient Died: A National Study of Nursing Students' Perception After Experiencing a Patient Death," *National League of Nursing*, Nursing Education Perspectives, 39, no. 6 2018: 355.

participate. The study participants reside within the Santa Clarita City limits. Therefore, they will not have to travel far for in-class education and interviews. Utilizing various sectors of the hospital's facilities will create a welcoming and unbiased environment for the participants. The study aims to improve the quality of care in select health departments by conducting surveys and questionnaires for staff members. As these departments have reduced staff sizes compared to other hospitals, greater participation is hoped and encouraged. This study will include nurses, medical technicians, and supportive staff with more than five years of experience in either the emergency room, intensive care unit, or labor and delivery. In addition, HCWs who have been working in the emergency room for less than two years will also be involved in addressing potential issues encountered in a fast-paced unit. The goal is to contrast the differences between nursing school training preparation and on-the-job experienced staff when dealing with trauma and death.

This action project research will culminate after eight weeks, with participants meeting for a sixty-minute in-class lesson on a specific topic each week as part of the study. The researcher will send surveys to HCWs' personal email addresses. All surveys will be anonymous to protect participant privacy, providing HCWs with a sense of security. The intent is to engage in questions about the overall mental health of the participants, including but not limited to depression, anxiety, fear, substance abuse, burnout, compassion fatigue, and thoughts of suicide. Consequently, the anonymity of each participant is crucial with the emergence of such personal information. For this action research project, the participants are required to keep a journal of their thoughts and observations related to the weekly discussions. Additionally, HCWs will be asked to maintain a journal after each shift they complete. The journal's primary focus is to record important events, emotions, or anything that impacted them during the project. In-class sessions aim to establish a community of HCWs who can exchange their observations and offer

feedback to the researcher and other HCWs involved in the study. Additionally, these sessions will enable the participants to interact with each other regarding the study and share their individual experiences. Peer-to-peer engagement will not only begin to foster trust among the group of participants but is essential for this study. The researcher conducting this action research project has worked in the same hospital as the participants, which ensures a likely trusted gateway for each participant to be asked for permission to conduct in-depth interviews and surveys. The relationships with healthcare professionals in Santa Clarita can facilitate the development of mental health programs to support HCWs.

Thesis Statement

A hypothesis for how this research will be conducted has been presented. This next component will illustrate the fundamental thesis for this action research intervention project. It is crucial for any organization, especially in the healthcare industry, to provide mental health training to its staff and management. Medical professionals are often the first to notice when a colleague is going through a crisis due to a patient's death, trauma, or a stressful situation. Although hospital chaplains support patients, offering integrated pastoral care to the medical staff is equally important. This initiative aims to train staff under the guidance of hospital chaplains to identify the signs and symptoms of a peer in crisis and provide a swift and appropriate evaluation and support to the HCW.

Subsequently, this action research project also aspires to educate hospital medical professionals on the importance of distinguishing mental health crises and signs of alcohol or drug dependency in their peers. While some symptoms may be laborious to detect, others may become increasingly probable to discriminate after experiencing the loss of a patient or a perturbing situation. This project is focused on supporting medical staff by aligning them with a

peer support program that can help them manage depression, anxiety, fear, and compassion fatigue–issues that chaplains commonly address. Since most hospitals employ several hundred medical professionals, this initiative can significantly benefit the medical staff and ultimately lead to a collaborative team environment and better patient care. The effects of depression, anxiety, fear, and compassion fatigue can linger in the character of a HCW for an extended period. With patient care being increasingly and negatively affected by medical staff suffering from compassion fatigue, a predominant focal point will be necessary. In the grand scheme, a staff that holds itself accountable through peer support will benefit the hospital and its stakeholders. Evidential research has shown a viable link between chaplaincy interventions and mental health to be immediately promising. Therefore, chaplains have a diverse role of both spiritual advisor and advocate for those suffering a mental health crisis.[35] It is imperative to address the mental health crisis quite probably affecting healthcare professionals at Henry Mayo Hospital.

Further, this action research project will create an awareness of this critical problem, as well as the personal trauma that is a contributing factor in creating a toxic environment. Hospital chaplains can play a significant role in intervening and being able to address issues related to mental health crises that affect the HCWs. Pastoral care is an essential part of the training that will teach the HCWs how to minister and attend to coworkers' needs. By including this, the necessary tools can be established to help deter depression, anxiety, fear, burnout, and compassion fatigue. If Henry Mayo acquires such an intervention program, it would greatly benefit the hospital, the staff, and the overall organization.

[35] Austyn Snowden et al., "Chaplains Work in Primary Care," *Journal of Health Care Chaplaincy* 29, no. 2 April 3, 2023: 212, https://doi.org/10.1080/08854726.2022.2077555.

CHAPTER 2: CONCEPTUAL FRAMEWORK

The thesis statement for this action research project offered guidance on educating healthcare professionals to identify mental health crises and offer peer-to-peer support. The next chapter will examine the conceptual framework that embodies ACIR. The literature primarily focuses on the mental health of hospital medical staff, leaving nurses, doctors, and other healthcare professionals unsupported during personal crises. While resilience to constant trauma can be beneficial, it can also have adverse effects depending on factors such as the level of resilience and the surrounding circumstances impacting the healthcare workers. In this context, resilience refers to the ability to adapt to overwhelming stress and adversity while maintaining normal psychological and physical functioning.[1] From the perspective of a hospital chaplain, medical staff members often lack the necessary support to address their mental health needs, even those who appear resilient to the trauma and chaos they encounter daily. Situations that can lead to HCWs experiencing a mental health crisis range from patient deaths to traumatic events that affect their emotional well-being, and can disturb even the most experienced healthcare professionals. Compassion fatigue, burnout, depression, and anxiety are all threats to acute care hospital professionals, and scholarly literature has addressed these issues. The following literature supports the thesis that mental health interventions are critical for medical professionals experiencing personal crises.

[1] Gang Wu et al., "Understanding Resilience," *Frontiers in Behavioral Neuroscience* 7 2013, 2, https://doi.org/10.3389/fnbeh.2013.00010.

Literature Review

Stress Management Education for HCWs

Healthcare professionals often experience high-stress levels while on the job, which can undulate the entire team. While nurses may receive some training in psychosocial methods, their nursing school training will typically provide only a brief course in stress management. The death of a patient can be particularly difficult for nurses, both experienced and those still in training, especially if they have developed a bond with the patient. Unfortunately, nursing students are often not adequately prepared to handle end-of-life situations. According to a study by Barbara Heise et al. titled "*My Patient Died: A National Study of Nursing Students' Perception After Experiencing a Patient Death,"* nurses were asked who supported them through their first traumatic death; the consensus was, "no one."[2] Nursing institutions offer the foundational knowledge required to comprehend the scientific principles and practical applications of patient care. Nursing institutions of learning may not provide the necessary psychological support for students to process the reality of a patient's passing and cope with the associated emotional strain. Thankfully, students can rely on the expertise of experienced nursing instructors, who have likely encountered such situations in their professional careers.

Rachel Jones' book, "Grief on the Front Lines," emphasizes that students in clinical settings often experience performance anxiety, feelings of inadequacy, and a lack of confidence when making critical decisions.[3] When confronted with end-of-life (EOL) scenarios, it is crucial for students to seek guidance from their faculty and/or nurse supervisor for support. If a student lacks the necessary emotional intelligence, it may lead to burnout, significantly impacting a

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[2] Heise, Wing, and Hullinger, "My Patient Died: A National Study of Nursing Students' Perception after Experiencing a Patient Death," 356.

[3] Rachel Jones, *Grief on the Front Lines: Reckoning with Trauma, Grief, and Humanity in Modern Medicine* (Berkeley, California: North Atlantic Books, 2022), 86.

nurse's career longevity. In such situations, seeking intervention or assistance from professional counselors may be necessary to address the emotional well-being of the nurse and other medical personnel. Likewise, trauma and death can have significant afflictions on the HCWs. The following section will provide more detail.

Trauma and Death

Stress management is one component necessary for medical staff to remain focused and diligent when on duty in their respective departments. Trauma and death seemingly transverse an array of emotions in the staff, especially in the ER, labor and delivery, and ICU. Emergency room nurses must be unfazed and hide any signs of fear or being afraid to 'earn their stripes.' Nurses must also ensure they stay disconnected from their patients and be functional to maintain the patient flow.[4] With this in mind, a vast number of people venture into a hospital emergency room at one time or another for an illness or injury or to visit someone. They are likely to experience a chaotic system based on an overload of hidden emotions. In a state of pain or illness, all anyone requires is the attention of medical staff. Unfortunately, many people expect immediate care.

If observed closely, the nursing staff can appear stressed and stretched thin as they go from one patient to another, attempting to aid the sick and injured. Sherry Lynn Jones expresses that nurses repeatedly exposed to emergency room violence, stress, and death are susceptible to secondary traumatic stress (STS). Comparable to that of post-traumatic stress disorder (PTSD).[5] The care for the patients could dramatically strain nurses and physicians suffering from either

[4] Kate Kirk et al., "'I Don't Have Any Emotions': An Ethnography of Emotional Labor and Feeling Rules in the Emergency Department," *Journal of Advanced Nursing* 77, no. 4 April 2021: 1965, https://doi.org/10.1111/jan.14765.

[5] Sherry Lynn Jones, "Nurses' Occupational Trauma Exposure, Resilience, and Coping Education," Walden University, 2016, 13.

STS or PTSD. If not addressed and or treated, the nurse could enter a state of crisis. Stress and anxiety are not an immune issue in acute care hospitals, and this can lead to mental health crises. The neonatal intensive care unit nurses face a particular set of stressors, as highlighted by Lary Atefeh et al. in their study, "*The Impact of a Stress Management Program on Stress Response of Nurses in Neonatal Intensive Care Units*."[6] The study sheds light on the nature and level of stress experienced by nurses in this specialty department. Although high demands are placed on nurses in every profession, Lary Atefeh et al. found that nurses working in neonatal intensive care units experience a higher level of work stress, which, unfortunately, has led to increased turnover.

A firm conviction for compassion, caring, and strong resilience sends the message, "I see and feel your pain," which can be characterized as the desire to relieve the patient's suffering.[7] Empathy and sympathy dominate the healthcare professionals' day-to-day workload. Carmela Mento et al. describes the strenuous and often dangerous vicarious trauma as the transfer process that occurs when HCWs build on a relationship with a patient's traumatic experiences, another form of ST.[8] Along with vicarious trauma, CF and ST can lead to burnout along with a multitude of subfactors that affect the psychological well-being of an HCW experiencing trauma. High-stress levels are a significant concern for nurses due to heavy workloads, nursing shortages, and increased turnover rates. The stress in intensive care units (ICUs) is exceptionally high compared to most other departments. Nurses working in the neonatal intensive care unit (NICU) experience

[6] Lary A. Borimnejad and M. Mardani-Hamooleh, "The Impact of a Stress Management Program on the Stress Response of Nurses in Neonatal Intensive Care Units," *The Journal of Perinatal & Neonatal Nursing* 33, no. 2 2019: 192, https://doi.org/10.1097/JPN.0000000000000396.

[7] Carmela Mento et al., "Secondary Traumatization in Healthcare Professions: A Continuum on Compassion Fatigue, Vicarious Trauma and Burnout," *Psychologia* 62, no. 2 2020: 182, https://doi.org/10.2117/psysoc.2020-B013.

[8] Ibid., 193.

the highest levels of stress. Stressors, such as witnessing infants suffer, caring for ill infants, and unpredictable and disorganized work shifts, take a significant mental toll on NICU nurses.

Veteran Medical Staff and Coping

Healthcare chaplains undergo training to minister to individuals who are going through a crisis or a traumatic personal problem. Through their experience and training, chaplains are considered essential mentors and spiritual guides during crises. It is critical to prioritize mental health support for HCWs, regardless of their years of experience. When a HCW experiences grief, their colleagues, superiors, staff chaplains, and HCW staff can be crucial in providing emotional and spiritual support. It is up to the nurse, doctor, or medical staff member who recognizes the need to initiate emotional support and care. A study by Kaur Jit Singh et al. found that grieving nurses often turn to their colleagues for comfort after a patient's death. Not all staff members are adequately trained to provide the necessary support to console a coworker. Only a few healthcare professionals are equipped to cater to the needs of grieving nurses and physicians.[9]

Compassion Fatigue

Caregivers, nurses, and doctors can experience compassion fatigue, which has become more severe over the past few years. Regardless of emotional I.Q., there comes a time when caring for a patient becomes more like a routine, and compassion diminishes. Heise et al. describe compassion fatigue as synonymous with burnout, and the lack of discussion and proper

[9] Gurbindar Kaur Jit Singh, Wah Yun Low, and Khatijah Lim Adbullah, "Validation of the Measurement Model of the Grief Support Healthcare Scale Among the Intensive Care Unit in Malaysia," *Florence Nightingale Journal of Nursing* 30, no. 3 2022: 234.

counsel can lead to not caring about the patients.[10] More attention has been paid to healthcare burnout and compassion fatigue in recent years. Defined as a stress response in healthcare providers that has given them the inability to care, they experience a loss of compassion for the patients.[11] In addition, healthcare professionals witness the agony and death of their patients, which predisposes them to mental and psychological problems, including compassion fatigue.[12]

Compassion fatigue is thought to be a combination of secondary trauma and burnout precipitated by contact with the suffering patient by healthcare professionals.[13] Yue Zhao et al. describe this relationship between compassion fatigue and burnout from a psychological and biological perspective. Burnout and compassion fatigue are believed to be extreme reactions when nurses cannot smoothly cope with work-related stress and are in a state of exhausted emotions, attitudes, and behaviors from long-term work pressure.[14] Notably, compassion fatigue is distinct from burnout. Reliable measurements, such as the Professional Quality of Life scale (see Appendix E), can assess the risk of compassion fatigue.[15] Stress and compassion fatigue take a toll on the healthcare professional over short and long periods. One possible source could be the long twelve to fifteen-hour shifts nurses endure three to four times a week. It is commonplace

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[10] Barbara A. Heise, Debra K. Wing, and Amy H. R. Hullinger, "My Patient Died: A National Study of Nursing Students' Perception After Experiencing a Patient Death," *National League of Nursing*, Nursing Education Perspectives, 39, no. 6 2018: 355–59.

[11] Wendell Waters, "A Qualitative Study of Relationships Between Compassion Fatigue and Burnout to Turnover Intention in Alabama Trauma Center Nurses," Liberty University, 2021, 18.

[12] Kabunga Amir and Ponsiano Okalo, "Frontline Nurses' Compassion Fatigue and Associated Predictive Factors during the Second Wave of COVID -19 in Kampala, Uganda," *Nursing Open* 9, no. 5 September 2022: 2390–96, https://doi.org/10.1002/nop2.1253.

[13] Brenda Sabo RN, BA, MA, PhD. Student, "Compassion Fatigue and Nursing Work: Can We Accurately Capture the Consequences of Caring Work?," *International Journal of Nursing Practice* 12 n.d.: 136–42, 138.

[14] Yue Zhao et al., "Burnout among Junior Nurses: The Roles of Demographic and Workplace Relationship Factors, Psychological Flexibility, and Perceived Stress," *Journal for Nurse Management* 2023, 2, https://doi.org/10.1155/2023/9475220.

[15] Nicola Cavanagh et al., "Compassion Fatigue in Healthcare Providers: A Systematic Review and Meta-Analysis," *Nursing Ethics* 27, no. 3 May 2020: 640, https://doi.org/10.1177/0969733019889400.

for HCWs to work three twelve-hour shifts per week with the option to take on additional overtime, leading to long hours and disrupted sleep patterns. Short intervals between shifts have been linked to health problems such as diabetes and coronary heart disease. Nurses are at risk of physical and mental fatigue, which can negatively impact their job performance, quality of care, and safety. Sleep deprivation and disorders can also lead to mental health issues such as depression, anxiety, and anger, which are often caused by long hours and lack of self-care. Generalized fatigue can result in decreased job satisfaction and compassion fatigue.

Compassion is generally considered to be a human response to someone's suffering. Suffering can refer to a painful social or emotional experience of another person. Compassion can be provided in different ways to those feeling highlighted multidimensional and emerging emotions.[16] Compassion fatigue can be measured and assessed to determine whether a healthcare worker is experiencing symptoms. A measurement called the Professional Quality of Life (Pro-QOL) can deliver results that will enable professionals to act and help those suffering from compassion fatigue.[17] Additionally, Lisa Lockhart provides these vital statistics:

> According to the Substance and Mental Health Services Administration, you may notice the following signs and symptoms of compassion fatigue in yourself or your coworkers: 1. Increased startle response to activity around you. 2. You feel irritable or "on edge;" 3. Difficulty making decisions or second-guessing your decisions.[18]

J. P. Cruz et al. agree that compassion fatigue can lead to burnout and other adverse effects, such as the quality of work and clinical competence.[19] If this is the case for many HCWs, some

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[16] Stanley Steindl, James Kirby, and Cassandra Tellegan, "Motivational Interviewing in Compassion-Based Interventions: Theory and Practice Applications," *Clinical Psychologist* 22 n.d.: 266.

[17] L. Lockhart, "How to Recognize Compassion Fatigue," *Nursing Made Incredibly Easy* 20, no. 3 2022: 32.

[18] Ibid.

[19] J. P.Cruz et al., "Spiritual Climate in Hospitals Influences Nurses' Professional Quality of Life," *Journal for Nurse Management* 28, no. 7 2020: 1590.

intervention is needed to support the affected staff. An intervention that identifies the struggling nurse or doctor and provides the help they require. Fellow peers are the front-line defense for such an intervention, and their support will be reciprocated through their respective departments.

Anxiety and Depression

The mental health crisis affecting healthcare workers has the potential to become increasingly harmful to the industry. The COVID-19 pandemic, which has been addressed in this action research project, has made a significant impact on healthcare worldwide. Emerging from the pandemic, it is crucial to focus on providing help and support to those who have been affected by anxiety or depression. In their study, Guillaume Fond et al. convey that preventing and actively managing depression in healthcare settings is a priority.[20] Preventative measures, increased awareness, and facilitating an intervention plan in hospital departments will enable peers to be advocates and supporters for fellow healthcare workers. Depression alone in a HCW may be enough to cause emotional damage and career-ending behaviors.

Factors for depression in healthcare workers are not absolute of on-the-job stressors. Depression can stem from personal problems in and outside the home as well. Not every HCW suffering from depression is going to have the same indicator as a source for their symptoms. Some HCWs may be subject to abuse or neglect. Some may suffer from chemical imbalances or an ongoing mental health problem that has been ignored for too long. Studies have shown that women are more likely to suffer from depression than men. Having children has been associated

[20] Guillaume Fond et al., "Depression in Healthcare Workers: Results from the Nationwide AMADEUS Survey," *International Journal of Nursing Studies* 135 November 2022: 104328, 2, https://doi.org/10.1016/j.ijnurstu.2022.104328.

with increased turnover in HCWs, but its potential for depression is probable.[21] In a different study by Robert P. Lennon et al., in the early stages of the COVID-19 pandemic, alarming statistics revealed a grim picture of the HCW's mental state. Not to neglect other mental health concerns but rather to highlight depression among nurses in their study. About 25 percent of HCW experience depression along with burnout that impaired judgment and clear thinking, with a probability of making vital mistakes. Of those, some respondents reported regularly having thoughts that they would be better off dead or about hurting themselves, indicating the immense need for changes in systems and reassessing the way HCWs are supported.[22]

The definition of anxiety, according to the National Library of Medicine, is a "feeling of fear, dread, and uneasiness."[23] It is not uncommon for healthcare workers to feel uneasy or fearful while working in the emergency department due to the unpredictable nature of the patients treated there. Anxiety can arise from various issues, such as unexpected events, lifestyle changes, or sudden changes at work. HCWs understand their work schedule can change at any moment, which may cause changes in their personal life. These changes could potentially disrupt their sleep patterns, leading to further anxiety. Ironically, variations in sleep can lead to insomnia, which triggers a host of other health issues, both psychologically and physiologically. Chronic insomnia has been linked to an increased risk of depression, anxiety, substance abuse,

[21] Guillaume Fond et al., "Depression in Healthcare Workers: Results from the Nationwide AMADEUS Survey," *International Journal of Nursing Studies* 135 November 2022: 104328, 5, https://doi.org/10.1016/j.ijnurstu.2022.104328.

[22] Robert P. Lennon et al., "Prevalence of Moral Injury, Burnout, Anxiety, and Depression in Healthcare Workers 2 Years into the COVID-19 Pandemic," *Journal of Nervous & Mental Disease* 211, no. 12 December 2023: 984, https://doi.org/10.1097/NMD.0000000000001705.

[23] National Library of Medicine, "Anxiety" Medline Plus, 2023, https://medlineplus.gov/anxiety.html#:~:text=Anxiety%20is%20a%20feeling%20of,before%20making%20an%20important%20decision.

suicide, motor vehicle accidents, and possible immune dysfunction.[24] This same study has concluded that statistically, HCWs are at greater risk of developing anxiety and anxiety associated with job burnout, sleeping problems, and lifestyle factors.[25]

Studies are revealing that much of the anxiety, stress, and depression in the HCW are caused by post-COVID PTSD. In January 2021, one study that involved 136 HCWs who worked in the ICU admitted to having mental health symptoms. Out of the 136, 84 were nurses, and 52 were physicians. Sixty percent reported burnout, whereas 53 percent (especially nurses) admitted to anxiety and/or depression. By May of the same year, 46 percent of HCWs reported symptoms of anxiety.[26] The phenomenal studies recently have shown that post-COVID symptoms of mental health problems are still evident. Depending on the department and the grief, trauma, and death endured, it will likely be a remarkable and emotional undertaking. Most hospitals' ICUs and emergency rooms draw many studies on healthcare workers who work in two highly stressful units. This is not to minimize any other units. Labor and delivery, NICU, PICU, or the OR all have high levels of stress associated with trauma and death. All HCWs require encouragement, support, and admiration to maintain mental health.

Support for Healthcare Workers

Anyone who experiences trauma and death is advised to find support in some way. In the same manner, processing death can be a challenging experience for many individuals. Humans were not created to cope with the loss of their loved ones quickly; this also applies to the death of

[24] Ozge Aydin Guclu et al., "Association between Burnout, Anxiety and Insomnia in Healthcare Workers: A Cross-Sectional Study: Burnout, Anxiety and Insomnia in Healthcare Workers," *Psychology, Health & Medicine* 27, no. 5 May 28, 2022: 1113, https://doi.org/10.1080/13548506.2021.1874434.

[25] Ibid., 1126.

[26] Claire Roger et al., "Occurrences of Post-Traumatic Stress Disorder, Anxiety, Depression, and Burnout Syndrome in ICU Staff Workers after Two-Year of the COVID-19 Pandemic: The International PSY-CO in ICU Study," *Annals of General Psychiatry* 23, no. 1 January 3, 2024: 14, https://doi.org/10.1186/s12991-023-00488-5.

someone they are caring for in an acute hospital setting. The COVID-19 pandemic created a world of death HCWs were not prepared for, and it took a toll on the emotions of the staff. Despite the inevitable deaths and human mortality before the pandemic, grief was still a factor for clinicians.[27] Unfortunately, intervention programs are not commonly utilized in hospitals to assist staff in processing their experiences with trauma, death, and the resulting grief. While not all hospitals offer individual grief counseling, most have chaplains who can provide spiritual counseling for HCWs in need. Hospital clergy, also called chaplains, primarily provide spiritual support to patients and their families. Staff at many hospitals also seek the chaplains' help to get through challenging, emotional events. Anna Maria Kostka et al. view religion and spirituality as tools that healthcare providers can use to their benefit, especially when processing emotions.[28]

Studies have shown that some hospitals across the nation have had success with chaplain/staff interaction. One study found that having a chaplain assigned to all potential organ donor cases eased the stress of nurses and had a significant impact. Another study found that staff interaction with the chaplain was associated with reduced perceived stress in nurses who tended to severely ill patients.[29] Unfortunately, in some hospitals, it is understood that chaplains' duties only sometimes include staff. Hospital chaplains can provide limited care to staff, considering the patient load for many larger hospitals. Chaplains can lead an intervention program and train other healthcare professionals to support one another.

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[27] Michael W. Rabow et al., "Witnesses and Victims Both: HCWs and Grief in the Time of COVID-19," *Journal of Pain and Symptom Management* 62, no. 3 September 2021: 648, https://doi.org/10.1016/j.jpainsymman.2021.01.139.

[28] Anna Maria Kostka, Adriana Borodzicz, and Sylwia Anna Krzeminska, "Feelings and Emotions of Nurses Related to Dying and Death of Patients- A Pilot Study," *Psychology Research and Behavior Management* 14 2021: 713.

[29] Alexander Tartaglia et al., "Supporting Staff: The Role of Health Care Chaplains," *Journal of Health Care Chaplaincy*, December 2022, 4.

Many hospitals across the nation have implemented a "Code Lavender" protocol, designed to help medical staff who require support after experiencing a trauma or the death of a patient. Unfortunately, only 45 percent of hospitals surveyed by Alexander Tartaglia et al. have implemented Code Lavender or similar supportive programs. Moreover, of those that have provided the programs, staff rarely make use of them. The principal reason is the need for a relationship between staff and chaplains who are usually responsible for counseling. Most medical staff rely on colleagues they trust and have relationships with to unburden their problems. Therefore, it is essential to have all medical staff trained in a mental health instruction program to ensure they receive the necessary support. According to Tartaglia et al., many hospitals in America assume that Code Lavender is widely adopted.[30] The principal difficulty is the need for more initiative and interest in implementing such a program at the management level.

On the other hand, the chaplain level recognizes the need for a program that can engage with staff in case of mental health crises. The data presented by Tartaglia et al. seem unrealistic as they focus on the desires of management rather than the needs of mental health first responders. Furthermore, management has the task of upholding the morals and ethics that are substantial to the mental health of all staff, including nurses, doctors, and the supporting staff. The morals and ethics of this ACIR will be discussed further in the next section.

Peer Support in Healthcare

There is merit and worth in co-workers understanding and supporting one another. Whether a nurse, an emergency room technician, or a physician, the human being that is the HCW has emotions. Peer support can benefit most organizations worldwide (writers' opinion).

[30] Tartaglia et al. "Supporting Staff," 3.

Research shows that healthcare facilities are staging and organizing peer support. Jo Shapiro and Pamela Galowitz insist that peer support needs to be readily available for clinicians who are experiencing a mental health crisis such as anxiety, depression, or burnout symptoms. Initially, the program did not attract any clinicians, but they quickly realized that the conversations needed to be open, allowing feelings to be exposed to colleagues. Coping strategies, discussions, and support had become the center for the program's success.[31] Stefancic et al. believe that the most common modalities of peer support for mental health can be participation in mutual support, peer-run organizations, and peer-delivered services. In addition, peer support for mental health is characterized by self-disclosure and sharing experiences of problematic mental health to combat and reduce isolation, promote hope, and aid in recovery.[32]

The peer approach to mental health does not require a healthcare worker to possess specialized counseling training. This approach involves empathetic listening and personal experience to understand the perspective of the other peer. There are various ways to address issues such as burnout and compassion fatigue. Different models have been used in the clinical setting, but some point to comforting rather than referring to a professional. For example, the Three Tier Program used at Gold Coast Mental Health and Specialty Services emphasizes these three modes: 1) activation of support when a HCW experiences an acute or stressful event, 2) activate a healthcare provider to provide caring and compassionate support, and 3) referral to a professional support agency, psychologist, or the EAP.[33] The approach is agreeable among

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[31] Jo Shapiro and Pamela Galowitz, "Peer Support for Clinicians: A Programmatic Approach," *Academic Medicine* 91, no. 9 September 2016: 1200–1204, https://doi.org/10.1097/ACM.0000000000001297, 1201–02.

[32] Ana Stefancic, Lauren Bochicchio, and Daniela Tuda, "Peer Support for Mental Health," in *Peer Support in Medicine*, ed. Jonathan D. Avery Cham: Springer International Publishing, 2021, 31–48, https://doi.org/10.1007/978-3-030-58660-7_2, 32–33.

[33] Debby Morris et al., "Collaborative Approach to Supporting Staff in a Mental Healthcare Setting: 'Always There' Peer Support Program," *Issues in Mental Health Nursing* 43, no. 1 (January 2, 2022): 48, https://doi.org/10.1080/01612840.2021.1953651.

healthcare professionals. However, the final assertion is to refer out for specialized care. This approach is being avoided in this action research project, and a fully encapsulated approach is broadened through peer follow-up and care to build relationships of trust.

Moral and Ethical Distress

Every company, organization, and entity has its own unique mode of functioning and operating. Hospitals, for instance, operate based on ethics and moral reasoning. An underlying dilemma can affect the medical staff throughout the acute care hospital. Nurses may experience moral distress, which can lead to depression, anxiety, and stress. Rachel Jones believes that moral distress would be characterized similarly to what was described by Andrew Jameton, who first defined the term in his 1984 book, *Nursing Practice: Ethical Issues*. Moral distress is when a nurse knows the right thing to do, but institutional limitations make it nearly impossible to pursue the right action.[34] The ethical and moral dilemmas that nurses and doctors face, particularly in the ICU during the COVID-19 pandemic, are complex and challenging. Informed consent and advanced directives can be significant constraints for medical staff when making end-of-life decisions. In critical cases where the patient or family member cannot give informed consent, medical staff must make ethical decisions on behalf of the patient. Most hospitals have ethics committees made up of staff doctors, nurses, and other experts to aid decision-making. Healthcare ethics committees are characterized as a body of persons established by a hospital or healthcare institution who are assigned to consider, debate, and make decisions on ethical issues that involve patient care.[35] Similarly, when a patient chooses a DNR (do not resuscitate) order,

[34] Jones, *Grief on the Front Lines*, 45.

[35] Waldemar Glusiec, "Hospital Chaplains as Ethical Consultants in Making Difficult Medical Decisions," *Journal for Medical Ethics* 48, no. 1 2022: 257.

the medical staff must honor that decision, even if the family disagrees. Conversely, if a patient chooses full-code status, the staff must attempt to save his or her life. These decisions weigh heavily on the medical staff and are inevitably fraught with moral and ethical crises.[36] H. Norman Wright denotes that nurses and other medical staff are susceptible to the stress that comes with moral and ethical decisions. The unresolved problematic stress can lead to harm of the medical staff, ultimately leading to mental distress. Although medical teams may debrief, it does not always provide a resolution to the thought patterns of stress and anxiety related to the death of a patient. Moral and ethical decisions can affect medical staff's mental and physiological well-being. Unfortunately, finding appropriate treatment or counseling within most hospitals can be challenging.

If a moral or ethical decision has been made and it causes distress among medical staff or healthcare workers, they will utilize various coping mechanisms and resilience strategies to process their emotions. These may include humor, emotional management, and incorporating their moral beliefs to help them deal with the situation. Sherry Jones provides suggestions for short-term help, but long-term mental health requires specially trained staff to help medical professionals through the most challenging times.[37] While medical ethics generally become stringent regarding religion and the faith community, a nurse's personal ethics do not override the decisions insinuated by a hospital. Unfortunately, this can put added strain on HCWs, morally and emotionally. Because of the advancements in modern medicine, there is a heightened debate over ethics in the medical field. Numbers and Amundsen argue that healthcare professionals' faith should stand firm as they believe God is the Great Physician, and their ethics

[36] H. Norman Wright, *The Complete Guide to Crisis and Trauma Counseling: What to Do and Say When It Matters Most!* Updated and expanded edition (Minneapolis, Minnesota: Bethany House Publishers, 2014), 280.

[37] Jones, "Nurses' Occupational Trauma Exposure, Resilience, and Coping Education," 21.

should align with their faith.[38] Numbers and Amundsen contend, even if policies diminish the faith of HCWs, they should still stand firm in their beliefs, and the well-being of the medical staff in the care setting should be at the forefront of the hospital management's agenda.

Moral and ethical decisions can become quite controversial in the labor and delivery unit. The medical staff has a moral obligation to save both the infant's and the mother's lives, which can be challenging at times. The neonatal intensive care unit is a specialized ward that provides care to infants in distress or infants who require life-saving measures. The nursing staff in this unit are trained to care for premature infants to terminal infants for a short or sometimes extended period, which can be weeks. While the HCWs focus on the infant, they still have to tend to the emotions of the parents, which can become troublesome. NICU nurses endure a great deal of moral distress, which can come from the infant's parents, other medical staff, and the limitations put on the HCW by the organization. Moral constraint comes from a lack of experience in treating the critically ill and from encountering the death of an infant. Moral conflict can occur through the dilemmas surrounding two or more views on the care of an infant, parents, other family members, religious beliefs, or the organization itself.

A study by Soojeong Han et al. reported that nurses in the NICU face and confront morally challenging situations more often than they do not. Some of the reasons are witnessing the pain and suffering of a patient, having an unsupportive healthcare system with adequate resources, and the inability to guide the patient's parents in ethical decision-making. In addition, most infant deaths occur in hospitals, especially in the NICU. Many nurses who have little experience with infant death find the situations upsetting, resulting in barriers to grief.[39] In the

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[38] Ronald L. Numbers and Darrel W. Amundsen, eds., *Caring and Curing: Health and Medicine in the Western Religious Traditions* (Baltimore, Md: Johns Hopkins University Press, 1998), 237.

[39] Soojeong Han, Haeyoung Min, and Sujeong Kim, "NICU Nurses' Moral Distress Surrounding the Deaths of Infants," *Nursing Ethics* 30, no. 2 March 2023: 276–87, https://doi.org/10.1177/09697330221134978.

NICU, it is often difficult to schedule regular debriefings due to the small staff size and the continuous care required for infants, which leaves little time for grieving or peer support. To address this issue, policy changes and additional staffing could provide more room for the NICU staff to be attentive to their duties. Ironically, low staffing levels are a major contributor to stress and anxiety in any department.

Medical staff face moral and ethical dilemmas when caring for patients, whether children or adults, at the end of life. Respecting the patient's religion, culture, and personal beliefs is crucial, even if they conflict with medical interventions. Unfortunately, honoring these beliefs can have a negative impact on healthcare workers. For example, if a patient is brought to the emergency room after an accident and requires a blood transfusion to save their life, but a family member demands that the transfusion be stopped due to religious beliefs, the medical staff must comply with the family's wishes, even if it goes against their medical judgment. Even with advances in the medical field and better life-saving tactics than in recent years, there is still an ethical and moral dilemma. Jennifer Rainer et al. assert that the dilemmas related to end-of-life issues and the prevalence of technological advances do not override the ethical standards imposed by either management or a patient's beliefs.[40]

Medical Staff Well-Being

During the COVID-19 pandemic, many hospitals relied on chaplains to become increasingly visible and present for families and staff, not only in person but virtually, as well. In one study, a hospital out of Europe found a greater appreciation and knowledge for what

[40] Jennifer Rainer, Joanne Kraenzle Schneider, and Rebecca A. Lorenz, "Ethical Dilemmas in Nursing: An Integrative Review," *Journal of Clinical Nursing* 27, no. 19–20 October 2018: 3448, https://doi.org/10.1111/jocn.14542.

chaplains do as well as the care they provide for the staff.[41] After a long shift and before heading home, HCWs often carry the stress and burden of the day with them. Coping with the pressure of the day may manifest itself in different ways, one such way is turning to alcohol or other substances. This happens because many of the healthcare staff often lack a positive outlet for overwhelming stress. Others may choose a positive outlet and engage in physical activities such as exercise to alleviate the internal turmoil they experience. With the proper channel, medical staff will likely perform optimally and maintain a professional mindset to accommodate the punctual needs of patients. Physicians must keep a clear mind and be alert for their patients. This is why they all take the twenty-five-hundred-year-old Hippocratic Oath upon completing medical school and at the conclusion of their studies. In 2017, a revision was created to declare that doctors will attend to their health and well-being so they may perform their jobs at the highest standard.[42]

All medical staff's primary cognitive stability and mental health are vital to their performance, especially with human lives in their hands, and split-second decisions are ineluctable. This oath physicians take should be the highest standard for all medical staff, and the mental health of HCWs encompasses the spiritual well-being that is significant to all cultures and has a level of personal dignity.[43] Patients deserve the very best, which means healthcare that embraces the respectable mental health of healthcare professionals at every level. The spiritual health of patients and HCWs is empirical to this project and deserves more attentive reasoning.

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[41] Beba Tata et al., "Staff-Care by Chaplains during COVID-19," *Journal of Pastoral Care & Counseling: Advancing Theory and Professional Practice through Scholarly and Reflective Publications* 75, no. 1_suppl April 2021: 28, https://doi.org/10.1177/1542305020988844.

[42] Rachel Jones, Grief on the Front Lines: Reckoning with Trauma, Grief, and Humanity in Modern Medicine (Berkeley, California: North Atlantic Books, 2022), 19.

[43] Taylor Oakie et al., "Coworker Health Awareness Training: An Evaluation," *Journal of Applied Biobehavioral Research* 23, no. 4 2018: 3.

Spiritual Care

Not all healthcare colleagues claim to have religious affiliations or beliefs. When medical staff is affected by events, such as a traumatic death in the emergency room or the sudden death of a child, religion and faith tend to become extraordinarily important. Chaplains have a remarkable yet personal role in the spiritual support of staff during a crisis. Alexander Tartaglia et al. believe chaplains can support staff at the individual and group levels when experiencing an event that requires spiritual attention. Moreover, chaplains can assist in facilitating ER, ICU, and NICU, among other unit debriefing sessions after a patient dies, to show better support to the staff.[44] While this may be true, it is only a short debriefing that may or may not expedite the personal emotions of the staff. Medical staff can lean on one another in that moment, but the healthcare worker will revisit the sentiments at the end of the day with no resolution to their emotions.

Professionals in palliative care include physicians, nurses, social workers, and chaplains. The team combines care for patients and their respective family members with the possibility of being at the end-of-life (EOL) or needing support for a long-term illness. While attuned to patient care, the entire team could assimilate the effects of stress from families and patients. Distress that affects the palliative care team and colleagues collectively can share their grief with the hospital chaplains. There is tremendous care when ministering to the team. Stifled grief is fragile.[45] Betty Ferrell makes a valid argument for personal grief. Even though medical staff are groomed to put on a brave face, they are human and grieve. The mental and emotional health of the staff is likely to be strained if not attended to immediately after death, crisis, or trauma, as

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[44] Tartaglia et al., "Supporting Staff: The Role of Health Care Chaplains," 2.

[45] Betty Ferrell et al., "The Urgency of Spiritual Care: Covid-19 and the Critical Need for Whole-Person Palliation," *Journal of Pain and Symptom Management* 60, no. 3 September 2020, 19.

well as attending to their daily problematic life situations. In a study of palliative physicians and their work-related emotions, Daniel John Hubik et al. discovered that junior physicians are likelier to display strong emotions for a patient at EOL.

Furthermore, senior physicians suppress their emotions to present a resilient appearance. Moreover, this study presented that palliative care doctors did describe a range of sentiments and recollections of negative emotions, including anger, sadness, and frustration.[46] The emotional state of physicians, nurses, and medical staff is enormously important for compassionate patient care.

Chaplain Compassion Care

The role of a hospital chaplain is likely patient-centered in many hospitals across the country, but chaplains should inevitably be utilized for staff and the hospital's patients' spiritual needs. Each department in the hospital, at some point, will experience some trauma and grief. The emergency room will likely experience traumatic death, whereas the intensive care unit (ICU) will experience a longer-term death in a patient. Religion and spiritual care are vital for the immediate care of the staff at all levels. Death experienced in other units, such as labor and delivery, may appear different, but the feelings are just as pronounced. Dani Helm provides an account for the grief shared in the early loss of a baby, asserting that doctors and nurses are of great support, but the chaplains have specific training in spiritual care for those who experienced loss.[47] Religious or not, the medical staff and patients have found comfort when chaplains are present. In their study of medical professionals, Natalia Ondrejkova et al. reiterate the necessity

[46] Daniel John Hubik, Clare O'Callaghan, and Justin Dwyer, "Strong Emotional Reactions for Doctors Working in Palliative Care: Causes, Management, and Impact. A Qualitative Study," *Psycho-Oncology* 30, no. 9 September 2021: 1588, https://doi.org/10.1002/pon.5731.

[47] Dani M. Helm, "A Grief Intervention for Early Perinatal Loss" Liberty University, 2023, 50.

for hospitals to employ a program/intervention to assess and combat CF. Their study explored the prevalence and differences in compassion fatigue among helping professionals. The researchers of this study recommend that hospitals require a well-designed program to teach medical professionals how to manage their work overload to reduce the possibility of CF.[48] Having religious and spiritual compassionate care is essential when dealing with nurses' and doctors' emotions.[49] Kostka et al. are correct if the staff is now willing to accept compassionate spiritual care.

Depending on the size of the healthcare facility and if the spiritual care department is fully staffed, it should be available to staff at some point in the day. Unfortunately, this is not always the case. Chaplains will be stretched thin if the patient load is heavy. Betty Ferrell et al. believe that chaplains are often limited in meeting the needs of seriously ill patients, less meeting the needs of staff.[50] Limiting chaplains' time for the healthcare team can take time and effort. Some needs may still need to be met even with a fully staffed chaplain team. They need to be met, highlighting the importance of having a team that can evaluate the mental health of healthcare professionals in hospitals.

Unfortunately, the COVID-19 pandemic has made it even more difficult for patients and staff to access spiritual care. Hospitals have had to implement strict rules and regulations that have hindered access to spiritual support. While each hospital may have its protocols, all medical facilities in Los Angeles County must abide by the more stringent regulations. As a result,

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[48] N. Ondrejková and J. Halamová, "Prevalence of Compassion Fatigue Among Helping Professions and Relationship to Compassion for Others, Self-Compassion and Self-Criticism," *Health & Social Care in the Community* 30 2022: 1680, https://doi.org/10.1111/hsc.13741.

[49] Anna Maria Kostka, Adriana Borodzicz, and Sylwia Anna Krzeminska, "Feelings and Emotions of Nurses Related to Dying and Death of Patients- A Pilot Study," *Psychology Research and Behavior Management* 14 2021: 714.

[50] Ferrell et al., "The Urgency of Spiritual Care: Covid-19 and the Critical Need for Whole-Person Palliation," 8.

healthcare staff have suffered significantly. As a result of the pandemic, hospitals must regularly adhere to protocols such as limited visitation hours and strict hygiene standards. Nevertheless, that same protocol must sometimes be overlooked for the sake of the mental health of medical staff. In the book *Experiencing God in Nursing*, Elizabeth Simon reflects on a time when a decision had to be made to overlook the protocol and seek counsel. The desperation changed to a delightful encounter.[51] It is only sometimes recommended to go against any policy, but nurses and other healthcare staff can get desperate for help. A team that recognizes and initiates the call to duty is essential to all medical staff for well-being and mental stability.

Ministry of Presence

The ministerial practice of a hospital chaplain is wider than speaking to families and staff. Instead, one of the most important qualities is a ministry of presence. Presence is a vaguely defined word chaplains use to describe patient interactions. Current literature defines presence as creating a trusting atmosphere for the nonjudgmental and compassionate sharing of another's story.[52] God's presence in the chaplain brings peace to patients, families, and staff simply by the chaplain sitting at the bedside or in a quiet room. The Gospel of John 14:23, Revelation 21:3–4 and Isaiah 6:1–5 show that God dwells in humans and makes His home with them. Through the ministry of presence, people feel the calmness and comfort of God through the chaplain. A ministry of presence is generally non-verbal but can become a meaningful dialogue between the chaplain and the HCW. The transformational presence of the chaplain aids in the emotional state of the HCW, allowing a deeper connection between the two.

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[51] Elizabeth B. Simon, Ryan Hodges, and Kathy Schoonover-Shoffner, "Experiencing God in Nursing," *Journal of Christian Nursing* 37, no. 2 2020: 97.

[52] Kevin Adams, "Defining and Operationalizing Chaplain Presence: A Review," *Journal of Religion and Health* 58, no. 4 2019: 1247.

Hospital chaplains consistently attend to patients' spiritual needs. Sometimes, a patient may not be able to correspond or may not want to communicate with the chaplain when they enter the room. For the healthcare worker, the chaplain could become available to be present in times of need, crisis situations, or emotions that have stemmed from home. During the COVID-19 pandemic, medical staff were stretched thin, and resilience diminished as stress levels increased. The presence of a chaplain was impactful, it increased the perceived value of chaplaincy when chaplains proactively and creatively sought to encourage staff in practical ways, continuously being available and interconnected with staff, the calmness of presence and active listening had become a solid solution.[53]

A chaplain's role encompasses a wide variety of duties, each equally significant. These duties are not confined to a specific area but rather are diverse. Hospital chaplains come from different religious backgrounds and communities, but their mere presence in the room brings a sense of tranquility to those around them. Although chaplains from various religious groups offer religion-specific sacraments such as communion by Catholic priests, they still provide a comforting presence to patients. When chaplains attend to the healthcare staff, who may have different religious beliefs, they offer an empathetic listening ministry that is often appreciated by all staff.

The chaplain's primary focus in the emergency room is on attending to the patients and their families, and it is also crucial for the chaplain to be available to the staff for spiritual and emotional support. Given the fast-paced nature of the ER, the chaplain may need to ask the staff if they require such support intentionally. Even if the staff declines, the chaplain's presence is

[53] Csaba Szilagyi et al., "Chaplain Leadership During COVID-19: An International Expert Panel," *Journal of Pastoral Care & Counseling: Advancing Theory and Professional Practice through Scholarly and Reflective Publications* 76, no. 1 March 2022: 56–65, https://doi.org/10.1177/1542305021106T.

still noticeable and appreciated. Sometimes, the chaplain may be asked to visit patients who are severely ill or have been through trauma. The healthcare team will appreciate the chaplain's presence and support in such cases.

It is crucial to be available for the staff in the ICU, as they endure a high level of stress in that unit. When a patient passes away, the presence of a chaplain is necessary not only for the family but also for the healthcare team. The lead nurse or the chaplain often engage the team in a debriefing session to help them cope. Afterward, the chaplain should remain present to provide comfort and empathetic listening if necessary. In these moments, the chaplain would be in tune with the conversations or noticeable changes in the behavior of the HCW. The chaplain would be in a position to observe and potentially recommend an intervention, and the emotional overload of anxiety, fear, or depression could be occluded. At the very least, the chaplain's ministry of being present brings the peace of God into the intensive care unit. Staff reported their experience of the chaplain's presence as being attentive to the situation, whether informally in the unit, in a resilience room, or more formally in a meeting.[54] The healthcare worker is human. They do have emotions like everyone else. Therefore, they deserve an attentive chaplain to listen to them.

Chaplain Self-Care

Hospital chaplains, like other healthcare workers, may face mental health challenges such as burnout and compassion fatigue. Thus, chaplains need to care for themselves to maintain their well-being and build resilience for their mental and emotional health. Whether they are attending to a trauma case in the emergency room or comforting a family who lost a baby at birth, chaplains may experience emotional exhaustion or stress throughout the day. Many hospital

[54] Carl Aiken, "Australian Chaplaincy Support of Health Care Staff: Presence, Professional and Relational," *Journal of Religion and Health* 61, no. 2 April 2022: 950, https://doi.org/10.1007/s10943-022-01526-4.

chaplains are required to be on-call, which can exacerbate stress levels. Therefore, chaplains must prioritize their physical, emotional, and psychological health to be efficient and attentive hospital representatives.

A chaplain, much like any minister, may tend to use religious coping, such as rituals of prayer and meditation. However, as described in this action research project, practical methods include self-awareness and self-care (e.g., eating correctly, exercising). Recent studies show that chaplains working primarily in palliative care appear moderately distressed, more than those working in the acute care side. Through the process of clinical debriefs alone and tending to people at the end of life, palliative chaplains are likely to fall into burnout much quicker than their colleagues.[55] Acute care and palliative chaplains are susceptible to burnout, compassion fatigue, and other mental health problems just as much as their clinical co-workers. The best practice for chaplains is the same level of care for the healthcare worker, utilizing holistic approaches to reduce mental health problems.

Acute care chaplains usually work independently, visiting patients in different departments, making rounds, and documenting their visits in an office. However, during the COVID pandemic, their job became more challenging due to restrictions that made it difficult to find patients to interact with. What was once considered regular and routine suddenly became a quiet, reserved, and lonely place. In the past, chaplains would interact with people throughout the day, providing emotional support and conversing with them face-to-face, but now they were forced to adapt to a new way of working. The questions would swirl: How long will it be like this? How long must one have to hold it all together? Those questions drive again the profound

[55] Kelsey B. White et al., "Distress and Self-Care among Chaplains Working in Palliative Care," *Palliative and Supportive Care* 17, no. 5 October 2019: 544, https://doi.org/10.1017/S1478951518001062.

inner debate between feeling helpless or paralyzed by the events versus feeling proactive and resilient in facing the unknown.[56]

The Pastoral Care Department in many hospitals might have independent chaplains who work autonomously visiting patients and staff. Palliative care is an example of a chaplain being a part of a team that includes attending physicians and nurses specializing in palliative care. Some hospital chaplains may work as part of a team for behavioral health patients, including social workers and other healthcare professionals. Support is essential to this study, and encouragement is directed at chaplains. They all require comradery to benefit one another. The chaplain's participation in an interdisciplinary team is crucial in promoting self-compassion and mindfulness through practices like loving-kindness meditation. The value of supportive relationships, such as mentors, co-workers, and peers, helps sustain the compassionate care chaplains provide.[57] Chaplains are encouraged to seek support from external clergy members whenever necessary. Chaplains should also take time to consult with other clergy, take breaks, exercise, maintain a healthy diet, and get adequate sleep. Engaging in self-care practices can benefit a chaplain's overall well-being and is the foundation for addressing the healthcare workers in this project. This next section will review the biblical principles that add stability to this action research project.

Theological Foundations

The Greek word for repentance, when translated, provides the impression of a change of mind—turning negative thoughts around and changing the way one thinks. In Romans 12:2, the

[56] Cate Michelle Desjardins et al., "Scared but Powerful: Healthcare Chaplains' Emotional Responses and Self-Care Modes during the SARS-Cov-19 Pandemic," *Journal of Pastoral Care & Counseling: Advancing Theory and Professional Practice through Scholarly and Reflective Publications* 75, no. 1_suppl April 2021: 93, https://doi.org/10.1177/1542305021993761.

[57] Ibid., 94.

Apostle Paul addresses this way of thinking by asserting that our thinking must change and be transformed from the old way to a new godly way. Of necessity, there needs to be an accordance between the heart of man and his mind, one that allows the renewing of thoughts. The writer of Psalm 51:10 pleads with God in saying, “Create in me a clean heart, O God, and renew a right spirit within me.” That is, in everyday life, the world can pollute our thoughts if we allow that to happen. The Bible will put our thoughts in the light of spiritual thinking, allowing God to renew, restore, and bless what transpires in the mind of anyone who believes.

Biblical principles can serve as a guide for healthcare workers supporting peers during and after a crisis. In the following portion, an outline of the theological foundations for this project will be considered. The main objective of this project is to provide healthcare staff with the necessary tools to support each other during crises or difficult times that may affect their mental health. The project is different from other programs as it is facilitated by hospital chaplains who will educate HCWs about the nature of depression, anxiety, and fear in their colleagues. The Bible contains many stories about defeat, trials, depression, and fear, which will be explored during the project. Paul’s teachings in the New Testament epistles provide ways to overcome these situations, and one of the first steps is to support and understand one’s peers.

Bear One Another’s Burdens

Developing a strong bond with a colleague through continuous work hours and multiple days of the week can be a valuable experience. The close connection can reveal any unusual behaviors or characteristics that may have gone unnoticed. Recognizing a coworker’s emotional or rational struggles is just the first step. Sometimes, all a colleague may need is someone to

listen to their concerns, which can positively impact their overall well-being.[58] In a hospital setting, bringing peace to a tense situation is valuable and can spread happiness among coworkers and ultimately lead to better patient care. Positive relationships with colleagues are vital for a successful and fulfilling work experience. As a healthcare worker, it is likely to experience significant emotional, physical, or spiritual suffering. It is essential to remember that this suffering is not solely your own, and God is there to help carry that.[59] In Galatians 6:2–5 Paul teaches that bearing one another's burdens is better than taking on the burden by oneself. Therefore, if a healthcare worker witnesses a coworker struggling and burdened, taking quick and decisive action is essential to ease their affliction. The action can be done through one of the intervention techniques provided in this project. The manifestation of deep-rooted or acute short-term depression and anxiety can appear in anyone at any time, so it is crucial to be alert and act promptly. The HCW can help lift the burden and show their coworkers they are not alone.[60] In 2 Corinthians 1:3–4, Paul mentions that God is the source of all comfort and one can comfort others as God comforts them in their troubles. By bearing one another's burdens, one can demonstrate the love of God and the very Spirit of God Who lives within. Being present for a peer and listening can support some of the attributes of the Fruit of the Spirit. There is value in just listening to a peer talk about their stressors, anxiety, and fears.

In Galatians 5:22–23, Paul provides attributes of the Fruit of the Spirit: love, joy, peace, patience, kindness, goodness, faithfulness, gentleness, and self-control, which are all excellent

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[58] Jason T. Hotchkiss and Ruth Lesher, "Factors Predicting Burnout Among Chaplains: Compassion Satisfaction, Organizational Factors, and the Mediators of Mindful Self-Care and Secondary Traumatic Stress," Journal of Pastoral Care & Counseling: Advancing Theory and Professional Practice through Scholarly and Reflective Publications 72, no. 2 (June 2018): 18, https://doi.org/10.1177/1542305018780655.

[59] C. Jones, "Encouragement for the Christian Nurse," *Journal of Christian Nursing* 39, no. 4 2022: 73.

[60] David Platt and Tony Merida, *Exalting Jesus in Galatians*, Christ-Centered Exposition (Nashville, Tennessee: Holman Reference, 2014).

characteristics for anyone to achieve. Regardless of the assumptions, healthcare professionals are not trained to absorb trauma, emotional pain, or death. They just learn that it is a part of the job. These emotional aspects are learned over time, through long hours and multiple shifts, to deal with the painful trauma and emotional disarray that affects their virtuous soul. Nurses, doctors, and other healthcare staff suffer the burdens of on-the-job stressors, such as death and traumatic experiences in patient care. Moreover, Paul reminds the reader that peace is one exceptional attribute of the Spirit.

The Hebrew word shalom is a salutation by Jewish people that means peace when greeting someone or saying farewell. With the right relationship with God, one can bring harmony to others, even co-workers, through peace. Christians are known as peacemakers at home and in everyday life, including the workplace.[61] Galatians 6 describes what Paul believes to be the soul of the Christian. Providing peace in a situation can bring harmony if addressed correctly, and this takes patience. In the Gospel of Matthew chapter five, Jesus speaks to the crowd in what is known as The Sermon on the Mount, and in verse nine, Jesus utters, "Blessed are the peacemakers, for they shall be called the sons of God." The peacemaker acted as an ambassador sent to treat peace. Another word that could be substituted is "peace-workers," which would indicate they are making peace at the will of God.[62] Accommodating HCWs with the necessary tools to engage in the inner peacemaker will be a precedence in this action project. One ascribed characteristic of a peacemaker is having the patience to communicate and listen. The next section will describe the characteristics of patience.

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[61] Timothy George, *Galatians* (Nashville, TN: Holman Reference, 2020), 697.

[62] James Orr, John Nuelsen, and Edgar Mullins, *The International Standard Bible Encyclopedia*, 1–4 vols. The Howard-Severance Company, 1915.

Patience

Tense moments can relay spiteful anger and regrettable words that were not meant to be spoken. Mental and physical trauma can take its toll on the human spirit, and the patience to brush off strife and anger is vital to the healthcare team so they maintain composure for the sake of patient care. Timothy George asserts that patience refers to the quality of the mind, that it is not easily offended.[63] Patience is one of the virtues that help keep the peace in the workplace, and by keeping peace through patience, the healthcare worker will make considerable strides to monitor those afflicted and minister to those individuals.

Having patience requires an unbiased opinion of another in peer support. Poremski et al. describe challenges in integrating peer support intervention barriers, such as lack of clarity in the peer's role, discrimination, prejudice, and lack of training, which led to the discontinuation of such programs.[64] The Good Samaritan, as depicted in the Gospel of Luke, demonstrated compassion for a man believed to be Jewish at a time when Samaritans and Jews did not get along, according to biblical history. The Samaritan took the beaten man to an inn and paid for his stay, an attribute of human kindness, without considering his background. It is not the hatred of one another. It is the act of the Good Samaritan that takes place. An unlikely hero renders a man who is down and beaten care.[65] Peers can become that unlikely hero through support training and intervention, which are necessary for any mental health program, and HMH has lacked the training for an intervention that will succeed. The stress and anxiety experienced by HCWs can

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[63] George, *Galatians*, 698.

[64] Daniel Poremski et al., "The Impact of Peer Support Work on the Mental Health of Peer Support Specialists," *International Journal of Mental Health Systems* 16, no. 1 2022: 4, https://doi.org/10.1186/s13033-022-00561-8.

[65] Iain M. Duguid et al., eds., *Matthew-Luke* (Wheaton, Illinois: Crossway, 2021), 1209.

often be overwhelming. Compassion, patience, and peace of mind can make a significant difference.

Stress and Anxiety

Stress and anxiety are weighty in some biblical characters and are evident throughout the New and Old Testaments. Ruth was a woman who was a grieving young widow. She was without resources for income, and the stress and anxiety would have been overwhelming for a single woman at the time. Ruth had overcome the challenges she faced when she found favor in God and her love for her mother-in-law, Naomi.[66] On the other hand, Moses was an example of a leader torn down by those who followed him, but God had redeemed him. Moses dealt with issues of depression, anxiety, and even fear as he led the multitude of Israelites through the desert for forty years. Moses had witnessed the daily hardships and struggles of God's people. Moses was a humble leader who thought more about the struggles of others than his own.[67] Positive thinking, combined with practical actions and faith in God, can bring about change even in the most challenging situations. Thoughts can overwhelm almost anyone, especially HCWs who work in high-stress units, such as the emergency room or intensive care unit. The HCW with negative thinking can lead to even higher levels of anxiety and stress, ultimately leading to depression. Thoughts can literally and figuratively keep a person captive, debilitating anyone to the point of needing help. Combating negative thinking can be done by remembering what the apostle Paul taught in 2 Corinthians 10:5, that arguments are destroyed, and every lofty opinion raised against the knowledge of God and take every thought captive to obey Christ. The

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[66] Ann Swindell, *The Path to Peace Experiencing God's Comfort When You're Overwhelmed* (Grand Rapids: Bethany House Publishers, 2022).

[67] H. Junia Pokrifka, *Exodus: A Commentary in the Wesleyan Tradition*, New Beacon Bible Commentary (Kansas City, and MO: Beacon Hill Press of Kansas City, 2018), 188.

healthcare professional can sojourn the negative rational and replace the thoughts with those pleasing to God.

This action research project is designed to teach participants compassionate methods of communication to further provide aid to a coworker who may be struggling with stress, depression, burnout, compassion fatigue, and trauma. Just as Moses was redeemed as the leader, the healthcare team can be the leaders of one another. There are times, just as Moses had endured, when a leader will feel overwhelmed with the pressures of the medical profession. The burden of stress is just as evident and prominent today, but having coworkers who can help pick up one another can create an environment of unity to decrease anxiety and fear.

Moses' successor, Joshua, took on the leadership role almost immediately after his predecessor's death. Much like Moses, he was to lead the Israelites into the Promised Land, and Joshua chapter one clearly explains how God supports his people during the struggle. Joshua was nervous, and God reminded him to be strong and courageous (Josh 1:9), for God is with His children everywhere and their faith in God keeps them strong. For the medical staff at Henry Mayo Hospital, there is no telling what events will unfold next in departments like the ER or ICU, where there could be death or trauma at any given moment. There may be a pregnant mother who loses her child, and it is through one's faith they find courage. Trained coworkers can help build one another up when feeling anxious, fearful, stressed, or overwhelmed.

The stress is prevalent in the emergency room at HMH on most occasions, especially in the evenings. Nurses, doctors, and the supporting staff will also experience the transferred anxiety from one healthcare professional to another, which can cause conflict. The fear of the unknown level of trauma coming into the emergency room raises unexpected problematic stressors. The questions swirl about how they will treat the patient and which team will need to attend to the situation, which all lead to anxiety. The Lord is near to those who feel the

overwhelming burden of stress, anxiety, and fear. Philippians chapter four provides the biblical principle of wisdom that was highlighted as evident and valuable then as it is now. Paul reminds the people in Philippi not to be anxious about anything. The rejoicing and gentleness are essential during challenging times but incomplete without prayer. The reader of Philippians four is told not to be "anxious for anything" they face. Still, they direct their "requests to God.[68] In verse seven, Paul reminds the reader that the "peace of God" replaces anxiety for the prayerful believer. Another mental health problem that can impede the true sentiment of healthcare workers is depression, which will be discussed in the next section.

Depression

Unlike Jesus, who was fully man and God, every Bible character was fully human and experienced real feelings and emotions. Depression is one of those anomaly responses to events of trauma or overwhelming thought patterns within the human spirit. In moments of depression, it is encouraging to know that significant figures in the Bible had life events that triggered depressive symptoms: David (Ps 22), Hagar (Gen 21:8–19), Job (Job 10:1–22), Jonah (Jonah 4:5–10), Joshua (Josh 7:6–10), Moses (Num 11:10–15), Naomi (Ruth 1:8–18), and Paul (2 Cor 1:8–11).[69] Just as the circumstances for the HCW's depression, biblical figures had multiple reasons for their melancholy, such as depression ranging from circumstances, death, fear, sickness, seeing life as meaningless, and sin. These are all examples of the emotions that can overcome the HCW experiencing calamitous situations. The prelude to an intervention is commiserating empathy with the HCW, which is the immediate focus.

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[68] Walter A. Elwell, ed., *Baker Commentary on the Bible* (Grand Rapids, Mich.: Baker Books, 2000), 1046.

[69] *Handbook of Bible Prayers*, Enhanced Credo edition (Trowbridge, Boston, Massachusetts: Manser, Credo Reference, 2023), 331.

The Bible also teaches that one's thoughts can significantly impact their disposition. The apostle Paul wrote to the people of Rome (the Epistle of Romans) about the importance of being a living sacrifice to honor God the Father. It is easy to become overwhelmed by the latest media reports and news stories about the world's events, especially during the COVID-19 era, which brought more negativity and depression. It should be noted that HCWs were subjected to vast amounts of negativity at the height of COVID-19, which has likely carried on to the current period. Most current news reports are oppositional and unsporting to the viewer, which can weigh down on thoughts and behaviors. In Romans 12:2, Paul reminds the reader that 'we should not be conformed' to the world but, instead, be transformed by the renewal of their minds. The thoughts that plague the minds of HCWs can lead to a depressive state. Hospital chaplains can lead HCWs through peaceful prayer to support and realign their thoughts. Otherwise, the negative thoughts of the healthcare worker can keep them captive and produce habits that are not warranted, such as substance abuse. "Therefore, it is important to prepare your mind for action and have clear thinking, setting your hope fully on the grace that was brought to you at the revelation of Jesus Christ" (1 Pet 1:13 ESV). Thoughts can cloud judgment, leading to senseless and unimaginable mistakes. Much like a police officer or firefighter, the healthcare worker must always be sober-minded and have clear thinking.

Empathy

The apostle Paul understood suffering, as depicted in Romans 12:14. Paul tells the reader to rejoice with those who are rejoicing and cry with those who are crying. There are moments when a member of the healthcare team, or the entire team for that matter, will reveal real emotions at the death of a patient. Gathering and supporting one another at that moment without much impediment is critical to initiating peace and healing. This action project will include

variables that will instruct nurses, doctors, and other healthcare professionals on the importance of supporting their teammates and colleagues. Paul asks in Romans 12:13 for those in connection with others to show empathy and sympathy.[70] The surrounding verses solidify what Paul is saying: to be loving towards one another and show the respect deserved in each situation. In the event of a trauma where one staff member is rendered distraught, showing the love of the Lord and being ambassadors of the kingdom will be addressed through this action research project. When the HCW is overwhelmed and lacks empathy for patients or coworkers, there is a chance the HCW is suffering from compassion fatigue. At HMH, few programs or training help HCWs understand or treat compassion fatigue (CF), which can become chronic if not addressed. Ultimately, CF can lead to mental health problems and burnout. CF can be assessed through measures that must be addressed in the MHFA program. One element of CF is burnout among healthcare staff, which has led to many HCWs leaving the industry. Resilience is the possibility of coping, learning, and growing from difficult situations.[71] Administering an assessment to a healthcare professional is one way to demonstrate the signs of compassion fatigue and its repercussions. The doctrine of God encompasses the Christian description of the Triune God's mercy. The Bible often pairs other divine attributes with mercy, such as compassion, grace, faithfulness, and kindness.[72]

A survey and self-assessment will be necessary to determine the level of compassion fatigue and burnout among staff at HMH. The study will use the Professional Quality of Life Scale (ProQOL) and a fourteen-item resilience scale (RS-14). These surveys will help provide

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[70] Fredrick Dale Bruner, *The Gospel of John: A Commentary* (Grand Rapids, MI: William B. Eerdmans Publishing Co., 2012), 139.

[71] Harvey Burnett Jr., and Kathleen Wahl, "The Compassion Fatigue and Resilience Connection: A Survey of Resilience, Compassion Fatigue, Burnout, and Compassion Satisfaction Among Trauma Responders," *Faculty Publications*, 2015, 3.

[72] Brannon Ellis and Mark Ward, *Lexham Survey of Theology* (:Lexham Press, 2018).

accurate results, and the assessment of CF can help this researcher identify those who need an Action Crisis Intervention Response. These more profound studies have been done in other settings and have succeeded. This action research study aims to discover through various studies which healthcare team needs intervention more than others. The MHFA program only helps the medical team recognize a crisis but lacks the much-needed intervention. Chronic trauma exposure can lead to burnout, and burnout for a healthcare provider will only hamper patients' treatments. A healthcare worker's trauma and burnout may segway to that HCW, leaving the industry virtually unnoticed. Understanding the resilience factor in this study will certainly help with the required intervention. In the next section, the theoretical foundations for this project will outline the necessity and urgency of a program that promotes the mental health welfare of healthcare professionals.

Theoretical Foundations

The theological foundations discussed in the previous section have established that mental health problems have affected people for centuries. This next section will administer the theoretical foundations for this action research project. Many corporations have established programs to provide on-the-job training for their employees, with a mandatory annual review of sexual harassment, slips, trips, falls, and safety compliance. Medical staff with state licenses must attend continuing education unit programs (CEU) every two years to maintain their license. Hospitals often face a challenge in providing sufficient training to HCWs to become peer supporters. The Action Crisis Intervention Response (ACIR) program, led by chaplains, has been introduced to address this issue. This program aims to teach HCWs how to respond to and support the mental health needs of their coworkers. This program aspires to help healthcare professionals and medical staff learn how to effectively handle a crisis such as depression,

anxiety, fear, PTSD, burnout, and compassion fatigue. The immediate response is a crucial aspect of the success of this program.

It appears that the efforts of programs such as Code Lavender and Mental Health First Aid are not sufficient in addressing the urgent needs of mental health. Adopting a practical and timely approach to extend compassionate care to healthcare professionals after a crisis or traumatic event is crucial. Code Lavender relies on a team of nurses, chaplains, and social workers to toil through a crisis and provide coping mechanisms such as music and meditation. Such a method is not a practical peer support approach and has yet to be implemented at Henry Mayo Hospital. The Mental Health First Aid (MHFA) program was introduced to the staff at Henry Mayo Hospital in early 2019 as a supplementary in-house training. Every chaplain employed at the time attended this course, and it provided relevant information that assisted HCWs in only recognizing mental health problems such as depression and instability. Following the training, those who participated were recognized as “MHFA Certified “ and were educated enough to recognize the characteristics of someone experiencing a mental health issue. The training was designed to be taught over six to eight hours, but the most recent and last activity was compromised and condensed to three hours. Although the material covered was essential, the training focused more on mental health sensitivity than an action response method for HCWs. The most significant aspect of the exercise was to erase the stigma associated with mental health, in a sense it was sensitivity training. The idea surrounding MHFA is well intended, but a peer and chaplain intervention would be ideal when attending to the HCW that requires immediate support. Rachel Richardson et al. identified problems with MHFA after a study had been conducted. She observed that there were adverse effects of bad advice and

inappropriate language in the study.[73] There appeared to be some residual imputation in trained HCWs, suggesting that MHFA was ineffective.

Peer Support

Peer support, in general, refers to the mutual exchange of emotional and practical support between people who identify as peers based on shared and similar experiences of mental distress and who can relate and provide the mutual support aid needed at a moment's notice.[74] The approach to peer support among HCWs can facilitate a community of reciprocity to provide support rather than seeking professional counseling. Some people, including healthcare professionals, will not enter counseling for the problems they currently present. Most people might conceptualize that counseling only manifests the issues with no real solution or means to an end. The research concludes that people generally require more trust in therapists and counselors. Some employees fear that utilizing the EAP (employee assistance program) for mental health concerns is tracked by their employers, which gives off fear for their careers.[75]

Employers may also refer employees to counseling for an observed on-the-job problem that warrants professional help. The issue is that employees may fear that the therapist or counselor will break confidentiality and provide personal information to human resources, leading to becoming a target for behavioral concerns.[76] This possibly may be why peer counseling/support is a trending method to facilitate a mental health crisis in healthcare facilities.

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[73] Rachel Richardson et al., "Mental Health First Aid as a Tool for Improving Mental Health and Well-Being," *The Cochrane Library* 9 2018, 4.

[74] Sarah White et al., "The Effectiveness of One-to-One Peer Support in Mental Health Services: A Systematic Review and Meta-Analysis," *BMC Psychiatry* 20, no. 1 December 2020: 534, https://doi.org/10.1186/s12888-020-02923-3.

[75] Sabine E. Hanisch et al., "The Effectiveness of Interventions Targeting the Stigma of Mental Illness at the Workplace: A Systematic Review," *BMC Psychiatry* 16, no. 1 December 2016: 1, https://doi.org/10.1186/s12888-015-0706-4.

[76] James Kinney, "Why Most Employee Assistance Programs Don't Work," 2022: n.d.

Peers can bear the burden of a coworker simply because they understand one another. Bearing one another's burdens has reciprocal benefits with peer support for HCWs. In most cases, HCWs in the same profession understand one another's emotions and thoughts, leading to trust built over time, especially in the healthcare field. Some concepts that outline the overall benefits of peer support have been developed. In almost any other profession within the healthcare field, showing support for one another has proven to be effective. Peer support actively assists a coworker, strengthens morale, and provides the comfort of being supported. Additionally, a coworker can carry all or some of the weight and keep a peer from falling or sinking in the wrong direction.[77]

A study by Laura Brady et al. identifies coworkers as a source of mental and emotional support, in fact one participant stated, "*I'd say my favorite part is probably my co-workers. There's very little to no ego; there's no competition.… the people I work with are very supportive and understanding*."[78] Peer-to-peer support can have a lasting trust and relationship-building factor in a trauma situation. This strengthens both the team and the effectiveness of their work. Healthcare professionals' efficacy relies on the emotional state that presents at any given moment. If there is a way to relieve the pressures of a crisis through peer support, the healthcare worker will be more effective in in-patient care. This researcher plans to build on the theory of peer support in this action research project. The importance of peer support relies heavily on the willingness and transparency of the healthcare worker.

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[77] Cindy-Lee Dennis, "Peer Support within a Health Care Context: A Concept Analysis," *International Journal of Nursing Studies* 40 2003: 323.

[78] Laura A. Brady et al., "Coping Strategies and Workplace Supports for Peers with Substance Use Disorders," *Substance Use & Misuse* 57, no. 12 October 15, 2022: 1775, https://doi.org/10.1080/10826084.2022.2112228.

Clinicians have found that workplace resources have yet to be utilized for various reasons. One of the concerns is personal confidentiality. Employee Assistance Programs (EAP) are available in most workplaces, but employees tend to reach out for pastoral/chaplain care or peer support. Employees find peers non-judgmental and central support in a crisis.[79] Henry Mayo Hospital has an EAP, but it is rarely utilized because employees need to discover that the program exists, and there is the trust factor that was explained earlier. Morris et al. assert that the program "Resilience in Stressful Events" (RISE) used at John Hopkins Hospital has shown success and improved staff emotions with peer-to-peer counsel.[80] This successful peer support program is an essential tool because of the non-judgment aspect that provides peace of mind in a crisis.

Stress Process

There are methods of utility to assist the HCW and alleviate stress within the acute hospital environment. Immediate care for the healthcare professional who is feeling overwhelmed and possibly suffering from a mental health crisis is vital. The MHFA curriculum teaches people how to direct someone to therapy or even a psychologist. Referrals for professional help are a short-term solution if the HCW uses the referral actively. The Stress Process Model, in theory, would provide a quicker response. There are three stress models. Understanding each will help with provisions and aptitude to render assistance. The three models are acute stress, episodic acute stress, and chronic stress. Recognizing which type of stress a healthcare professional may have will help with the required response. The outcomes of stress

[79] Debby Morris et al., "Collaborative Approach to Supporting Staff in a Mental Healthcare Setting: 'Always There' Peer Support Program," *Issues in Mental Health Nursing* 43, no. 1 January 2, 2022: 42, https://doi.org/10.1080/01612840.2021.1953651.

[80] Morris et al., "Collaborative Approach to Supporting Staff, 43.

are burnout, depression, or a combination of both. The Stress Process Model will likely help those with acute to chronic stress find relief. This targeted research model presents the data needed to discover where the stressors occur and what mediates those stressors. For example, a study by Nish et al. discovered that relationships could relieve some stressors. Moreover, anxiety and depression may require an intervention of increased significant therapy.[81] Suppose stressors are not evident or found in the HCW and go unaddressed. In that case, there is a likelihood that alternative methods of coping will develop, i.e., alcohol or drug abuse, neither can nor should become the solution.

In the acute hospital setting, a healthcare professional may have to provide prescribed narcotic medications to patients as a form of pain relief. Prompt and immediate care for patients in the emergency may require a nurse to provide a patient with schedule II pain relieving narcotics as requested by the physician. Scheduled drugs that are administered in hospitals are for patient therapeutic purposes, not with the intention of abuse by the patient or healthcare professional. The schedules are dictated by the DEA (Drug Enforcement Agency) and are listed employing the potential of abuse. Schedule I drugs have a high potential for abuse, and schedule II drugs have the next highest potential for abuse and can create severe psychological and physical dependence.[82] HCWs dealing with stress and anxiety may not know how to regulate feelings and might be tempted by the narcotics (schedule II) they provide patients with as a form of self-medication. Though some peers may have never had a problem with self-medicating, there is almost always someone in the department who empathizes.

[81] A. J. Nish et al., "Applying the Stress Process Model to Stress-Burnout and Stress-Depression Relationships in Biomedical Doctoral Students," *CBE Life Science Education* 18, no. 4 December 2019, 5.

[82] DEA, "Drug Scheduling," 2023, https://www.dea.gov/drug-information/drug-scheduling.

The manifestation of problematic abuse is an increasingly likely situation for the healthcare worker riding on the fact that stress can be elevated. The symptoms can go unseen by coworkers until mistakes or other behaviors become increasingly evident. Statistically, nurses do struggle with mental health issues and turn to substances for relief. Substance use disorder (SUD) is a real progressive and chronic disease that affects 8.4 percent of the U.S. population. Registered nurses are not immune to substance disorders, and if not treated, they can be fatal.[83] An empathetic peer who has gone through the battles of addictions can be the person to turn to for relatable and compassionate care in a chronic situation. Not all nurses will look to a coworker or peer for help due to fear of management being advised of the situation. A resounding 20% of practicing nurses have admitted to misusing or abusing narcotics in the U.S.[84] The compassionate and empathetic yet possibly addicted nurse may seek empathy from peers. Healthcare professionals should have a humanistic, empathetic trait embedded in them when making career decisions. Empathy toward patients is a general characteristic of healthcare professionals at almost every level. Peer-to-peer empathy is not always a given choice for HCWs in the acute care hospital. This action research project will utilize the ProQOL assessment and Questionnaire, and the data will be collected to analyze the HCWs' empathy level at Henry Mayo Hospital. This survey will be introduced to those participating at the beginning of the research. Empathy helps facilitate the healthcare professional's communication, as it also helps reduce conflict.[85]

Psychological First-Aid (PFA), not associated with MHFA, is a program utilized post-COVID-19 in healthcare settings that introduces the basics for the individual or coworker

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[83] "Substance Use Disorder and Mental Illness in Nursing," *California Board of Registered Nursing*, Intervention, November 2022, https://www.rn.ca.gov/intervention/impairedrn.shtml.

[84] T. Monroe and H. Kenaga, "Don't Ask Don't Tell: Substance Abuse and Addiction among Nurses," *Journal of Clinical Nurses* 3, no. 4 2011: 504–9, https://doi.org/10.1111/j.1365-2702.2010.03518.x.

[85] Q. Wan, L. Jiang, and X. Wu, "A Big-Five Personality Model-Based Study of Empathy Behaviors in Clinical Nurses," *Nurse Education in Practice* 38 2019: 67.

experiencing distress by showing empathy. The "Well-Being Buddy" assists the healthcare worker with their emotional state and provides an empathetic presence. They assist when the opportunity arises to speak to a "buddy" rather than management or a psychological professional. The study has shown positive results because of the care from a peer supporter.[86] This simulated program would be well-suited for employees in healthcare settings, although additional data would be required to facilitate a solid hypothesis.

Learning Models

Peer-to-peer support among healthcare staff can provide numerous benefits to the organization. The educational sequences in the in-class presentations will help HCWs understand the emotional state of individuals withstanding a mental health crisis. Once trained to recognize the problems, the HCWs will engage in mock demonstrations to better comprehend the necessary steps to evaluate and process mental health complications. The training for peer support will cover several vital functions, which include recognizing a mental health crisis, approaching a peer with care, providing overall support, and de-escalation if necessary. While de-escalation may not be required in every situation, it is essential to be prepared for such circumstances. Peer support involves empathizing with fellow HCWs and building solid relationships.

If one peer cannot relate, there is a possibility for a coworker who can understand the emotional crisis. Additionally, consistent follow-up is crucial for a successful intervention. Continuously pursuing compassion and care is essential for successfully intervening in a healthcare professional's crisis. Healthcare professionals attending to their peers may develop an intimate knowledge of the situation and immediately provide the needed intervention. Those

[86] H. Blake et al., "Covid-Well Study: Qualitative Evaluation of Supported Well-being Centers and Psychological First Aid for HCWs During the Covid-19 Pandemic," *Int J Environ Res Public Health* 18, no. 7 March 2021: 3.

HCWs who have been enduring mental health challenges and have had a successful intervention may eventually become mentors in the program, whereas reciprocity would be a successful product for this program. Relatable, empathetic reasoning comes from experience through personal trials and eventual triumphant victories. Again, they will be able to relate to other coworkers going through the same situation in a future event. This only benefits the staff, the department, the patients, and the organization. Individually and interpersonally, people who have benefited from peer support services and have gained experience in successfully managing their mental health condition are excellent candidates to become peer supporters.[87] HCWs, because they work long hours with one another, are prime candidates for becoming advocates for those who may be suffering in silence. Through consistent interrelations, HCWs become close and involved in one another's lives.

Methods of Intervention

The assimilation of the theoretical foundations was rendered previously. The methods for each intervention model will be detailed in this section of the chapter. Depending on the situation facing the individual healthcare worker, there are dissimilar opportune ways to provide peer support in which ways this project will outline the methods used. Only some problems a HCW faces will have a solution or subsequent quick fix. Many HCWs will benefit from the intervention alone. Others may require additional psychological care. Those who work in stressful environments are susceptible to taxing dilemmas that come with the territory. A 2018 American Psychological Association article claims that when work stress becomes chronic, there

[87] Megan Evans, *Peer Support Services Reaching People with Schizophrenia: Considerations for Research and Practice* (Cham: Springer, 2023), 39.

is an overwhelming effect that is harmful to both physical health and mental health.[88] Stress, or traumatic stress disorder, can be debilitating and weigh down the emotional euthymia for many people. Within the complex definition, the solutions for this project will use models that cover more than one mental health crisis. Exasperated stress is more complex than everyday stress and can overtake a healthcare professional physically, emotionally, and mentally. There are methods, in theory, that will help pacify the healthcare professional in the current situation. Complex stressors are those events that produce negative, growth-stunting, and damaging effects. These stressors are events, experiences, and exposures that exceed the individual's capacity to control, cope, or withstand and that compromise the individual's stasis.[89]

From a hospital chaplain's perspective, different intervention models have not been thoroughly introduced to medical professionals. One model that will be introduced to the participants of this study is Cognitive Behavioral Therapy (CBT). The Mayo Clinic defines CBT as a common type of therapy structured for people suffering from mental health disorders such as depression and PTSD.[90] CBT promotes improvement in depression, anxiety, PTSD, substance abuse disorders, and sleep deprivation disorders. There are elements of assessment, the causes of emotions, bodily responses, facial expressions, thoughts, and interpretations. Each participant will learn how to approach and ask pertinent questions, leading to a summative understanding of the situation in that intervention.[91] CBT will cover a wide range of emotions that the healthcare

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[88] "Coping with Stress at Work," *American Psychological Association*, October 2018: 1, https://www.apa.org/topics/healthy-workplaces/work-stress.

[89] Julian D. Ford and Christine A. Courtois, eds., *Treating Complex Traumatic Stress Disorders in Adults: Scientific Foundations and Therapeutic Models*, Second edition (New York: The Guilford Press, 2020), 4.

[90] Scott C. Litin, Sanjeev Nanda, and Mayo Clinic, eds., *Mayo Clinic Family Health Book*, Fifth edition (Rochester, MN: Mayo Clinic, 2018), 978.

[91] Lawrence Howells, *Understanding Your 7 Emotions: CBT for Everyday Emotions and Common Mental Health Problems* (London: Routledge, Taylor & Francis Group, 2022), 12.

worker might present. This study section will instruct the fundamentals of the human emotions associated with HCWs and how to apply the learned material to an immediate intervention.

Compassion Fatigue and Burnout

Burnout (BO) has increasingly become the No. 1 reason nurses leave the healthcare profession altogether. It appears that nursing unions have not been supportive of the mental health welfare for their associates either. Stanford Hospital at Stanford University, a top-ranked hospital, has experienced high turnover rates, understaffing, and high burnout rates. There, 45% of nurses have admitted that they plan to leave the profession in the next five years.[92] With the lack of empathetic support for the healthcare staff and nurses leaving the profession, it is a matter of time before a shortage, more so than what is seen now, will be unavoidable. Emotional support is vital. Again, at Stanford University Hospital in 2022, a nurse who was contracted with the acute care hospital left one day and killed herself, highlighting the need for better mental health and wellness support services.[93] It is necessary to provide a clear distinction between compassion fatigue and burnout. Both have implicating factors that are detrimental to the HCW but are essentially differences. CF can be understood as a healthcare practitioner's diminished capacity to care as a consequence of repeated exposure to the suffering of patients and from the knowledge of their patient's traumatic experiences.[94] The action of compassionate care is at the soul of the medical professional in primary patient care. Charles R. Figley has studied compassion fatigue (CF) in many other professions. Figley clearly states that the act of

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[92] Michael Sainato, "Burnt Out and Tired: Nurses at Leading Hospitals Prepare to Strike," *The Guardian*, April 13, 2022: 22.

[93] Ibid., 23.

[94] Cavanagh, Nicola, Grayson Cockett, Christina Heinrich, Lauren Doig, Kirsten Fiest, Juliet R Guichon, Stacey Page, Ian Mitchell, and Christopher James Doig, "Compassion Fatigue in Healthcare Providers: A Systematic Review and Meta-Analysis." *Nursing Ethics* 27, no. 3 May 2020: 648, https://doi.org/10.1177/0969733019889400.

compassion is to bear suffering.[95] CF can lead to PTSD, which will be addressed and intertwined with the other methods for crisis interventions. This research project will encompass a range of assessments aimed at CF. However, the Pro-QOL assessment will address the opposite of CF, compassion satisfaction.

CS is defined by the amount of pleasure derived from helping others that correlate with positive resilience. A HCW can experience both CF and CS at the same time, but with an increased CF, CS will decrease leading to the possibility of BO.[96] Although burnout syndrome is widely ambiguous, it can be characterized by three components: emotional exhaustion, depersonalization, and a low sense of personal accomplishment at work. Many problems healthcare professionals face stem from compassion fatigue and burnout, such as losing the ability to empathize and care for patients. The multifactorial origin and the vagueness and subjectivity of the burnout diagnosis criteria make it difficult to get a concise prevalence in the general population.[97] Within the healthcare realm, there appears to be a prominent self-diagnosis for "being burned out" on the job, but it will hardly be spoken aloud to peers. Coworkers would be the first to recognize if a peer is experiencing burnout, and through training, they will have the skills to approach and initiate an intervention. There are ways to approach a coworker experiencing CF or burnout, along with different methods of assisting. The following methods will ensure that a direct intervention will provide the support HCWs need to overcome CF or burnout.

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[95] Charles R. Figley, "Compassion Fatigue: Psychotherapists' Chronic Lack of Self Care," *Journal of Clinical Psychology* 58, no. 11 November 2002: 1434, https://doi.org/10.1002/jclp.10090.

[96] Mikaela Dehlin and Lars-Gunnar Lundh, "Compassion Fatigue and Compassion Satisfaction among Psychologists: Can Supervision and a Reflective Stance Be of Help?," *Journal for Person-Oriented Research*, December 27, 2018: 97, https://doi.org/10.17505/jpor.2018.09.

[97] Stefan De Hert, "Burnout in HCWs: Prevalence, Impact and Preventative Strategies," *Local and Regional Anesthesia* Volume 13 October 2020: 172, https://doi.org/10.2147/LRA.S240564.

Talk Therapy and CBT

Cognitive-behavioral therapy (CBT) aims to reduce the severity of problematic cognitive disorders. The use of CBT for anxiety and depression focuses on changing the thought patterns of an individual by applying a set of techniques.[98] It must be clear that this study is not intended to address the long-term needs of anyone who has PTSD, manic depression, or generalized anxiety disorder (GAD). In the interim, talk therapy can help the healthcare professional with an immediate prevalent situation. PTSD is known as trauma stored in the body and brain, and immediate intervention is critical for a healthcare professional suffering from a sudden traumatic stress episode. This intervention will use CBT to help the individual challenged with intense emotions. CBT is taught through four primary skills:

1. Mindfulness: Learning how to be present in the moment.
2. Emotional Regulation: Gaining an understanding and bringing awareness to the situation for emotional control.
3. Distress Tolerance: Understanding and managing emotions in difficult and stressful situations without engaging in self-harm or negative responses.
4. Interpersonal Effectiveness: Learning to ask for what one wants or needs and setting appropriate boundaries.

Empathetic Listening Model

Compassion fatigue interventions are derived chiefly from talking points, which can start with listening carefully. The central focus for attending to the HCW who exhibits CF is self-care, self-compassion, setting boundaries and limits, and assertive communication. The best-suited model for helping and assisting the HCW suffering from CF is the empathetic listening model. Empathetic listening is the most effective listening technique for understanding a person's

[98] Behrooz Afshari et al., "Study of the Effects of Cognitive Behavioral Therapy Versus Dialectical Behavior Therapy on Executive Function and Reduction of Symptoms in Generalized Anxiety Disorder," *Trends in Psychiatry and Psychotherapy*, 2022: 18, https://doi.org/10.47626/2237-6089-2020-0156.

behavior, emotions, and motives.[99] Collectively, this model has been proven effective for people who are debilitated by compassion fatigue. In addition to the following techniques for CF, it is necessary to encourage the HCW to become intentional with self-care such as getting enough sleep, eating well, relaxation and exercise. The following immediate talking points will provide the care the HCW requires:

1. Acknowledge the HCW's courage in facing CF. Thank the HCW for its transparency in this situation, and express gratitude for the trust he or she has placed in you.
2. During the conversation, focus on what the HCW is saying. Be interested without interjecting unnecessary talking points. Repeat what they have spoken; this shows that one is listening actively.
3. Character-boosting: Encourage the HCWs to talk about their feelings. Strengthen the HCWs' characters, never minimizing what they say.
4. Convey care about the HCW: Reassurance is essential. Let the HCW know that you care and are present for them. This will likely lead to a follow-up conversation that must be taken seriously and attended to immediately, even over the phone.
5. Check-in regularly: A simple phone call or in-person check-in is valuable to the intervention's long-term results. Texting is impersonal and should be avoided.

Exposure Therapy

Exposure therapy has a proven track record of effectiveness in certain situations for those exhibiting PTSD symptoms. Although it primarily assists people suffering from phobias, panic disorders, and social anxiety disorders, it has been an effective mechanism to help those suffering from generalized anxiety as well as PTSD. It is notable to mention that exposure therapy requires proper procedures for the interventions with the HCW. Although there are several approaches for exposure therapy, one specific exposure therapy model, Vivo Exposure, should not be utilized as a method for this study. It involves direct exposure to the feared

[99] Pareto Labs, "How to Implement Empathic Listening to Engage Your Team," October 7, 2021.

stimulus and should only be used by professionally trained therapists. Moreover, this study will proceed with the exposure therapy intervention necessary for the HCW.

The process of exposure therapy that will be utilized is often referred to as the ladder method, meaning various small steps will be taken to resolve the situation. Imaginal or image exposure involves recalling the feared image or situation that had brought acute anxiety to the HCW.[100] An additional method is to advise the HCW to draw the image or write the situation that caused the traumatic experience. At this point, the HCW will verbally describe the event that triggered anxiety. Looking at the picture or repeating what caused the anxiety will bring awareness to the HCW. From this point, the interventionalist will ask the peer to look away from the picture and then look at it again. This will be repeated until the level of anxiety begins to diminish. A hospital chaplain teaching the intervention can guide the interventionalist to the chapel or resilience room to become familiar with a peaceful place to meditate and pray. As a disclaimer, this is for situational anxiety, not long-term trauma that was induced years or decades prior.

Somatic Therapy

Somatic therapy can be a valuable tool to help HCWs who are experiencing PTSD, grief, depression, anxiety, trust issues, and self-esteem problems. The emphasis of the interventions in this section will be on depression, PTSD, and anxiety. This situational intervention is designed explicitly for HCWs and targets the emotions that affect their body. Disturbing feelings that may have a debilitating impact on the body can be reduced, and the physiological guise can be transformed. Somatic therapy aims to alleviate the power of these emotions, thereby relieving

[100] American Psychological Association, "What Is Exposure Therapy?" Div.12 Society of Clinical Psychology, 2017, https://www.apa.org/ptsd-guideline/patients-and-families/exposure-therapy.

pain and other symptoms of stress, such as sleep deprivation or inability to concentrate.[101] The following steps will guide the HCW through the intervention.

1. The HCW will take a deep breath and exhale, then take notice of their composure, such as muscle tension and heart rate.
2. The interventionalist will ask the HCW to reflect on the last moment they felt calm and safe.
3. The HCW will reflect and identify when their body began to experience stress.
4. Through reflective imagery, the HCW will replay the moments from a calm state to a triggered stressed state. The HCW will identify people, conversations, and behaviors that may have triggered the stress. The HCW will verbalize each moment, and the interventionalist will take note of the events.
5. The body sensations will provide some understanding of the events that brought on the acute stress or depression. The HCW will tune into their body and take notice of any sensations of tingling, warming, tension, and body temperature that might be felt.
6. The healing will come through placing hands on the area that feels the most tension. The HCW can place their hands mid-chest if it is the whole body. The HCW will take deep breaths and exhale, noticing if the images or sensation becomes evident again. The HCW will continue breathing in and out until their mind is clear of negative sensations or images. This intervention will guide the HCW to a state of peace.

Chaplain Observations

Being a hospital chaplain for roughly five years, the researcher has had numerous opportunities to minister to healthcare staff during and after a traumatic or stressful situation. The first of many was a janitor (not healthcare but still an employee and human) who cleaned the blood off the emergency room floor that belonged to a fifteen-year-old who was the victim of a shooting at a local high school. The janitor had tears as he cleaned, yet nobody approached him while he was grieving the loss of a child. Later, it was found that he had taken personal time off. The opportunity to minister had been lost. A peer response would have helped if it had been done immediately rather than allowing this man to suffer the loss of someone he had not known.

[101] Maureen Salamon, "What Is Somatic Therapy?" *Harvard Health Publishing Harvard Medical School*, July 7, 2023.

Theoretically, this employee may have found solace or peace if a chaplain-initiated active intervention was available.

The intensive care unit achieves everything possible with the science learned and the medications available to keep patients alive. Unfortunately, the ICU staff cope with death weekly, if not daily. Nurses will verbalize that death is a part of the job. They knew this when they signed on as a critical care practitioner. Patients in the intensive care unit can range in age from eighteen to one hundred with conditions that are acute to terminal. When a father/husband died unexpectedly from a traumatic episode, the family was devastated and heartbroken. One of the nurses, who will be called Joan, had become personal with the patient and family in the consciousness that she was emotionally attached. When the patient had taken his final breath, Joan ran out of the patient's room in visible tears and into the staff breakroom. An intervention response would have helped when Joan became distraught because her patient had just died. Joan was not religious, and although the chaplain checked on her, he could not empathize with her emotions, but a coworker/peer would have. The assimilation of Chapter 2 will end with a brief conclusive overview of what was presented in this last section.

Conclusion

The problem at HMH is that its mental health awareness training failed to address how staff engages with peers suffering from mental health problems. Reducing conflict helps with relationships, and building on the trust of relationships will provide a safe place to confide in a coworker. This action research project aims to create a peer-to-peer resolution to work-related anxiety, fear, compassion fatigue, burnout, and depression. If the models utilized in the research prove accurate, the program is established as successful. MHFA provides the foundation for helping HCWs suffering from depression, anxiety, fear, alcoholism, and addictions. This DMIN action project aims to design and implement the Action Crisis Intervention Response (ACIR) and

will determine the levels of need among the staff at Henry Mayo Hospital so there is a working intervention. HCWs understand that they may have to deal with trauma and death. The responsive outcome to this emotional trauma is different. As discussed in the literature review, nurses and healthcare professionals are not taught how to deal with trauma and death, and interventions are often required but not consistently implemented. Supporting HCWs is necessary to prevent depression, anxiety, fear, or compassion fatigue.

The healthcare team must receive a quick and decisive response when a peer is suffering from a mental health crisis. The well-being of the staff should be at the forefront of concern for every department in the hospital. Therefore, peer counseling and chaplain-led spiritual care can help prevent a mental health crisis among staff. Educating the healthcare team in stress management, working through the emotions of death and trauma, the effects of compassion fatigue, and how to support HCWs have been discussed. Through the models described and the steps provided, fellow HCWs can be equipped with effective peer-to-peer interventions. The Action Crisis Intervention Response is absolutely essential for raising awareness and taking immediate action when a healthcare team member at Henry Mayo Hospital faces a mental health crisis. The upcoming chapter will present the methodology for this crucial action crisis intervention project.

CHAPTER 3: METHODOLOGY

Intervention Design

This section addresses the methodology for the DMIN. action research project, with the purpose of providing a strategy and rationale for the problem stated in Chapter 1. For this project to succeed, the full scale of each assessment, interview, and training must be methodical and well-delivered. At Henry Mayo Hospital, the mental health awareness training had not addressed how staff should engage with peers who suffer from mental health problems. HCWs have been under much stress and anxiety due to the post-COVID era, resulting in burnout and compassion fatigue. Although there have been programs that address issues faced by the medical team, little has been done to address how to take immediate action to relieve the symptoms of a mental health crisis.

To confront the problem, the researcher introduces the Action Crisis Intervention Response (ACIR) with a phased approach. The intervention will focus on crucial assessment capacities such as depression, anxiety, fear, compassion fatigue, and burnout. The researcher will provide in-class instruction to help participants comprehend, evaluate, and offer peer-to-peer support. To provide empathetic training, the researcher will render several assessments and surveys to assess the overall mental health of the participants. It is significant to note that the mental health state of the healthcare team is directly proportional to the quality of care a patient receives at Henry Mayo Hospital and any acute care institution. This intervention will, therefore, focus on factors such as clear thinking and emotional stability. The researcher will provide a detailed explanation of the intervention’s design below.

This study framework is designed to last for eight weeks and is intended for the healthcare professionals at Henry Mayo Hospital. Upon receiving the approval necessary from the Liberty University IRB, a schedule of in-person classes will be designed. The management at HMH has generously provided classroom space for the researcher to conduct the study, and a reasonable approval letter was obtained from the senior vice president of human resources at HMH and included in the IRB approval process. The participants who wish to subsidize the ACIR will receive an email invitation that clearly outlines the scope of the research and the low risks involved. If a participant accepts the invitation, they will subsequently be contacted via email with specific details regarding the time and location of the study. Furthermore, each participant who concurs with the invitation and is an ideal candidate will receive a packet of relevant information separately.

The ideal participants will be HCWs at Henry Mayo Hospital and have been working regularly for at least five years in the ICU, ER, NICU, or labor and delivery (L&D) departments. These specific departments were chosen because HCWs in these sectors are more likely to have been exposed to stress, anxiety, fear, and death, making it more likely that they have experienced a mental health crisis themselves or have seen a colleague go through one. This is not to minimize the HCWs in less stressful departments but to evaluate and teach HCWs who have been highly exposed to the stressors. As part of the study, all participants must sign and date the consent form (see Appendix A). The form provides detailed information about the research and determines whether the participant will be eligible to participate. Once the consent form is signed, it should be returned to the researcher via email or DocuSign. The initial response will determine the exact number of participants. A minimum of ten participants is hopeful, but twelve to fifteen would be ideal. The researcher will compile a list of all participants' phone numbers and email addresses, which will be kept confidential on a password-protected computer.

Interviews

Once the interview date and time have been established and agreed upon with each participant, the dialogues will occur in a public setting such as a coffee shop and may take 30 minutes to an hour to complete. If, in the event, a participant cannot meet in person, an alternative method, such as Zoom or via phone call, will be used. During the interviews, the researcher will use an iPhone voice recorder for audio recording and manual documentation on paper to take quick notes. The voice recorder will be used to play back the interview in case something is missed, while the manual documentation on paper will serve as a backup in case the voice recorder fails.

The researcher will ensure that confidentiality and protection of personal information will be mandated by using a two-fold method to record the interview. The interview will consist of twelve open-ended questions, which can be found in Appendix F. Although not all participants can answer every question, they should be able to partially engage with each question after meeting the qualifications. The questions are designed to initiate a conversation about the mental health state of each participant. A participant's time in healthcare is crucial. The experienced HCW will likely provide deeper insight with appropriate end results. The pre-questions in the consent will verify the validity of their occupational tenure. Hospital healthcare professionals should have a valid healthcare license for their designated profession. For instance, registered nurses must renew their licenses every two years, while physicians must maintain and renew their medical licenses in the state where they are employed. Additionally, HCWs in specific departments (such as ICU, ER, and NICU) must undergo some specialized training that is vital to the specific occupation in addition to holding a license. For example, a HCW in behavioral health unit will have human behavior or psychology training.

In contrast, a nurse in the ICU will be identified as a critical care provider. The participants may have to recall and relive through some of the other questions in the interview. Asking the participants if they have witnessed a patient die is critical, but this might stir up old emotions. Additionally, the question is asked how they felt when a patient died becomes personal, which they may not answer if it brings discomfort in the recall. A participant may be dismissed from this study if the questions cannot be answered thoroughly. Seemingly more complex questions require the participant to become transparent. Several questions will require the participant to remember if they had a mental health crisis, such as depression or anxiety, or were subjected to burnout.

After conducting one-on-one interviews and collecting data, this action research project will move on to in-class teaching sessions. The annex training rooms provided by HMH will be used for this eight-week study. The researcher will coordinate with the participants to pick a date that works for everyone. A series of prompts from the interview questions will ignite the conversation, with the aim being to foster the sharing of experiences of anxiety, fear, and depression and discuss burnout. The importance of peer-to-peer interventions will also be discussed during the group meeting, which is expected to last approximately sixty minutes.

Assessments

Before the in-class meeting, each participant will receive several assessments via email, with the first questionnaire, "Burnout, Compassion Fatigue, and Vicarious Trauma," included in Appendix C and consisting of twenty-one questions. Participants will use this assessment to measure their burnout, compassion fatigue, and vicarious trauma. The assessment results will categorize the participants as low, moderate, high, or extremely high. After completing the assessment, participants will provide their results to the researcher, who will compile and analyze the data for the project.

The Chaplain's Role

In this study, hospital chaplains will play an important role in facilitating an intervention program once full IRB approval has been obtained. After an assessment, the researcher and chaplains will schedule each participant to meditate and pray in the chapel at Henry Mayo Hospital, one of the two designated resilience rooms. The chaplains and researcher will schedule a block of thirty minutes, ensuring that nobody else uses the chapel during the meditation time. Participants will be asked to score their peace level before and after the meditation on a scale of one to ten, with one being not at all at peace and ten being entirely at peace. The researcher and chaplain will record these scores. Then, the researcher will guide the participant through a guided meditation during meditation while the chaplain leads a prayer afterward. This exercise aims to create awareness in participants about the resilience space.

Emotional I.Q.

Participants will be asked to take an emotional I.Q. test as part of the study, which will help them recognize certain behaviors and attitudes. The test will be provided after the meditation session during week two of the study. This test consists of fifteen questions that assess the participant's ability to perceive, identify, understand, and manage emotions. The answers will be categorized as "always, usually, sometimes, and rarely" and scored according to SMART components: S for self-awareness, M for managing emotions, A for activation, R for relating to empathy, and T for teaming with others. Once completed, participants will deliver the results to the researcher, who will use the data to measure their emotional intelligence.

Pro-QOL Assessment

At the end of the eight-week study, the researcher will ask the participants to provide feedback on how journaling may or may not have helped them. The final assessments will be

conducted during the last week of the study. To assess the participants' professional quality of life, the "Professional Quality of Life" (ProQOL) assessment will be made available online with a provided QR code or the use of the PDF provided (refer to Appendix E). This assessment determines if someone has experienced the negative or positive effects of working with people who have suffered from traumatic stress disorder. In addition, it measures compassion satisfaction and burnout. Participants must scan the QR code and scroll down to the bottom of the page to begin the assessment. Once completed, the results will be emailed to the researcher. Participants can delete their assessment from the website's database by checking a box after submitting their results. The researcher will then collect the data for the action research project.

Location

The study will be conducted at Henry Mayo Hospital's education annex building in the City of Santa Clarita in Northern Los Angeles County. Participants will have come from one of several departments selected by the researcher. The study will span over eight weeks, with one week dedicated to conducting interviews in the community. Most of the study will occur in the annex classrooms, following the initial interview conducted in an outdoor café or coffee house.

Participants

The study targets HCWs at HMH, including nurses, doctors, technicians, laboratory technicians, and scientists. While some HCWs may not witness death or traumatic events, the researcher focuses on those who have experienced such incidents. Emergency room nurses consistently encounter trauma and death, ICU staff members form connections with patients and their families during long admissions and labor and delivery, as well as NICU staff, face traumatic situations such as the loss of a baby or an infant's death.

Participants are expected to be willing to share their testimonies with others while maintaining confidentiality. The schedule for participation is flexible, with options for both day and night shifts as the participants attend an eight-week study at Henry Mayo in the annex/education building. Each class will last one hour, and various means will be used to administer each lesson, such as using media, scenarios, role play, and PowerPoint presentations. Each week will present a specific lesson on a different topic that will be covered. Refer to Appendix G for more information.

A step-by-step intervention guide that takes the participant through the "approach, assist, assess, provide, and action" (AAAPA) is provided. Topics to be covered include traumatic stress disorder (week one), suffering and grief (week two), anxiety (week three), depression (week four), burnout (week five), compassion fatigue (week six), mental health and the healthcare worker (week seven), and a recap and debrief (week eight). As part of the course, each student is required to maintain a weekly journal reflecting on the lesson covered during that week. The journal subtopics will be like the topics covered in class. Through the course, participants will learn about the definition of each topic, how to identify what the topic entails, the associated risk factors, how to assess HCWs, and finally, how to approach and support them. At the end of each class, a group discussion will recap what was covered and the key takeaways.

Throughout the program, participants will learn about compassion fatigue, a state of emotional exhaustion that can lead to a lack of patient care, an essential topic for this research. As part of this class, an assessment will be conducted to evaluate the participants' compassion fatigue scale. Week seven will cover a broad topic of mental health in HCWs; each topic will train participants to not only recognize a mental health crisis but also act on it immediately. To summarize the program, week eight will entail a Q&A and debrief. During this week,

participants will be able to engage with one another by role-playing and discussing the communicated scenarios.

Week One: Introduction/ Traumatic Stress Disorder

During the first of the eight-week program, the participants will review the questionnaires and documents they have previously filled out. The privacy of each participant is highly valued, and they have complete freedom to decide whether they want to share their results. The program will be introduced to the class, including the reason for the study, what healthcare professionals hope to gain, and the program's benefits. Before the start of the first class, every participant will be asked to bring a journal. The instructor will explain how to use the journal and what to document during the eight-week program. The journal aims to record any challenges HCWs face during the eight-week program. In addition, each participant will receive a syllabus outlining the entire eight-week study. Participants will also be presented with a thorough explanation of each week and the class timeline. In addition, the participants will receive any relevant documents ahead of time, such as statistics and scholarly journals describing mental health crises in healthcare professionals. While the participants do not need to read all the material, it is essential to acknowledge the prevalence of mental health problems among healthcare professionals.

During week one of the course, the researcher will cover five points that detail each intervention model. The first point focuses on recognizing healthcare problems among peers in the workforce, a synopsis of what was covered in MHFA. Participants will be shown images and video clips as examples of what someone in crisis looks like, including their facial expressions, body language, and verbalization during conversations. The second point involves approaching HCWs who may be showing signs of crisis, and they will learn the proper and safe way to approach a peer or coworker to ensure that the approach is feasible. Mock scenarios will be

included in week eight to practice these skills. The third point concerns assisting the peer to a safe place where the intervention begins. After assisting the peer, the fourth point involves assessing the appropriate action. Lastly, participants will learn how to support their peers through videos, images, and demonstrations.

Week Two: Grief Suffering

Entering week two of the Action Crisis Intervention Response program, implementation will begin by taking careful and practical steps. In this phase, various topics will be covered related to traumatic stress and grief and teach techniques for dealing with them. Traumatic experiences can often lead to stress, grief, and suffering, and there will be a focus on methods for addressing them. The participants will use talk therapy as the primary intervention method for the first week. The class will cover various symptoms that can arise in healthcare professionals every week, with the opportunity for participants to share similar stories they have encountered. In clinical practice, talk therapy is primarily used to treat PTSD, stress, and grief. The class will begin with attendance being taken, followed by an introduction to stress and grief recognition, then the researcher will present a video demonstrating the symptoms and how to use the AAAPA method for intervention.

The class will be introduced to talk therapy by following a video and methodically instructing the AAAPA model for intervention. The effectiveness of talk therapy and its methods will be tested through mock scenario training. Participants will work in pairs. One participant will be given a prompt to act as either depressed or experiencing feelings of grief. Partners will then engage and practice talk therapy techniques on one another. After the training, the class can ask questions or raise concerns regarding the scenario training. At this point, the researcher will make notes of the concerns the class may present, and the sixty-minute class will conclude with participants making a journal entry about the class.

Week Three: Anxiety

In week three of the Action Crisis Intervention Response, the class will discuss anxiety in healthcare professionals. Anxiety can quickly overwhelm a healthcare professional, so it is essential to recognize the symptoms and take appropriate action. Anxiety can be debilitating and can hamper decision-making abilities. The peers of a coworker suffering from anxiety would likely recognize these symptoms displayed. The class session will focus on anxiety symptoms, recognition, and intervention techniques to help healthcare professionals cope with anxiety. The class will start with attendance taking, followed by discussions about the previous week's topic in an open forum. After the discussion, the researcher will introduce the topic of anxiety. Since healthcare professionals are likely familiar with anxiety, the researcher will use two instructional methods: the exposure model for the intervention, and exercises from the book *Anxiety: Finding Comfort and Reassurance from God.*[1] The class will begin with the exposure therapy model, and the exercises from the book will also be fully utilized during the class. A video demonstrating the recognition of anxiety will be introduced to the class. Additionally, the video will show how exposure therapy can be effective. The efficacy of exposure therapy and the book exercises will ensure that the class is prepared well. Participants will get into pairs of two. One will be given a blank card to draw something that has caused or can cause anxiety. The coupled pairs will walk through the prompted exercises as instructed to understand how drawing a picture can bring peace to the situation.

In the upcoming session, the participants will read small portions of the book mentioned previously. The researcher will ask, "Why are you anxious?" The class will discuss a few questions. One of the questions will be about the positive and negative ways anxiety has been

[1] Skip McDonald, *Anxiety: Finding Comfort and Reassurance from God: 8 Studies for Individuals or Groups*, LifeGuide Bible Studies (Downers Grove, Illinois: IVP, an imprint of InterVarsity Press, 2020), 9.

handled, and a group discussion will follow. After this discussion, the participants will write a personal reflection on the prompt, “When was your most recent time of anxiety? How did it affect you, and what did you do about it?” The researcher will collect the personal reflection for the study and used for statistical purposes. The last part of the class will focus on the importance of meditation, which can aid in reducing stress and anxiety. The participants will be guided through exercises using the exposure model. Participants will start by breathing in and out and picturing the one thing that brings anxiety until it slowly becomes less prevalent and no longer causes anxiety. The participants will then journal their thoughts before being dismissed from the session.

Week Four: Depression

Depression can and does affect HCWs. Even though they may not be aware of it, their peers will likely notice a behavior change. Week four is focused solely on how participants can help a peer who is suffering from depression. This technique or intervention is not aimed to replace long-term care for chronic depression but to aid in situational depression, such as a patient dying. Somatic therapy is used to aid in an overload of stress that consequentially brings on depression. During the first part of week four, attendance will be taken, and any questions from the previous weeks will be answered. Thereafter, the researcher will introduce the signs and symptoms of acute depressive disorder, also known as sudden-onset depression. The researcher will use videos and images of depression in a healthcare professional to help participants recognize signs of depression. This will enable HCWs to quickly identify and help alleviate the problem’s symptoms. Participants will engage in somatic therapy and mindfulness, similar to meditation. This in-class session will be primarily video-based to save time and ensure a better

understanding of the techniques. The video will provide not only techniques but also practical ways to help peers who are feeling depressed.

After the video, the researcher will answer any questions before participants journal their thoughts on the effectiveness of somatic therapy. The session will conclude with a visit to the hospital chapel to ensure participants know the location and resources available. Resilience spaces like the chapel are ideal for somatic therapy as they are quiet and conducive to the practice.

Week Five: Burnout

In the upcoming fifth week of the ACIR program, participants will receive comprehensive instruction on assisting peers experiencing burnout. The program will employ a combination of talk therapy and empathetic listening models, enabling participants to discuss the issue and learn to better listen to and understand their peers. To begin, attendance will be taken at the beginning of the class, and the students will be allowed to ask questions or provide feedback. Next, the class will discuss a prompt that asks, “Have you ever experienced burnout at work?” This discussion is intended to raise awareness about burnout and reveal how many HCWs experience burnout. The discussion should last no more than fifteen minutes before moving on to the exercises for week five. Talk therapy was utilized during week two, and the same methods will be applied to this session. A review of talk therapy will be presented before introducing the empathetic model, which will be used again in week six. A video covering the signs and symptoms of burnout will be presented to provide the participants with a better understanding of burnout. Following the video, the researcher will provide facts about burnout in healthcare professionals to give the group a foundation of information before the strategic simulations occur.

During the activity, the participants will be divided into pairs and given a card with a prompt about burnout symptoms. One person will act out the symptoms while the other listens empathetically. The listening participant will also guide their partner through questions based on the empathetic model.

- Resist the urge to speak and respond to someone while they are speaking. This sends a message there is more interested in listening to the other person's words. Also, it is wise to know and listen to the entire conversation to jump to conclusions.
- Analyze what is being said and respond accordingly. If what others say is ignored, one cannot respond appropriately. Therefore, listening and understanding others is a must to enable effective communication. This allows clear assessment of the situation and suitable advice to be given.
- Lastly, paraphrase what the other person said and respond accordingly and with some empathy. Take the discussion forward by listening to what the person has to say. It would be best to catch the non-verbal cues.[2] The more someone talks, the better they feel supported. The HCW will have felt heard, hopefully relieving the symptoms of burnout. If they persist, the HCW might realize their potential in other departments.

After this week, the participants will journal their thoughts on the above exercise. They should also have time to ask questions about burnout in healthcare professionals. Once any questions are answered, the class will wrap up for that week.

Week Six: Compassion Fatigue

During week six of the Action Crisis Intervention Response program, participants will learn about compassion fatigue, a commonly encountered condition. Compassion fatigue has similar symptoms to burnout, where individuals feel a lack of passion and caring towards others or themselves. Hence, the exercises will be used interchangeably in week six of the program. Attendance will be taken at the beginning of the class, followed by addressing any questions

[2] Stephen R. Covey, *The 7 Habits of Highly Effective People: Powerful Lessons in Personal Change*, Revised and updated (Simon & Schuster edition New York: Simon & Schuster, 2020).

from the prior weeks. The class will start with videos demonstrating the importance of compassion and the symptoms of compassion fatigue in healthcare professionals.

Participants will engage in scenarios like those in previous weeks in week six lessons. Each participant will pair off and receive a prompt related to compassion fatigue. The prompt will present a scenario where a peer feels powerless, without concern, and helpless while attending to a suffering patient, and participants will discuss and act on the prompt as they see fit. Afterward, they will collectively discuss how they would typically approach the situation if it were to happen in their perspective units. Additionally, they will receive instruction on using talk therapy and empathetic listening to handle the situation, and the differences in approach will be thoroughly discussed. At the end of the class, participants will be given time to journal their thoughts on compassion fatigue. The class discussion will continue for the remaining time, as the researcher assigns the only homework task in the action research project, which involves each participant being watchful for signs of compassion fatigue in peers they work with and taking notes. These notes will be used to facilitate a discussion during the next class.

Week Seven: A Compilation and Mock Scenarios

Healthcare professionals face a significant challenge in dealing with mental health crises due to a lack of information on how to approach, assess, and engage with them. In week seven of the ACIR program, participants can practice their approach in specific scenarios. The Mental Health First Aid program, which was previously introduced to medical staff at HMH, needs to provide more education on engaging HCWs during a crisis, and the ACIR program aims to address this issue.

Upon arrival in the class, attendance will be taken, and participants can ask any questions they have from the previous weeks and discuss the findings from the previous class on

compassion fatigue. Week seven of the program aims to consolidate most of the learned material and provide mock scenarios to solidify training. Participants should feel better equipped to be interventionalists after this session. Once the participants break off into teams of two, they will be given scenarios. After each scenario, they will engage with a different classmate in the alternate scenario. There are two practice scenarios for the participants. The first scenario revolves around traumatic stress disorder. In this scenario, participants are asked to handle a situation where a coworker has just been a part of a trauma in the emergency room. The patient died from gunshots sustained from a drive-by shooting, and their coworker seems confused and stressed. How should the participant approach this situation, and with what technique? The mock session for this scenario will last no more than fifteen minutes.

The second scenario involves grief in observing one of the participant's peers who has not been very talkative since starting her shift, which is not commonplace for her. She continuously wipes tears from her eyes before seeing her patients, and the patients are complaining about not getting the care they need. A coworker advises the role-playing participant that this coworker's mother just passed away. The participants are asked to approach and engage with this coworker in this scenario. How to do this, and with what method? This mock session will last no more than fifteen minutes. The third and last scenario for week seven involves depression. The role play will have worked with a peer for over two years and have reasonably developed a relationship with this peer. She comes to work late and seems to not care about much of what is happening in the department. Your coworker goes to lunch alone and does not speak to anyone. How should they approach this situation, and with what method? This scenario will last no more than fifteen minutes. At the end of the class, the participants will have a serious and open discussion. They can provide their feedback on the scenarios presented in the class, and the researcher will note their responses individually. Once the discussion is over, the

participants are expected to journal all their thoughts related to the scenarios. This will mark the conclusion of in-class participation for week seven.

Week Eight: Conclusion and Recap

Week eight will summarize the research classroom participant portion of the ACIR. It will begin with recording class attendance, and all the participants' questions will be presented. To conclude the classroom time, the researcher will recap all the material covered over the last seven weeks. The participants will then choose from a list of topics to engage in one final mock scenario, and the list will consist of compassion fatigue or burnout. During the session, participants will engage in fifteen- to twenty-minute scenarios. Upon completion, there will be an open discussion about the significance of interventions for CF and burnout. The remaining class time will be dedicated to an open discussion, and finally, the researcher will provide feedback instructions for the entire program. The feedback will be given as a survey link, which participants will take online in the following days. This will then conclude the focus group portion of the study. The following segment will provide insight into the intervention design for this action research project.

Implementation of the Intervention Design

Implementing this DMIN action research project began shortly after receiving approval from the IRB (see Appendix K) and Henry Mayo Hospital (see Appendix J) and a plan to recruit participants, which was applied through methodical and decisive planning. Each selected healthcare professional was sent an email with a welcome letter and a consent to participate acknowledgment to sign and return to the researcher. Participants were informed in writing that the information gathered for this focus group study would remain secure and anonymous.

Participants were then notified of the schedule over the eight-week study, and arrangements were made for personal one-on-one interviews. A class schedule was established, which commenced the focus group for this action research project. Participants were emailed the introduced dates, times, and subject matter that would be delivered. All information gathered through the study will be transmitted into the research section for this project. The triangulation for this action research project includes integrating the abovementioned personal interviews, assessments, and an eight-week focus group (see fig. 3.1). The utmost care was rendered for the protection of each participant. Anonymity and integrity, along with its sensitivity, will be further discussed.

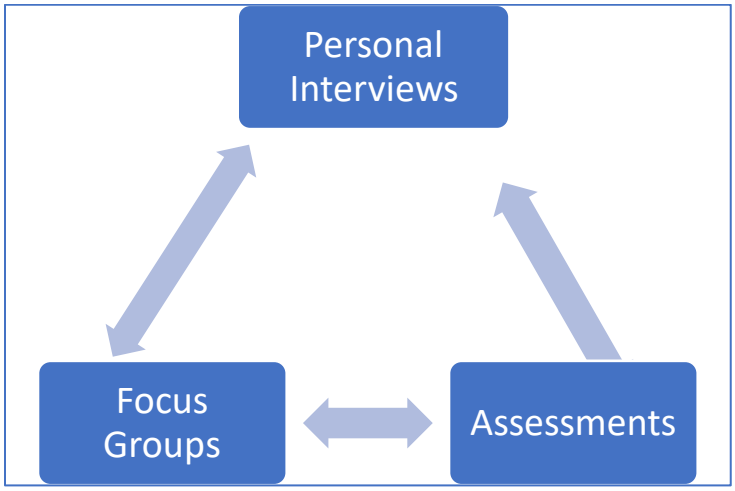


Figure 3.1. Triangulation of case study research

Anonymity and Integrity

Details for implementing this action project were introduced in the previous section. This next segment will explain the integrity and security of all participant information. Extraordinary care was taken with the information gathered in this study, including each participant's name, address, email, phone number, and work department. The anonymity of each participant in the implementation of this project was kept in a password-protected laptop computer that was only accessible by the researcher. In the first focus group session, participants were assigned a letter and number as personal identifiers (ex. P-1= Participant 1, P-2=Participant 2, etc.; see fig. 3.2),

and only the researcher knew the participant pseudo marker. The subject matter in this action research project included the participants' personal information, religious stance, marital standing, and self-proclaimed mental health status each participant derived from the assessments and interviews. Therefore, the highest standard of integrity was maintained throughout. The selected participants are from diverse backgrounds in healthcare and have diverse levels of capability. Additional details on the participants will be provided.

Participants

With the establishment of integrity and anonymity confirmed in the above section, this section discusses details of the participants. The researcher has chosen a specific group of participants for an action research project. The group consists of registered nurses from the emergency room (former and current), a critical care nurse working in the ICU, two medical technicians, a labor and delivery nurse, and a registered nurse/educator with over twenty-five years of experience in the healthcare industry. The registered nurse/educator will also serve as an outside expert for this action crisis intervention. The outside expert has agreed to contribute based on the assessments and in-class information gathered in this study provided by all participants. The results will then be cross-checked and added to the results. The expert is also a participant in this study and brings years of healthcare knowledge from the emergency room, ICU, and hospice. She is now the co-chair for the registered nursing program at the local college in Santa Clarita and has first-hand information about students experiencing burnout within their healthcare career's first two to three years. An outside expert will evaluate all research conducted in this action research project, and any similarities or discrepancies will be identified and addressed.

Initially, the target number of participants was fifteen, but some HCWs dropped out of the study due to unforeseen circumstances, such as schedule conflicts, family matters, and school. As a result, the researcher was left with seven committed participants. The researcher split the first in-person focus group into two sessions to accommodate those who worked late or split shifts. Additionally, the researcher considered that some participants might have to work overtime at some point. For additional observation and evaluation, a chaplain will attend as many focus group sessions as possible, depending on the chaplain's schedule. The purpose is to familiarize the chaplain with the class-style intervention training process**.**

Analytic Outline of Data

The participant details have been established and confirmed in the previous section. In this next portion, a detailed outline of the data that will be collected is familiarized. The researcher interviewed HCWs experienced in emergency rooms, ICUs, labor and delivery, PICU, and NICU. During these interviews, participants were asked about their work history and the specific units in which they have been employed. The researcher utilized a voice recorder and wrote notes from each participant's interview. The researcher delved deeper and asked questions about the participants' personal experiences with mental health symptoms, such as depression, anxiety, fear, compassion fatigue, and burnout with either themselves or peers. Additionally, participants were encouraged to share situations where they have observed their colleagues display these symptoms and how they were approached and supported. The data gathered from these interviews will be analyzed to provide probable evidence that HCWs need better mental health support in crises. Journals that are being kept by the participants during this study will be voluntarily given to the researcher at the end of week seven. Each participant was asked to create a journal entry for any observations that would benefit this study, such as peers possibly relaying

symptoms of depression, anxiety, burnout, or compassion fatigue. The researcher will assess the information provided through the participant's journals for any probability of confirming statistics or assumptions for this action crisis intervention research project. Each participant will provide the data for the assessments done in this study. The next section will cover the assessment details for this project.

Assessments

The assessments section will balance the previous section for the data collection from interviews and journaling. The study aims to ensure that HCWs from different departments can express different levels of mental health in the workplace. To achieve this, three assessments and questionnaires were emailed to the participants with instructions for returning them to the researcher. The purpose of the evaluations was also explained in the instructions to clear any ambiguity among those contributing to this study. Participants were informed that no one other than the researcher would have access to the information provided in the assessments. After the participants had completed the assessments, they were required to return them to the researcher using their email without including any other identity markers, such as their full name.

Vicarious Trauma-Burnout-Compassion Fatigue

The participants were asked to complete the comprehensive "Vicarious Trauma, Burnout, and Compassion Fatigue" (VT, BO, CF) questionnaire as the first assessment tool. These three concepts are interrelated, and the collected data will be used to describe the negative emotions experienced by healthcare professionals in their jobs. Vicarious trauma will measure the impact of exposure to trauma in the healthcare setting. CF and BO are synonymous, and burnout can be measured by combining CF and VT. This survey will also evaluate the level of traumatic exposure experienced by the participants, considering the additional two reviews of burnout and

compassion fatigue. The goal is to gain consistent knowledge across all participants to produce measurable CF, BO, and VT results in the HCW.

Emotional I.Q.

The research study aims to evaluate the emotional intelligence of healthcare professionals using qualitative data provided by the participants. To identify commonalities and differences among the participants, they will be scored on a scale of 45 to 165, with 105 being the average score. Scores of 120 and above will be considered exceptional, while scores below 45 will be considered low. The study will compare the results with national data to assess similarities and differences. Marginal error data will also be considered during the analysis.

The emotional intelligence assessment will consist of 15 questions to help evaluate the skills contributing to the appraisal and regulation of emotions (see Appendix D). The collected data will be compared with national data to evaluate the participants' results. The assessment aims to reveal the competence of HCWs in social situations and their relationship with management. The assessment will utilize a four-quadrant E.I.Q., which includes self-awareness (questions 1–3), managing emotions (questions 4–6), activation/motivation (questions 7–9), relating with empathy (questions 10–12), and teaming with others-social skills (questions 13–15). These are collectively known as SMART components of E.I.Q. (fig. 3.3), all of which are important to attain as a healthcare worker.

Figure 3.3. Craig's "17 Emotional Intelligence Tests & Assessments"

The study will present the scores in a graphical format to show the participants who scored lower and higher on the assessment.[3] The collected data will help to identify those who require assistance and those who can be peer supporters. Those with higher E.I.Q.s have stronger relationships, can reduce stress at work, defuse conflicts, and improve overall job satisfaction.

Pro-Quality of Life Assessment (Pro-QOL)

Assessment is a helpful tool to determine the positive and negative effects of helping people. The Pro-QOL (see Appendix E) instrument measures compassion fatigue, burnout, and secondary traumatic stress in this study. The findings of this study will show the strengths and weaknesses of the Pro-QOL assessment. Participants will answer thirty questions and provide a number between 1 and 5, depending on their response (1 for never, 2 for rarely, 3 for sometimes, 4 for often, and 5 for very frequently). The score obtained by each participant indicates the areas of concern or no concern. The level of compassion satisfaction, burnout, and secondary traumatic stress will be revealed as low, moderate, or high. The Pro-QOL data tool is helpful for

[3] Heather Craig, "17 Emotional Intelligence Tests & Assessments," *Positive Psychology*, February 2024.

researchers in evaluating the quality of life of a particular focus group, mainly when the group includes participants from different units. By analyzing the statistics, the researcher can determine if HCWs at Henry Mayo are experiencing burnout, compassion fatigue, or secondary trauma. Appropriate interventions can be put in place to improve the quality of life of these HCWs if any issues are identified.

After the assessment, the researcher asks the participants for feedback on the results. The individual statistics, along with participant feedback, are evaluated to conclude the validity of the assessment with this focus group. The researcher will consider everyone's overall score to determine the presence of compassion fatigue, which includes secondary trauma and burnout. Moreover, the overall score for all participants will be averaged to determine if an intervention program such as ACIR would benefit Henry Mayo staff (see fig. 3.4). The Pro-QOL assessment is a valuable and accurate tool used to obtain data for people in healthcare, law enforcement, and firefighting. Each participant's assessment will provide information on whether they have or had symptoms of anxiety, depression, burnout, compassion fatigue, traumatic stress disorder, or grief.

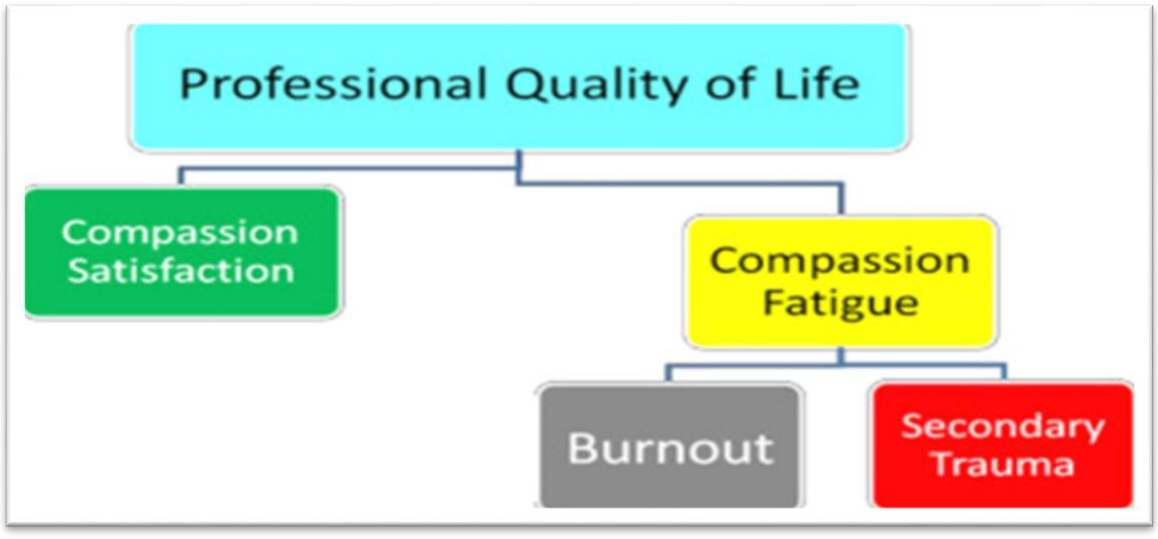


Figure 3.4. Pro-QOL quality of life

Peer Intervention Focus Group

In the previous section, the assessments provided to each participant who agreed to participate in the action research study was discussed. Next, the focus will be on the peer intervention focus group. Ideally, it was with great intention for the HCW participants to be a part of the focus group weekly so they would be able to interact with one another and share their commonalities of mental health problems among staff. The primary objective of this focus group is to engage participants in the techniques used to help healthcare workers who are suffering from mental health problems. For example, acute anxiety can possibly be relieved through talk and somatic therapy. The focus group will occur over eight weeks, with each week devoted to a specific topic that will be thoroughly discussed with all participants. The class schedule for the focus group discussions can be found in Appendix G. All discussions will be recorded to ensure that the details conveyed by the participants are accurately captured. Furthermore, it is crucial to obtain high-quality feedback from each participant, given the diverse backgrounds of healthcare professionals. The data recorded during the focus group discussions will be compared with each participant's interview and assessments completed earlier to triangulate the data (see fig. 3.1). Completing all data and comparing the data to Chapter 2 will give the necessary results for this project. The results will be accumulated and comprehensively compiled for review in Chapter 4.

CHAPTER 4: RESULTS

This project aimed to collect accurate testimonies and valid information through research to highlight the reality of mental health challenges within the healthcare industry. As presented in Chapter 2 of the intervention design, the researcher provides results of the triangulation of interviews, assessments, and focus groups. This study focused on seven healthcare workers (HCWs) at one hospital, who all shared the common goal of providing the best possible care to their patients. At the beginning of the study, twelve participants were dedicated to helping the HCWs through any difficulties they might face. Unfortunately, some of the participants had to drop out of the study due to various reasons such as scheduling conflicts, family obligations, and one who left to work at a different hospital. Nevertheless, those who continued participating were open about their mental health and welcomed the solutions introduced as part of this research project.

During the eight-week study, the researcher utilized several methods to gather results. To introduce the ideology of this action research project, the researcher started with a one-to-one interview with each participant, which served as an icebreaker. This next section will detail the personal interviews, the results of each assessment the participants took, and a synopsis of each week's focus group session.

Collective Results

During the study, interviews were conducted with the participants in various formats. To ensure confidentiality, both the researcher and participants agreed to complete anonymity. Figure 4.1 below displays the results of the interviews, with each participant identified using a unique

acronym. The graphic also includes information about the participant's occupation and years of experience in the healthcare industry, with an overall mean average of 11.5 years collectively. This will assist in identifying each participant in the action research project's results section.

Participant	Occupation	Years of Experience
P-1	ER-TECH / EMT	6.5 YEARS
P-2	ICU RN-APRN CRITICAL CARE	7 YEARS
P-3	LVN	6 YEARS
P-4	RN NICU	11 YEARS
P-5	RN LABOR AND DELIVERY	16 YEARS
P-6	MEDICAL TECH-PRIMARY CARE	8 YEARS
P-7	RN, MSN, NP - ER AND EDUCATOR	26 YEARS

Figure 4.1. Focus group occupation and tears of experience

The participants expressed that they felt valued by being a part of a study that targets HCWs and their mental health. The following interview results will provide a brief background of each participant. To better understand several of the interview questions, figure 4.2 provides details for the initial mental health state of each participant in relation to stress, burnout, anxiety, fear, and depression that was assessed in the initial interviews. Each question was phrased as, "Have you ever felt on____ the job…? Or are you experiencing any of these emotions now?" The results of the questions asked in personal interviews will be addressed in the next section.

Participant	Feeling of Depression	Feelings of Anxiety	Feeing's of Fear	Feelings of Burnout Now	Stress
P-1	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**
P-2	**Yes**	**No**	**No**	**Yes**	**Yes**
P-3	**Yes**	**Yes**	**No**	**Yes**	**Yes**
P-4	**Yes**	**Yes**	**Yes**	**No**	**Yes**
P-5	**Yes**	**No**	**Yes**	**Yes**	**Yes**
P-6	**Yes**	**Yes**	**No**	**Yes**	**Yes**
P-7	**No**	**Yes**	**Yes**	**Yes**	**Yes**

Figure 4.2. Participant poll on expressions of mental health state

Reflecting on the chart presented in figure 4.2, it is noteworthy that there were more "Yes" responses than "No" to the questions posed to the participants. However, it is important to note that the responses to these questions were different from the rest of the research. The initial questions asked in the interview were intentionally broad and vague to obtain generalized answers. The specific and narrowed questions were conducted in the focus groups yielded more insightful and nuanced responses. As a chaplain for over five years, it was found that the answers presented in this chart were not surprising at all. Nevertheless, it should be noted that this chart should only serve as a guide and should not be taken as indicative of the entire research. This study commenced with initial personal interviews with all participants. The following section provides the details of each dialogue.

Collective Interviews

The initial research for this qualitative action research project was conducted through personal interviews with participants using different methods, such as in-person meetings at a café, on Zoom, or over the phone, due to their work schedules. The researcher ensured the participants that confidentiality was a top priority and that their names would not be exposed at any point. The following will address each question along with the response from each participant. Some answers given were brief, while others were comprehensive. Each participant will be addressed by the acronym provided above.

Questions one to four have been addressed in figure 4.2, as they were easy to respond to. However, questions five to fifteen required detailed verbal responses, which are summarized in this section. Each question aims to get a complete and honest response that can help understand the emotional and mental health issues HCWs face.

Question five asks if the participant has ever had a patient expire or die while being directly treated by the participant at any time during that admission to the hospital. P-1 responded that she had a patient from a motorcycle vs. automobile accident come into the emergency room. Referring to the motorcycle rider, the P-1 verbalized, “We quickly assessed the patient, and there was no pulse. We tried CPR, but nothing brought him back.” P-2, being an ICU nurse, would be assumed to have seen many patients die. P-2 responded in the interview, “I have put many people on comfort care, which is at the end of life. After the family gives the go-ahead, the patient is given something like morphine, so they are comfortable when they pass away.” P-3 is an LVN. When asked if she had lost a patient she was treating, the answer was simple, “No, I have not because the patients are usually transferred to another unit before they die.” P-4 is a neonatal intensive care nurse who tends to infants who are critical at birth. P-4 responded that she had infants die when being treated. Respondent P-4 stated, “Sadly, yes, I have had babies die for various reasons.” P-4 did not continue or elaborate on her answer. P-5 works as a labor and delivery nurse who treats infants at birth, but not the critical infants as P-4.

Labor and delivery staff are responsible for helping with the birth delivery and continued treatment for the remainder that the mother and infant are hospitalized. When asked if she had treated a patient who had expired or died, P-5 responded, “I have had multiple fetal demise and stillborn deliveries, and it is devastating.” P-6 is a primary care technician who has worked in different units with various levels of critical care. When asked the same question, she stated, “Yes, I have treated many patients who have passed away from either an accident, old age, or COVID-19.” P-7 has vast experience, as shown in figure 4.1, working in the emergency room, ICU, and hospice. P-7’s response to this question was, “Yes, I have treated many patients who have died over the years, more in hospice, though.”

The researcher had a generalized idea that the answers to question five would provide detailed and authentic responses. There is no surprise that a HCW was present at the time of a patient's death. Something of this nature goes with the territory of healthcare. Although the participants reflected on the number of deaths, none gave tangible detail to nature, possibly to avoid a total recall of the events. However, the emotions of how they felt afterward are indicated in the next question.

All participants answered questions six through fifteen with shorter responses. Question six asked the participants to describe how they felt after a patient had died. The following are the responses from each, except P-3, who admitted that she had not had a patient die while on duty. P-1 responded to this question: "Initially, I felt numb, but I knew we did everything we could." P-2 responded, "Depending on how close I was to the patient, I would usually cry." Whereas P-4, who previously stated that she saw many stillborn and fetal demise, had a similar consensus, "It is heart-wrenching sadness." P-5, being in a similar unit as P-4, expressed, "It is sad and depressing. Oftentimes, I would cry." P-6 admitted, "It is hard losing a patient," while P-7 had a much different response, "I felt honored that the patient picked me to be the nurse in their transition."

Although the reactions here are mixed, each participant shared the emotional state of the HCW at the time of a patient's death. There was an apparent connection between the participant and their patient for such emotion. In Chapter 2 of this action research project, Kate Kirk indicated that the nurse should remain disconnected from the patient in order to provide patient flow.[1] The natural human side of the HCW in this research shows compassion rather than

[1] Kirk et al., "I Don't Have Any Emotions," 1965.

systematic flow. Death is a part of the healthcare professional's job, unfortunately. How someone copes with death is an avenue that will be addressed in this research project.

This action project is not intended to exploit the HCWs' natural human emotions. Instead, it is intended to demonstrate the implications of how they process their emotions in a proven high-stress occupation. The next series of questions asks specific and targeted questions about emotions in the HCW and their peers. Question seven inquires if the participant has ever felt depressed after a shift. Not all participants admitted to feeling depressed after working. However, those who did will be cited here. A consensus does demonstrate the resilience of the HCW in general, with none of the participants admitting long-term depression. P-1 stated, "I felt depressed only after very long shifts." P-2, the ICU nurse asserted, "Only when I feel I let the patient down, but it only lasted a day." P-3 says, "I have, but only with certain co-workers who didn't respect the patients or staff." P-4 and P-5 delivered a similar response: P-4 stated, "Yes, I have, but the feelings did not last long," and P-5 said, "Yes, it's a somber moment, but it passes fairly quickly." Ironically, they both work with the birthing of infants. P-6 and P-7 denied that they had felt any depressive feelings right after working a shift.

Question eight is relatable to the previous question, which asks if the participant had experienced depression at work prior to the COVID-19 pandemic. The purpose of asking this question was to establish a standard and timeline for depression symptoms since COVID-19 has contributed significantly to mental health distress in the HCW. The answers the participants provided were rather straightforward, and there was a mixed reaction. P-1 and P-5 admitted to having some depression that was work-related before COVID-19. P-1 verbalized, "Yes, because of the long hours and not enough days off to recover." P-5 answered, "Some nights, I would feel such heaviness and go home feeling down." All other participants provided a simple answer of "No," with nothing further explained or verbalized. This action research project is intended to

give an overall and justified response from participants who can assert truthful responses. A topic such as depression unveiled quality answers. What is not surprising is that most of the depression is related to the long hours worked. The standard twelve-hour shift, often day after day, would preclude the symptoms of depression.

In question nine, during the interview process, the researcher asked the participants if they had ever felt anxious while working. More specifically, overwhelming anxiety. Participants 2, 4 and 5 stated that they had not felt anxiety at work. For this question, remember that P-2 is an ICU nurse, P-4 is a NICU nurse, and P-5 is the labor and delivery nurse. The responses from these three HCWs are quite extraordinary, considering the level of care they provide. P-1 stated, "In the emergency room, you never know what is coming in. When a call goes out that a code trauma is coming, anxiety goes up." P-3 mentioned, "Yes, I get anxiety before every shift, maybe because of my co-workers or the lack of management support." P-6 generalized her comment with, "Of course we do. I think everyone in healthcare gets anxiety, and sometimes it is the worst feeling." Referring to a specific cause, P-7 verbalized, "Yes, now the workload for healthcare workers is so intense. It is hard to keep up with the technology and hinders patient care." When asked to elaborate on how this can cause anxiety, P-7 asserted, "While we are so involved with trying to add medications or reading the doctor's orders, we have patients either yelling for a nurse, or they buzz the nurse's station. It gets frustrating, and anxiety takes over." The definition of anxiety was given in Chapter 2, which indicated feelings of uneasiness, fear, and dread. Indicators of anxiety all overwhelm the emotions of the HCWs interviewed. While technology is a significant factor, it is unavoidable in healthcare, along with patient demands and care.

Question ten in the interview asked if the HCW had felt any fear while working. This question was intentionally generic and open-ended to spark conversation about fear in the HCW. The reaction was split among the participants. P-1 acknowledges fear on the job and recalls a

specific event: “When I was working in the emergency room, a teenager was brought in. He had been smoking marijuana, from what the fire department said, and the teen began to hallucinate and convulse. We had to call and inform the parents about his condition. I think that brought on so much fear. I didn’t know what was going to happen.” P-5, the labor and delivery nurse, stated, “Yes, fear comes with high-risk pregnancies that come in. We know that anything can go wrong quickly with them. We tend to monitor these women more often, and anxiety levels go up.” P-7 provided this statement regarding newer nurses, “Yes, fear is a real feeling post-COVID-19, and there are a lot of inexperienced nurses and healthcare workers. What is scary is you wonder how they will react and function on the job.” P-3, P-4, and P-6 suggested they have not felt fear on the job or after a shift. Interestingly, those who indicated they had felt fear on the job did not verbalize personal safety. Instead, the fear is aimed at job performance in the face of high-level problematic patients. The fear of patients dying or not being sustained, although the participants did everything they could in their respective jobs.

Questions eleven and twelve will be combined in the answers received from each participant during the interviews. Question eleven asked the participants their definition of burnout, and question twelve asked if they had felt burnout at any point see figure 4.3. P-1 defined burnout as a “Long-standing loss of motivation and drive to continue doing what you are doing without the ability to grasp the silver lining or healthy means of coping.” When asked if P-1 had felt burnout, the answer was, “Yes, most definitely!” P-2 defined burnout as “Having too much on your plate and feeling defeated.” When asked if P-2 had experienced burnout, the response was, “Once, when I worked five-to-six twelve-hour shifts for six months straight.” P-3 defined burnout as “Having little or no interest in working.” P-3 responded to question twelve, “Yes, I felt complete burnout when I worked long hours overnight at a nursing home.” P-4 defines burnout as “Burnout comes from working too much, losing all interest and enthusiasm

for the job that comes with twelve-hour shifts with little help." When asked if P-4 had felt burnout, the response was, "Yes, during COVID, it was difficult. I was at burnout." P-5 defined burnout as "The feeling of dread, sadness, and anxiety when going to work." When asked if P-5 had felt burnout, the response was, "I have felt burnout, but usually, it is related to management and how the unit is staffed. We would have a high census and were understaffed." P-6 defined burnout as "Overworked and overstressed with no light at the end of the tunnel." When asked if P-6 had felt burnout, a resounding response was, "Yes, just recently. I needed a break and did not know how to get away. So, I took a few weeks off, which helped a little." Lastly, P-7 defines burnout as "Extremely exhausted with work, not wanting to be there. Burnout is when you become disconnected from work and do not want to put extra effort or energy into the position. The work feels overwhelming and draining from the start of the day." P-7 admitted to burnout, "Yes. I feel it now. I do not have the energy to do what I used to do." In the interview process, when burnout was discussed, all participants had a reaction that indicated it was a problem. They all experienced burnout at one point or knew a peer suffering from it. They all could relate to the prodigious, unenthusiastic feelings of not wanting to work in healthcare. Chapter 2 of this action research project described the characteristics of burnout as three components: emotional exhaustion, depolarization, and a low sense of personal accomplishment at work.[2] Exhaustion is emphasized in the participant's answers to this question.

[2] Mary K. Wakefield et al., eds., *The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity* (Washington, DC: National Academies Press, 2021), 308–309.

Participant	Has or Experienced Burnout?
P-1	Yes
P-2	Yes
P-3	Yes
P-4	Yes
P-5	Yes
P-6	Yes
P-7	Yes

Figure 4.3. Participant questionnaire responses on personal burnout.

The following section allowed the participants to describe the emotions and feelings behind any questions answered with "Yes." Question thirteen asked the participants how they coped. This question was asked in the interview to allow any elaboration to stimulate conversation and allow the participants to provide unambiguous responses. P-1 provided the following answer to the question related to burnout: "I had to see a therapist first, then figure out how to get more rest so I could recharge. I still needed to find a long-term solution, though." P-2 responded to the prompt, "If I were to get to that point of burnout or have any symptoms where I knew I could not do my job, I would likely see a therapist. I would need to talk to someone about how I felt and got to that point." P-3 felt there was a simple solution to stress, "I would just sleep it off and start a new day." When asked if this is the solution to long-term problems, P-3 stated, "No, but I never think that stress and anxiety would last long, but I think I would talk to someone if I had to." P-4 asserted that there was no real solution unless she quit her job. She stated, "My health and sanity are more important than my job. It would not be easy just to quit, and I would miss the patients and my co-workers." P-5 provided a positive inlet to the prompt: "I hope I always work with a good group of co-workers who support one another." Each of the participants mentioned here has provided what they believe to be the best solution for burnout. A

therapist is a solution, but it is vital that a HCW not get to that point. Although sleep is a solution to exhaustion, it may not be a likely elucidation for treating burnout.

P-6 correspondingly shared, “I would have to stay positive, no matter what. Knowing I had positively impacted my patients would help me get through most anything.” Lastly, P-7, who has been in healthcare for over twenty years, finds resolution as, “I see a therapist, more now than ever. It has been helpful, but it would be better if I could get the same kind of therapy by talking to a co-worker or someone who can relate.” Although it is not surprising that several of the participants sought therapy, it was surprising that none indicated asking Human Resources for help. The answers to these questions prompted a response similar to question fourteen, which asks how the participants cope when they go home from a long shift. They all provided similar answers in the way of self-care and rest, and a couple of participants admitted drinking alcohol helps as well. This leads to the last question in the interviews.

Question fifteen asks the participants if they had ever observed a co-worker or peer suffering from depression, anxiety, stress, burnout, or verbalized thoughts of suicide. The hope with this question is to understand if the participant observes their co-workers in this capacity. The answers were mixed but transparent. P-1 responded, recalling a former supervisor, “My most recent supervisor had long-term depression, body dysmorphism, and anxiety. She and I would have serious conversations about where we were mentally. Last I heard, she did seek professional therapy, but there were moments when she talked about suicide or self-harm, and I would talk her out of it. I should have said something but hoped for the best for her.” P-2 responded with, “I haven’t exactly had a co-worker open up to me about suicide, but there have been comments made from co-workers that would make me fear for that person, and it made me paranoid, to be honest.” When asked P-3 the same question, she responded with, “I am fortunate to have never heard anyone I work with say they wanted to end their life. But that doesn’t mean

it was never talked about. Some of my co-workers are angry people." The response from P-4 provided good interaction for the question. "I have seen co-workers go from happy to being depressed in one shift. There was a nurse I worked with who had a miscarriage. She was out for a couple of months, but when she returned, she was down all the time. I think seeing babies all day made her depressed. She was transferred to another unit, but it never helped. She needed therapy. I have not heard anyone talk about suicide, but it makes me nervous because people who do not talk about it are the ones we hear that follow through with it."

P-5 detailed, "No one has confided thoughts of suicide, but many healthcare workers have new anxiety requiring new medication and days off. Many nurses talk about their therapy sessions and needing new coping techniques." P-6 gave a generic and less descriptive synopsis to the question, "Never suicidal thoughts, no. Depression, anxiety, stress, yes. The number of patients we see who are understaffed is the problem." Lastly, P-7's response will be discussed later in this project. P-7 not only has twenty-plus years of experience but has also been a contributing expert in healthcare and provided detailed information for the researcher. P-7's response to this question is, "Yes, especially after COVID, people seem on edge more and unable to cope with any additional stress. Nurses I know have started to leave or left nursing as a career for a better work-life balance."

The researcher conducted interviews with each participant, lasting approximately thirty minutes to one hour. The duration of the interviews varied depending on the participant's work schedules or family situation. The information gathered during these interviews has assisted the researcher in conducting this action research project.

Researcher's Valuation of the Interviews

The personal interviews provided quality responses that went unfiltered and aligned with the initial research. Each response indicated that there is a problem with mental health attention for healthcare workers at Henry Mayo Hospital. The emotional voice of all participants was an effective indicator that not only is there a need for mental health interventions, but management may also need to grasp the vast urgency the healthcare worker requires fully. The researcher was aware that there are levels of burnout, compassion fatigue, stress, depression, and anxiety among the healthcare workers at HMH from past observation and attending to the needs of some staff. There is a diminutive reservation that the research done on this project lines up well with the indication of mental health tribulations healthcare professionals face every day. All but one participant had experienced the death of a patient. As for the others, the patients included individuals with traumas and long-term illnesses, as well as children and infants. Healthcare workers, like anyone else, experience and process emotions in unpredictable ways. One participant admitted to crying after the loss of a patient with whom she had grown close with. The feelings and emotions of all participants were authentically displayed in the interviews.

During the interviews, COVID-19 was a common topic, and it was acknowledged that it could potentially impact the participants' mental health. Depression, anxiety, and CF were some of the issues that some participants reported. However, fear was not discussed as much, even though it is a relevant and important topic. It would have been helpful to have pre-written response queries to gather more information. Additionally, more questions should have been asked about the level of depression, anxiety, CF, and BO. For example, instead of just asking if the participant had felt overwhelming anxiety on the job, a more specific follow-up question would have been more appropriate. In order to better understand each person who agreed to take part in this project, three assessments were sent via email. These initial assessments will help

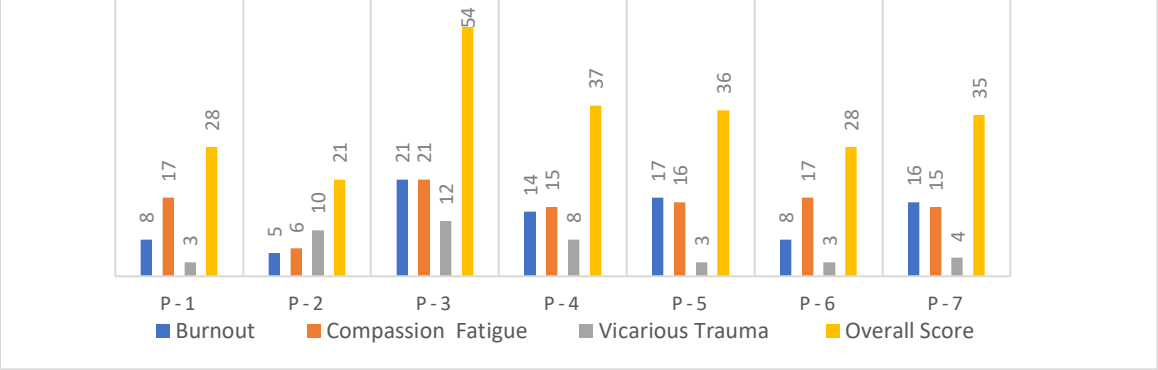
guide the initial research on the participants. The assessments were sent to each participant in the study after they gave their permission to participate. An ample evaluation will be included with the results in this proceeding component.

Assessments

It is essential to be aware of vicarious trauma, compassion fatigue, burnout, the emotional intelligence quotient (E.I.Q.), and the Professional Quality of Life (Pro-QOL) assessments. These assessments can raise awareness for individuals in high-stress professions, such as healthcare, social work, and emergency services, to recognize and address their work's impacts on their emotional well-being. By taking proactive steps to support their mental health, individuals can better serve their clients and maintain a fulfilling career.

Vicarious Trauma, CF, and BO Assessment

Healthcare workers often work as a team to take care of patients involved in traumatic accidents, facing end-of-life biological failures or death. Such situations can be emotionally overwhelming for HCWs and can lead to feelings of disarray. This study has a strong focus on compassion fatigue (CF), traumatic stress, and burnout among healthcare professionals. The assessment involves responding to twenty-one questions, and the results provide a score that indicates whether a healthcare worker is at low risk or high risk (see Appendix C). To better understand the methods for this assessment, the participant takes the entire survey and then adds the scores according to the category. The participant is then to add up all three scores to receive an overall total for this assessment. A lesser score from zero to fifteen is considered low, fifteen to twenty-one is at moderate risk, twenty-two to twenty-eight is at high risk, and twenty-nine to thirty-five is considered extremely high risk.



22 or less	Low
Between 23 & 41	Moderate
42 or higher	High

Figure 4.4. Vicarious trauma-compassion fatigue-burnout assessment

The researcher had assigned assessments/surveys to the following healthcare professionals: P-1 is an ER Technician/EMT, P-2 is a critical care nurse in the ICU, P-3 is an acute care LVN, P-4 is a neonatal intensive care unit nurse, P-5 is a labor and delivery nurse, P-6 is a general acute care nurse, and P-7 is an RN who has worked in the emergency room, ICU, and as an educator for student nursing at a local college. Figure 4.4 displays four assessment categories that were taken by the participants in their own time. Once completed, the results were sent to the researcher. The scores varied among the participants, and the researcher used these scores to prompt self-reflection by the participants.

Vicarious trauma, also known as secondary traumatic stress (STS), can result in long-lasting emotional harm to an individual's well-being. The CDC defines STS as a traumatic experience that arises from exposure to another person's traumatic event.[3] First responders may accumulate stress, which may lead to burnout, and resources should be readily available during times of crisis. In this assessment, P-2, P-3, and P-4 scored higher for VT, which is not surprising

[3] Centers for Disease Control and Prevention, "Emergency Responders: Tips for Taking Care of Yourself," 2018.

considering the three have seen traumatic death more often. All seven HCWs took part in the Pro-QOL measurement tool. Research on this action project has shown that compassion fatigue has the most significant impact on HCWs. Therefore, it is not surprising that every participant has compassion fatigue of some sort. It was astonishing and unexpected that the participant who works in the ICU shows less CF than any other participant. Overall, ICU nurses see death often and treat trauma patients on a regular basis. P-1, who works in the emergency room, scored low on compassion fatigue, which was also unexpected. Other than the ICU and ER participants, the values do line up with the research.

PRO-QOL Assessment

The Pro-QOL assessment, found in Appendix E, is a thirty-question self-administered questionnaire designed to help individuals gain insight into their positive and negative work-related experiences. It is a reliable tool that measures compassion satisfaction, fatigue, and burnout. Figure 4.5 illustrates the overall Pro-QOL scores of each participant. One assessment component relays compassion satisfaction (CS), which is the opposite of CF. Compassion satisfaction is displayed in this assessment and can serve as a guide to the participant's mental health status. Compassion satisfaction indicates the HCW's pleasure derived from helping others.

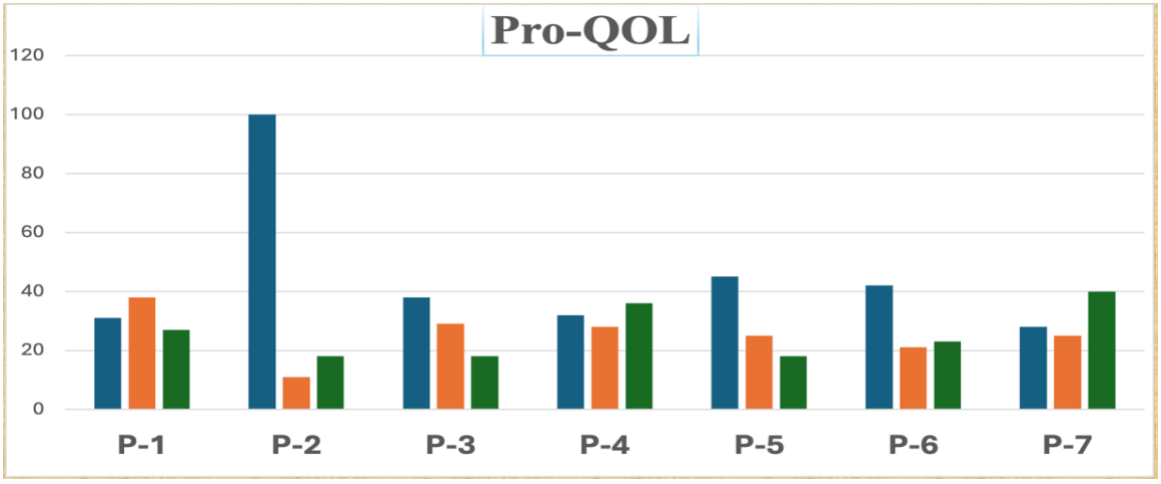


Figure 4.5. Pro-QOL inclusive scoring for each participant

The chart displayed above, figure 4.5, depicts the results of the Pro-QOL assessment. The first bar graph indicates the level of compassion satisfaction, while the middle orange bar represents the statistics for burnout. Lastly, the green bar represents the level of secondary trauma. The following graphs will display a breakdown of each category and participant score.

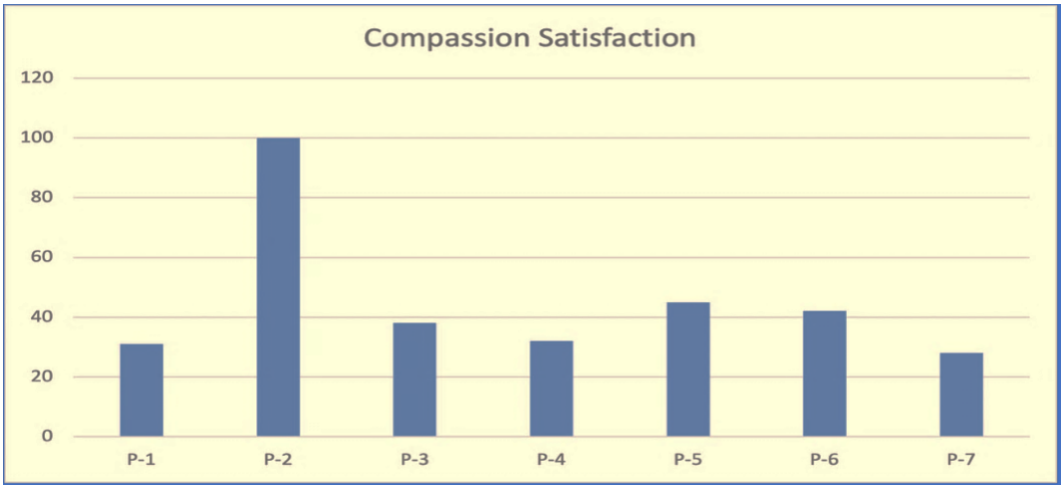


Figure 4.6. Pro-QOL compassion satisfaction

In figure 4.6, the focus is on the level of compassion satisfaction for each participant. The scoring factors range from 0 to 45. However, it is possible for a participant to score higher than the maximum cutoff. P-2, an ICU nurse, has the highest level of compassion satisfaction, scoring thirty-eight out of forty-two. On the other hand, P-7, who has been working in the industry for

over twenty years, has the lowest score in compassion satisfaction, with twenty-three out of forty-two possible points.

The overall consensus in the CS section of this Pro-QOL fields interesting results. The ICU nurse (P-2) has the highest level of CS, which coincides with the low CF this participant exhibited in the previous assessment. With P-3 and P-7 being on the lower end of CS, it stands true that these participants have greater CF, as displayed in figure 4.4 above. All other participants are relatively on course with both assessments. These results are remarkable and indicate that there is a variation among HCWs in different units.

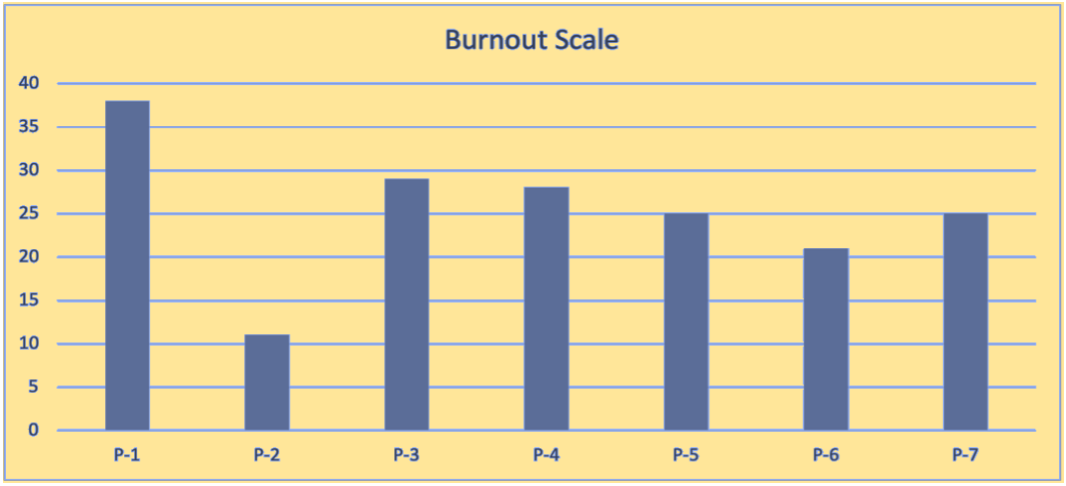


Figure 4.7. Pro-QOL burnout scale

Figure 4.7 reviews each participant's burnout scores based on a scale of 0 to 40. Knowing the differences between CF and BO is essential, as well as understanding that burnout generally leads to compassion fatigue and ultimately leads to the HCW leaving the industry altogether, as referenced in Chapter 2. The higher the score on this graph, the more likely the participant is headed towards burnout. In this case, P-2 is less likely and is not experiencing any symptoms of burnout. Nevertheless, P-1 is on the high side, and P-3 and P-4 are prospectively headed in the wrong direction.

Burnout pulls from compassion fatigue and/or vicarious trauma. Burnout can be achieved relatively quickly and can even affect student nurses in their early clinical stage. As indicated in Chapter 2, a study in 2021 shows that 60 percent of ICU healthcare nurses report burnout.[4] Interestingly, P-2, the ICU nurse, denotes fewer intentions for BO. What is relatively indicative of BO but not surprising is P-7, who is currently an educator for a college nursing program. This participant stated in her interview that she is presently facing the BO phase. After all, P-7 does have over twenty years of combined clinical and educational experience. The research and interviews with the participants do indicate their need for interventions. The remainder of the participant statistics did not all match as expected. The researcher was expecting lower scores on this survey.

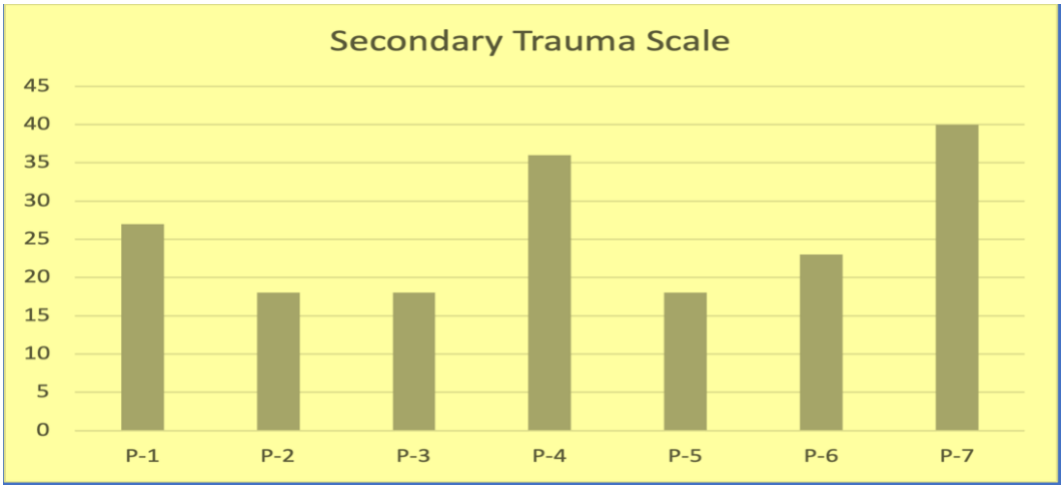


Figure 4.8. Pro-QOL secondary trauma scale

To put secondary trauma into perspective, P-1, P-4, and P-7 all work or have worked in units that see trauma and death on larger scales than most departments. In the Pro-QOL assessment, figure 4.8 illustrates the numeric value of each participant's secondary trauma scale

[4] Claire Roger et al., "Occurrences of Post-Traumatic Stress Disorder, Anxiety, Depression, and Burnout Syndrome in ICU Staff Workers after Two-Year of the COVID-19 Pandemic: The International PSY-CO in ICU Study," *Annals of General Psychiatry* 23, no. 1 January 3, 2024: 14, https://doi.org/10.1186/s12991-023-00488-5.

score. Honest assessment answers provided by the participants on the ST or STS will indicate a value either at the mid to high level or at the higher level, depending on the number of years spent as a HCW and the exposure department. This section of the assessment measures the level of secondary exposure to significantly or traumatically stressful events, which is commonly known as vicarious trauma. P-4 and P-7 have essentially been distressed by trauma and death, leading them both to have surprisingly higher numbers on the secondary trauma scale. The statistics for these participants are unsurprising because one works in the NICU, and the other has previously worked in the emergency department. Interestingly, these two participants had not received the needed interventions early and would likely be candidates for professional therapy. To add context, deaths in the NICU are far and deep between, but because they are infants, their emotional fortitude is compromised. Therefore, it is unsurprising to see statistics elevated among P-4 and P-7.

To summarize, the study includes several assessments to evaluate the well-being of the participants. One of these assessments is compassion satisfaction, which measures the level of pleasure and satisfaction one derives from performing one's job well. Another assessment is burnout, which assesses the level of hopelessness and difficulty individuals experience while performing their jobs. Additionally, the study also evaluates secondary traumatic stress resulting from exposure to stressful or traumatic events. In Chapter 2, Brenda Sabo best described the impact on the HCW as described in the above assessments, "Compassion fatigue is thought to be a combination of secondary trauma and burnout by contrast with the suffering patient by healthcare professionals."[5] It is crucial to ask further questions if a healthcare worker displays symptoms of a mental health condition to determine the specific issue and provide appropriate

[5] Sabo RN, BA, MA, PhD. Student, "Compassion Fatigue and Nursing Work: Can We Accurately Capture the Consequesnces of Caring Work?" *International Journal of Nursing Practice* 12 n.d.: 138.

support. All assessments indicate a need for the seven HCWs, highlighting the prodigious need for the residual of the hospital staff. The statistics for the assessments above have variables compared to the research conducted. This does prove that the research is accurate to decry that healthcare workers suffer through mental health distress.

Emotional I.Q. Test Assessment

Emotional intelligence refers to the ability to observe and understand one's own emotions and those of others, differentiate between various emotions, and label them correctly. The E.I.Q. assessment aims to evaluate the emotional well-being of the participants, as outlined in Appendix D. The evaluation is based on SMART components such as self-awareness, emotional regulation, motivation, empathy, and social skills. The assessment consists of fifteen questions, with responses ranging from always, usually, sometimes, and barely. Participants add up their scores to determine their total E.I.Q., which ranges from forty-five (low) to one-hundred twenty (high). One participant scored above the benchmark of one hundred twenty, while another scored lower than the rest. Figure 4.9 below illustrates a healthy E.I.Q. of self-awareness, self-care, and compassion, which are strong, accenting an emotionally flourishing person. A detailed breakdown for each is as follows:

- **Quotient 1**- Self-Recognition: Self-awareness/understanding, connections of cause and affection, self-appreciation, consciousness, emotional identification.
- **Quotient 2**-Social Recognition: Empathy, service, holistic communication. Situational perceptual awareness, interpersonal development.
- **Quotient 3**-Self-Management: Self-control, goal-directed performance, integrity, motivation, creativity.
- **Quotient 4**- Social Management: Developing relationships, leadership, change catalyst, negotiation, teamwork & collaboration.

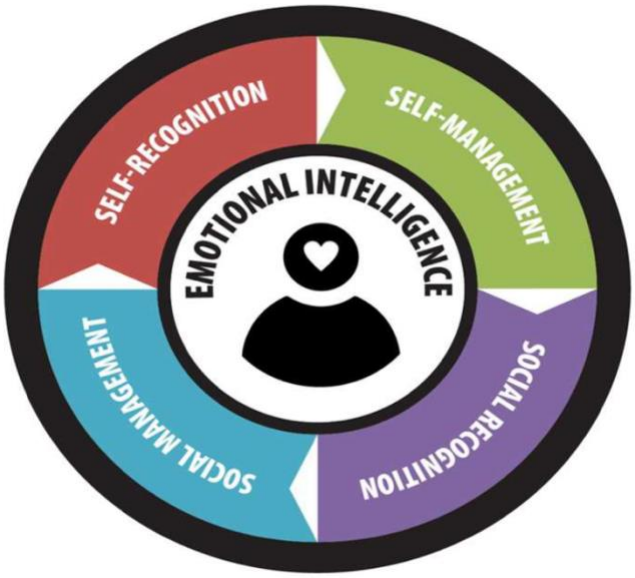


Figure 4.9. Healthy emotional I.Q. online DISC profile

As a part of this action research project, each participant's individual scores and breakdowns will be provided. Although the assessment was administered before the in-person focus groups, all the responses and scores are regarded as reliable and truthful. Figure 4.10 provides a graphical representation of each participant's E.I.Q. outcomes, while figure 4.11 outlines the SMART components scoring as it relates.

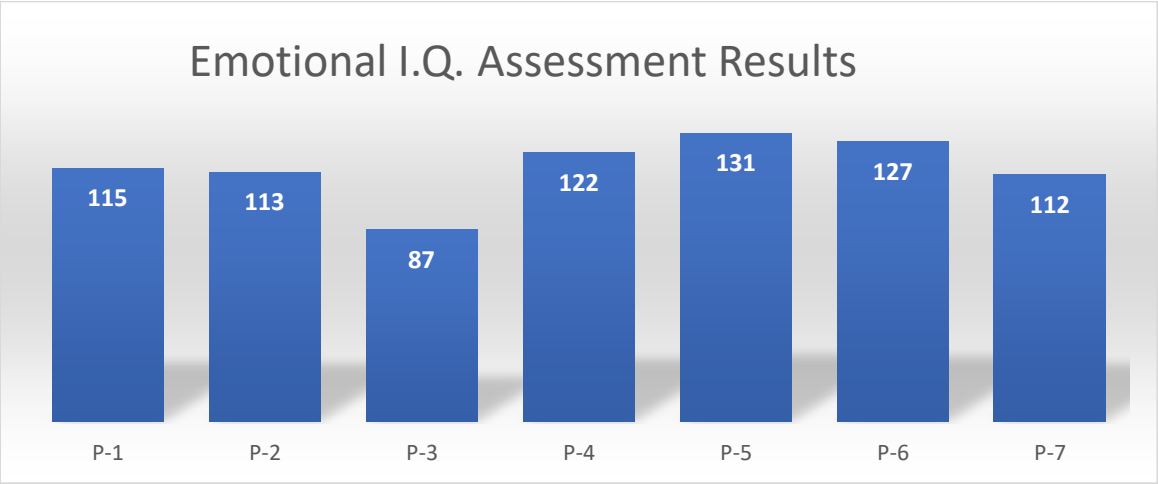


Figure 4.10. E.I.Q. individual assessment results

SMART Components	E.I.Q. Scoring
S-Self Awareness	**Questions 1–3**
M- Managing Emotions	**Questions 4–6**
A- Activation Motivation	**Questions 7–9**
R-Relating with Empathy	**Questions 10–12**
T-Teaming with others (social skills)	**Questions 13–15**
Mean Average Among Participants	**115.285**
E.Q Score Range	**45–165**
The National Average	**105**
*** A total score of 120 or above is exceptional**	

Figure 4.11. SMART components and scoring scale

Establishing a baseline for Henry Mayo healthcare workers and their E.I.Q. is ideal, although the results are not indicative of all healthcare workers. Future investigations on other HCWs may yield different results that can be determined when this program is set into motion. The E.I.Q. can weigh team dynamics, productivity, and job satisfaction in almost any profession. A participant who worked as a Labor and Delivery RN (P-5) obtained a score of 130, which indicates an exceptional result. The remaining participants' scores fell in the normal to higher range: P-1 (115), P-2 (113), P-4 (120), P-6 (127), and P-7 (110). The scores as a whole indicate what was hoped in this research project. Each of the participants displays even emotions, as well as empathy and being able to team with others. This assessment aimed to establish a starting point for healthcare workers with moderate to high emotional intelligence quotient. To complete the triangulation for this research, participants attended weekly in-person focus groups. A comprehensive summary of the focus groups conducted over eight weeks will now be discussed.

Focus Groups

The focus group study, which lasted eight weeks, began when all the participants had submitted their interest forms to the researcher. The participants were informed that the study would be confidential and that their information and discussions would remain anonymous. Initially, twelve participants had committed to the focus group. Unfortunately, two participants who worked in the emergency room and in the ICU quit their jobs at HMH. One other participant had family problems and asked to be removed from the group, while the other two had changes to their schedules and could no longer commit to the group. With these changes, seven participants remained committed to the focus group. Each week, a new topic was introduced for discussion, and the participants received an introduction to peer assistance therapy. At the end of each week's focus group, the participants were sent questions related to the week's topic via Google Forms. The responses to those questions will be displayed after a synopsis of each week's session. Stress can be overwhelming. In this first week of the focus group, traumatic stress will be introduced.

Week One: Traumatic Stress

In week one, a focus group was conducted with seven participants and one hospital chaplain present for observation. The researcher introduced the eight-week program and explained the purpose of the research. The one-hour session consisted of a video on traumatic stress and lengthy discussions. Participants were taught about the practical use of talk therapy, a method explained in the intervention design. The goal of the program is to prepare each participant how to talk to a peer who is suffering from traumatic stress. After the discussion, participants were paired up for a mock scenario based on pseudo situations written on a card. At the end of the session, there was a Q&A session on the topic and a one-hour session. The

researcher then sent out Google Forms with questions each participant could answer at their convenience. The questions and participant answers are in figure 4.12 belo

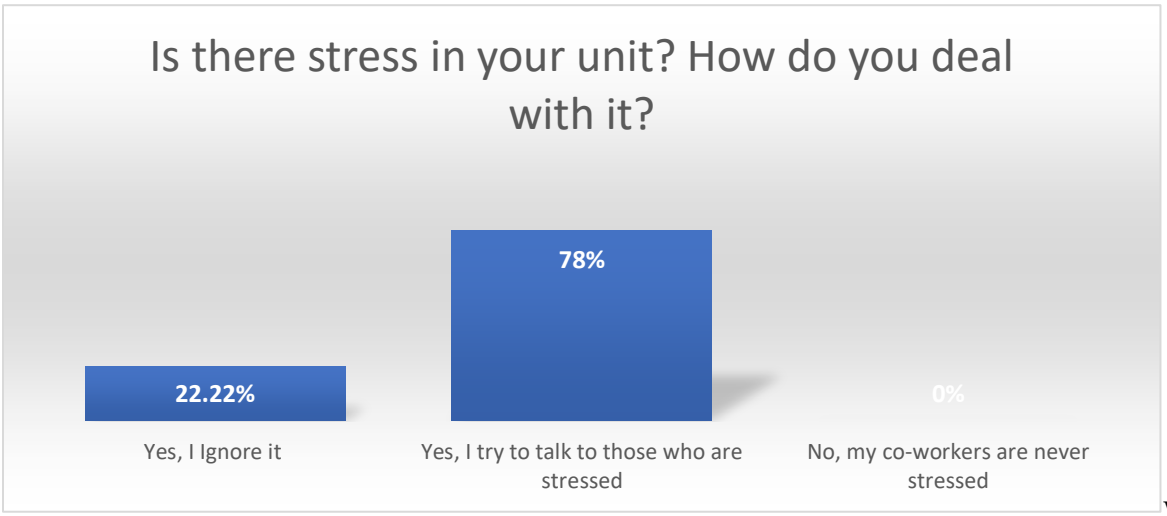


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Figure 4.12. Stress survey

In figure 4.12 the participants were asked if there was stress in their assigned unit and how they coped with it. Overwhelmingly, they all admitted there was stress. One participant said she ignores the stress, while the others said they try to talk to stressed peers. This aligns with the method introduced in this week's intervention. Talk therapy can be used to bring down a peer's stress levels. This will be discussed further next.

During the focus group discussion on stress, participants shared their dissatisfaction with staffing levels, which were identified as the primary cause of stress. Voicing concern to management for increased staffing could be the starting point for alleviating some stress. Participants did agree that they could relate to one another regarding general and traumatic stress related to their job. The researcher was not surprised by the participants' reactions, which aligned with the survey results. However, there was some hope that HCWs could support one another and manage high-stress levels. Participants discovered talk therapy techniques to be the best option for addressing the problem.

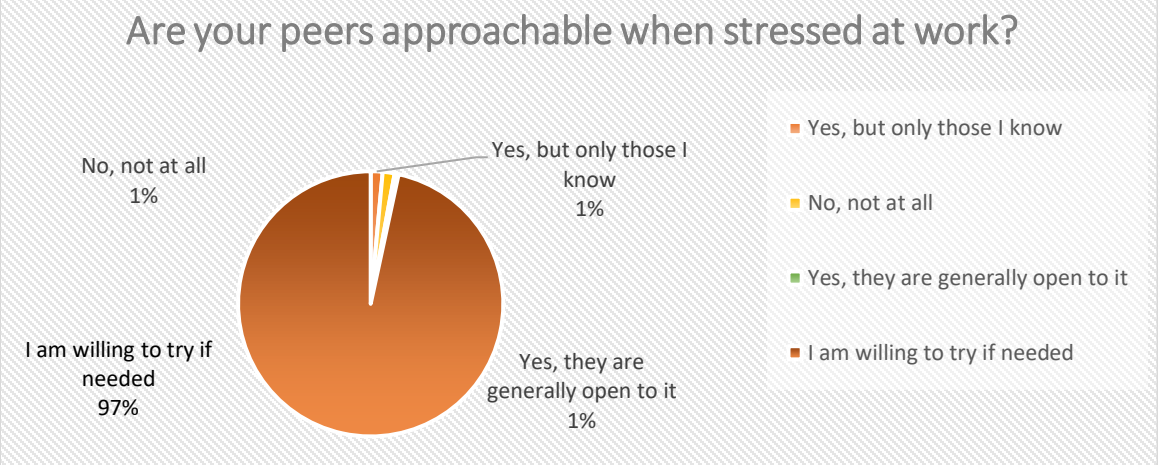

Figure 4.13. Peer stress survey

The above graphic indicates that most participants would actively converse with a stressed co-worker at work. It is astounding that most participants would believe that their peers are approachable. Healthcare relies on team dynamics for a thriving working environment. The one percent is likely a disconnected team or peers who do not have much trust in one another. For this intervention project to succeed, the HCWs would require the ability to approach one another.

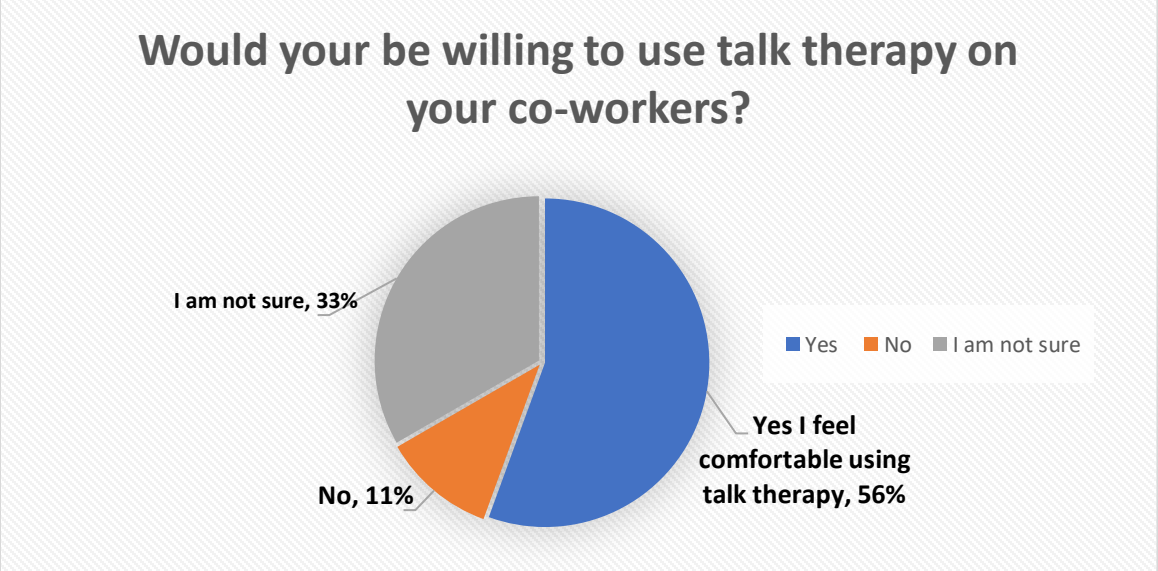

Figure 4.14. Willingness to use talk therapy survey results

The graphic presented in figure 4.14 illustrates the participants' responses when asked about their willingness to use talk therapy to help a co-worker. Most respondents, accounting for 56 percent, expressed their desire to try talk therapy. On the other hand, 11 percent of the participants claimed they would not use it, while 33 percent were unsure. This suggests that the more a participant engages in talk therapy, the more they are likely to utilize it. It is essential to have the confidence to use new techniques to assist peers in this action project. Although talk therapy was a novel method for most participants, it was a welcomed approach. During several mock sessions, the participants became accustomed to the technique. The participants alternated and used talk therapy on different participants during each session. The results from the mock sessions were conclusive that all participants had become adaptable to the technique. However, even with finding talk therapy acceptable, two still expressed concerns about being rejected by co-workers. The researcher provided the needed verbal assurance that not everyone is going to welcome assistance when suffering from a mental health problem.

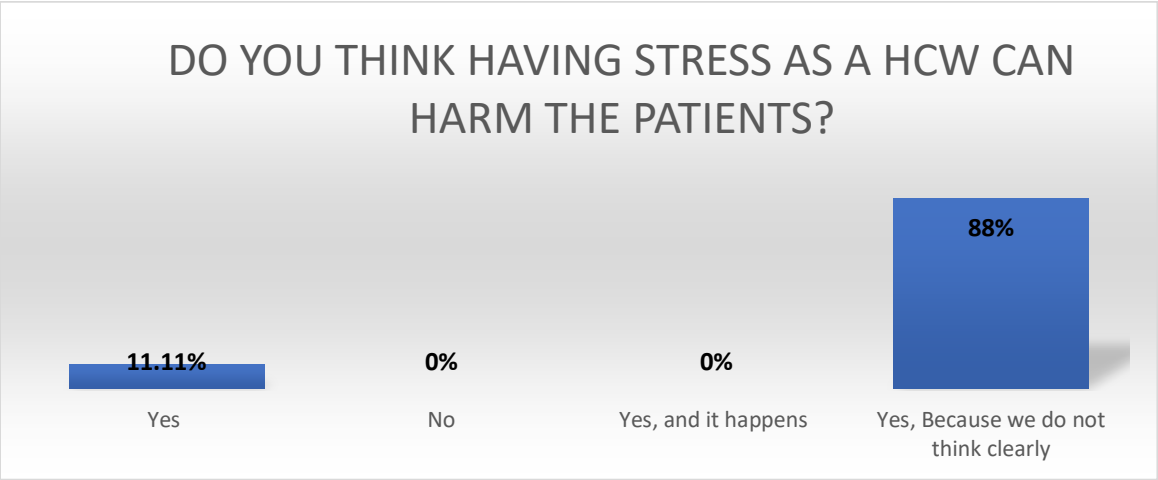

Figure 4.15. Healthcare worker stress and patient care survey

The study examined the distress levels experienced by healthcare workers for various reasons. Respondents were specifically enquired about stress related to patient treatment. A discussion among the group confirmed that anyone in healthcare could potentially harm the

patients if the healthcare workers were experiencing high levels of negative stress. All participants agreed that a “normal” amount of stress comes with the job, but the stress can be extreme when there are problems such as being understaffed or lacking management support. With higher stress levels, thinking can become clouded, and mistakes can be made. All participants agreed that patient care can be compromised, as seen in figure 4.15. Talk therapy, therefore, is significant to reduce stress.

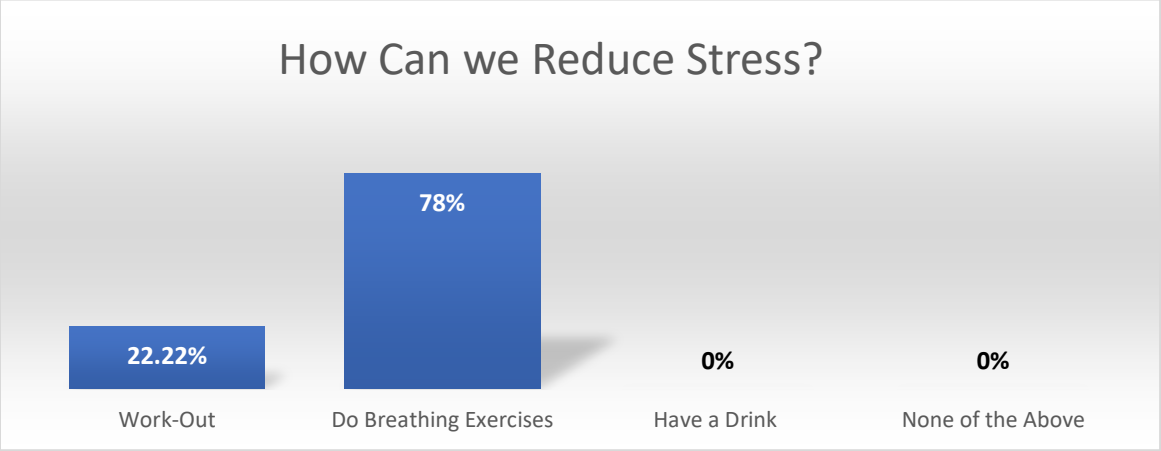

Figure 4.16. Stress reduction survey

During the research study focus group on reducing stress, the class was asked about holistic methods to decrease stress levels. According to figure 4.16, all of the participants believed that exercise would be an effective way to reduce stress, which is promising for this project. Although alcohol was also presented as an option, it was not chosen. However, as mentioned in the limitations section, it is possible that not all participants were completely honest with their responses. In fact, during the group session, one participant mentioned that healthcare workers often use alcohol to cope with stress during their off time. The sensitive topic of grief and suffering in healthcare workers will be discussed in the second week of the focus group.

Week 2: Grief and Suffering

During the program's second week, the participants engaged in a meaningful discussion about suffering and grief. As healthcare professionals, they were well-versed in this subject matter. The session commenced with a review of the previous week's topics, and then a thought-provoking video presentation on grief and suffering was shown. Following the video, the participants were paired up and given a scenario to role-play, using talk and somatic therapy as an intervention method. Each group had ample time to act out their scenario, with twenty minutes provided for the role-play. The session then concluded with a Q&A session, allowing participants to ask questions and share their thoughts on the topic. Lastly, each participant was given a set of questions to answer via Google Forms at their convenience, and the results were later presented in a set of informative graphs below.

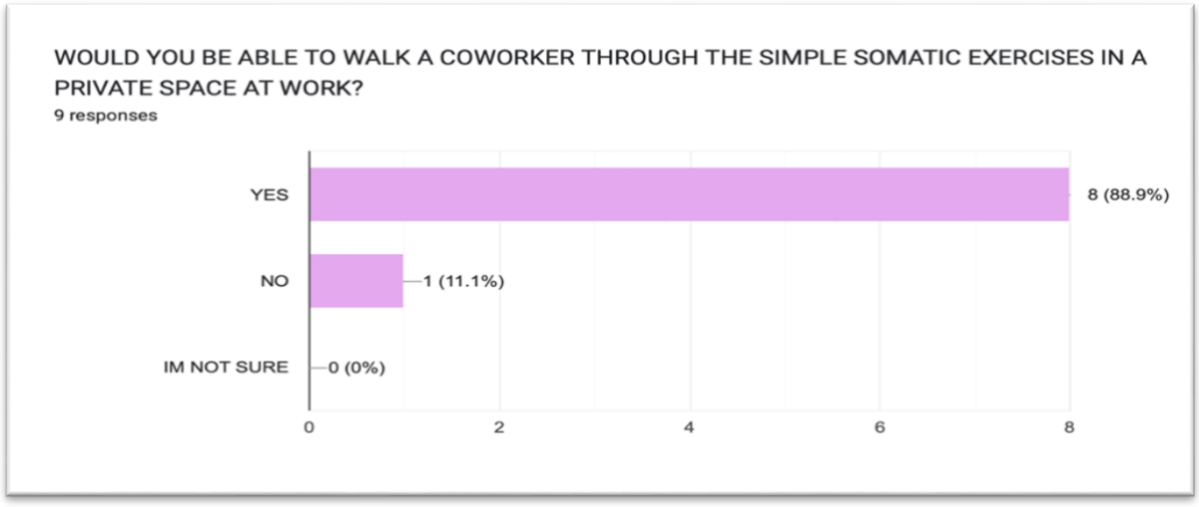

Figure 4.17. Somatic therapy survey responses

During the study, the participants were encouraged to use talk therapy as a starting point and then apply somatic therapy to a willing co-worker at some point during the week. Most of the participants attempted to engage a peer, but one participant did not. Despite the challenge, the results were positive. The participants reported that they attempted somatic breathing exercises

on their co-workers, and the co-workers all believed it helped at the time. As depicted in figure 4.17, the participants were willing to use the provided steps to approach and engage in somatic therapy. The success of the study suggests that somatic therapy can be a beneficial tool in promoting wellness and managing stress.

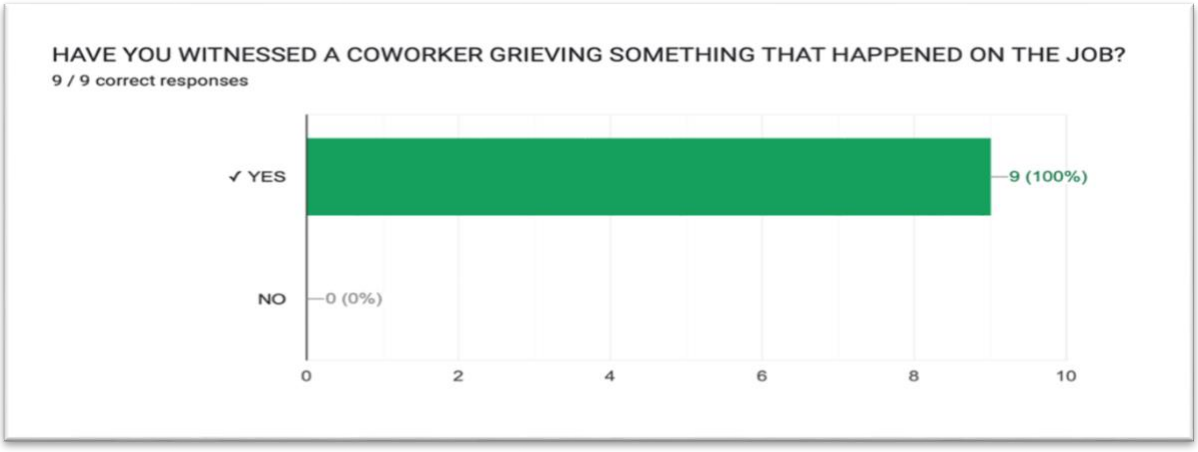

Figure 4.18. Grieving co-worker survey responses

In the second week of the focus group, the participants were asked a question which is displayed in figure 4.18. During the class sessions, the participants shared that most co-workers experience grief over the death of a patient. However, one participant mentioned that some co-workers also grieve over the feelings of personal failure when a patient passes away. On the other hand, all participants expressed their willingness to spend time with their co-workers outside of the hospital, as shown in figure 4.19. One participant shared their personal experience of taking a co-worker out for a walk and spending time talking about the grief they were experiencing, which proved to be helpful.

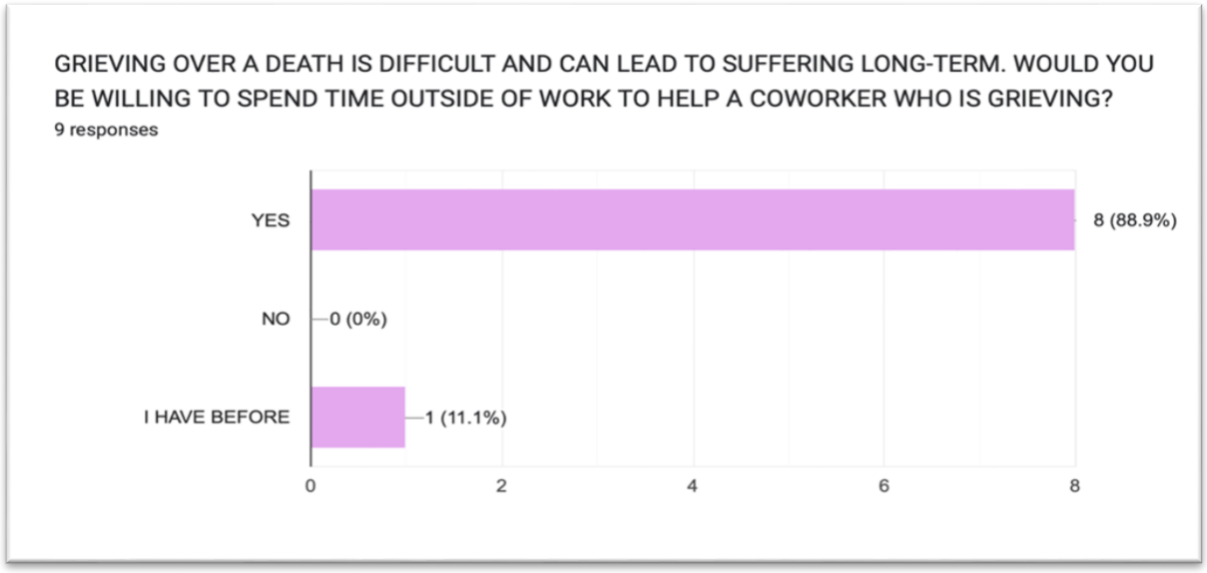

Figure 4.19. Spending time with a grieving co-worker survey results

The researcher requested each participant to share a journal entry about their personal grief to connect with the exercises. Below are some summarized responses:

P-4: “There are so many times in the NICU when we help each other and families through the grief of losing a child.”

P-5: “Multiple hug-outs and cry sessions after a fetal demise or poor delivery outcomes, we support the family and each other with hugs and tears.”

Other participants related by sharing about the loss of a family member or close friend. More importantly, they all shared that they could relate to grief. When asked if the somatic therapy of relaxation combined with talk therapy would be an effective method, all participants agreed it would help, apart from P-1, who was apprehensive but shared that she would attempt the somatic/talk therapy model. Anxiety can derail almost anyone, and understanding how to deal with it can often be difficult. Week three addresses acute anxiety in the healthcare worker.

Week 3: Acute Anxiety

During the third week, a focus group was held to discuss anxiety. Participants were shown a video that explained the signs and symptoms of acute anxiety. Exposure therapy was introduced, and the intervention design was discussed. The exposure therapy model was also explained. Each participant was given a blank piece of paper and a mock scenario to pair up with another participant. An example was given about someone who fears spiders, where one participant would have the other draw a picture of a spider, followed by methodical steps toward actually looking at a live spider. Using this example, participants were asked to give a mock fear that could actually happen in their respective departments. They were then required to conduct a mock scenario using the exposure therapy model, where they had to help their partner write down the items that cause anxiety, ultimately arriving at a point of less anxiety. At the end of the session, a Q&A was held, followed by instructions to answer the questions sent via Google Forms. The responses to those questions are found in the next section. The idea around exposure therapy is to bring the level of anxiety back to a normal state. This is one of the more difficult exercises to master, and further explanation and demonstration may be necessary.

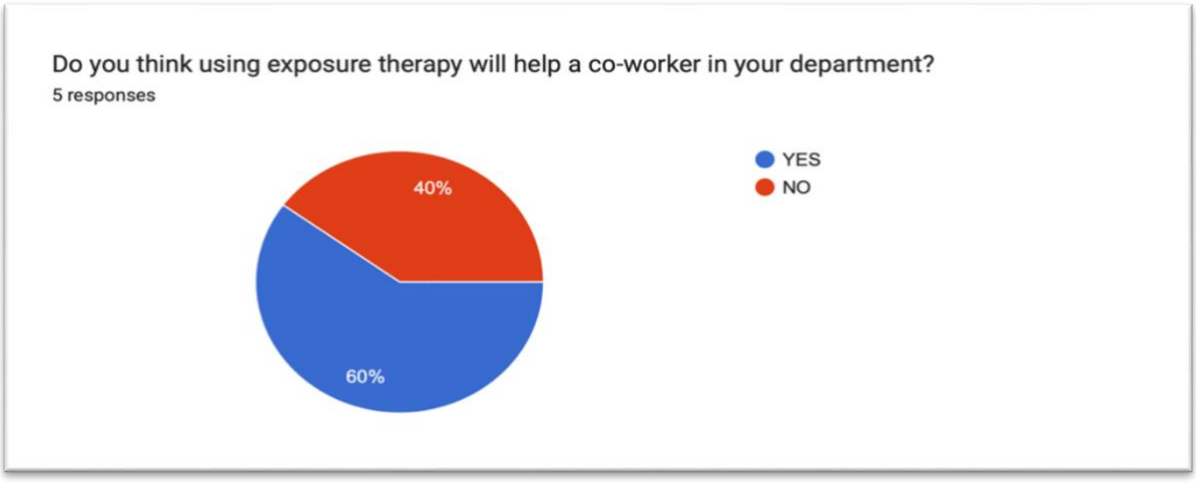

Figure 4.20. Exposure therapy survey results

During the mock sessions, it was observed that the group took the exercise seriously. In a group discussion, all participants agreed that this has been one of the more challenging exercises they had done so far. Furthermore, the participants believed that this model could be highly effective for individuals who had experienced severe trauma. One participant expressed that this would not be effective in labor and delivery. After the mocks were completed and the group was dismissed, the researcher sent the questions as seen in figures 4.20 and 4.21. Out of five responses, a majority have attempted exposure therapy at some point. The consensus among participants was positively related to using exposure therapy among HCWs. In a later discussion, some participants expressed the need for exposure therapy in their departments. With 60 percent believing it would be helpful and 60 percent admitting to experiencing exposure therapy, there is promise that it would be useful.

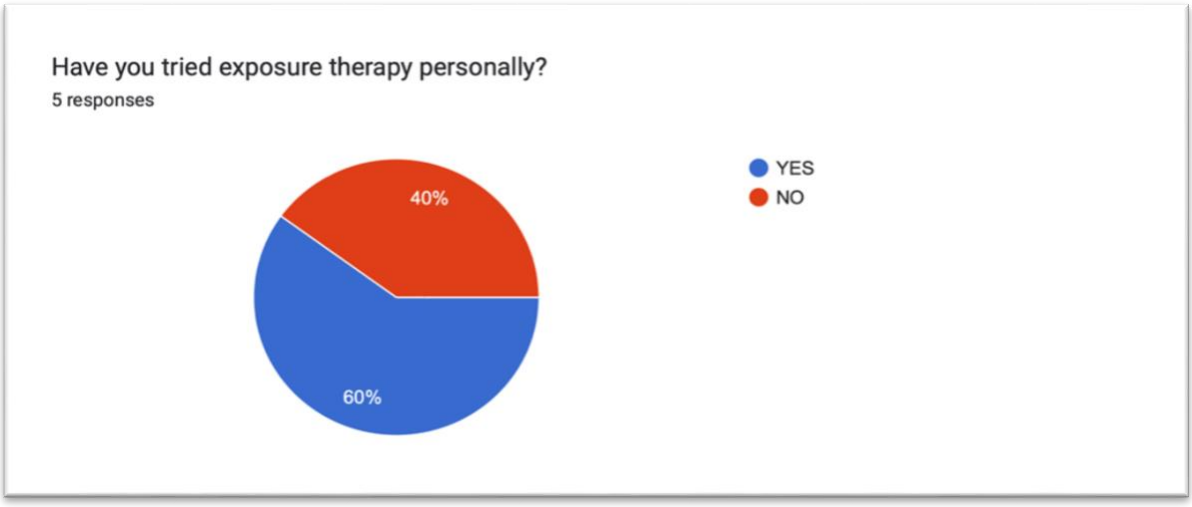

Figure 4.21. Exposure therapy survey results

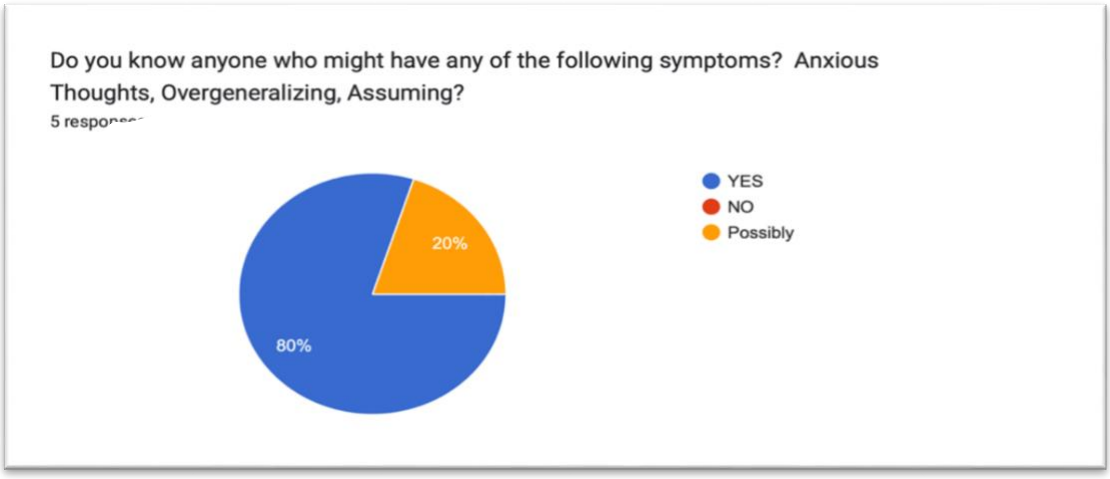

Figure 4.22. Anxious thoughts, overgeneralizing, assuming survey results

In the group discussions for this week's topic of anxiety and related mental health problems, the questions posed in figures 4.22 and 4.23 had the expected results. All participants in the discussion believed everyone has someone in their lives who suffers from anxiety. As discussed in Chapter 2, COVID-19 has brought healthcare workers a new kind of anxiety. The National Library of Medicine refers to anxiety as feelings of fear, dread, and uneasiness.[6] The methodology used for anxiety and fear is substantial and will likely benefit the healthcare workers in this study.

[6] National Library of Medicine, "Anxiety."

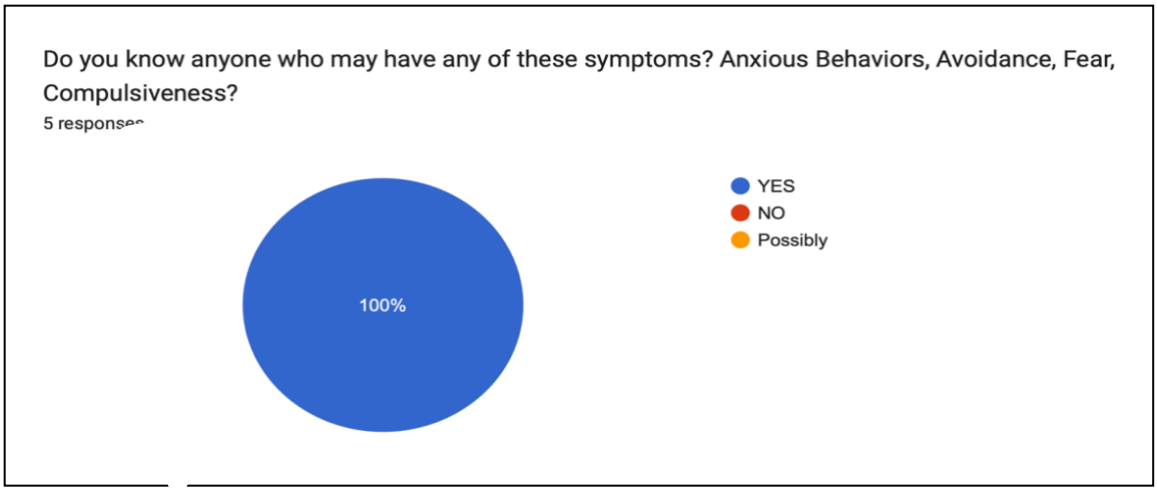

Figure 4.23. Anxious behavior, avoidance, fear, compulsivity survey results

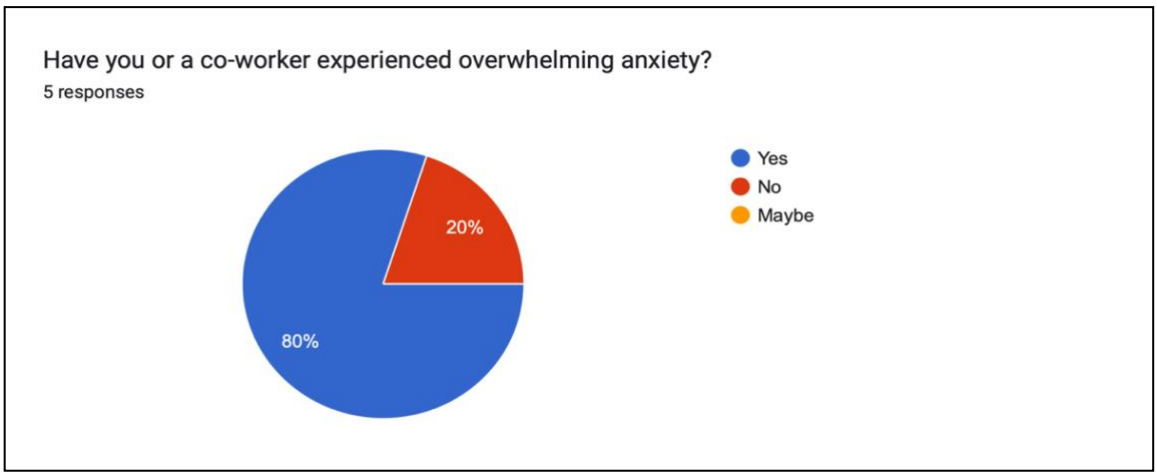

Figure 4.24. Co-worker overwhelming anxiety survey results

In the week's focus group, a question was posed regarding their approach to someone with anxiety. One participant shared their experience of cautiously approaching a supervisor, feeling like they were walking on eggshells. Another participant shared a successful experience of approaching a co-worker, reassuring them they could talk about anything without fear of judgment. The researcher enquired about the exposure therapy method and whether it would work for the participants' departments. To the researcher's astonishment, a critical care nurse in the ICU responded that while they believed in the technique, it might not work in their department due to the high-stress environment and unique personalities of those who work there.

It seems that this would actually be an ideal method for such a department. The statistics were less than ideal and did not agree with the research conducted. ICU, along with Labor and Delivery, are units that generally would see increased anxiety. Week four moves into the topic of depression, which is another sensitive area of concern.

Week 4: Depression

During the focus group for week four, participants were asked to engage in various scenarios with a partner and explain the methods they learned in somatic therapy and mediation using a prompt. The session concluded with a Q&A session, during which participants were encouraged to ask questions and share their feedback. Instructions for submitting questions and feedback were provided via Google Forms to facilitate this process.

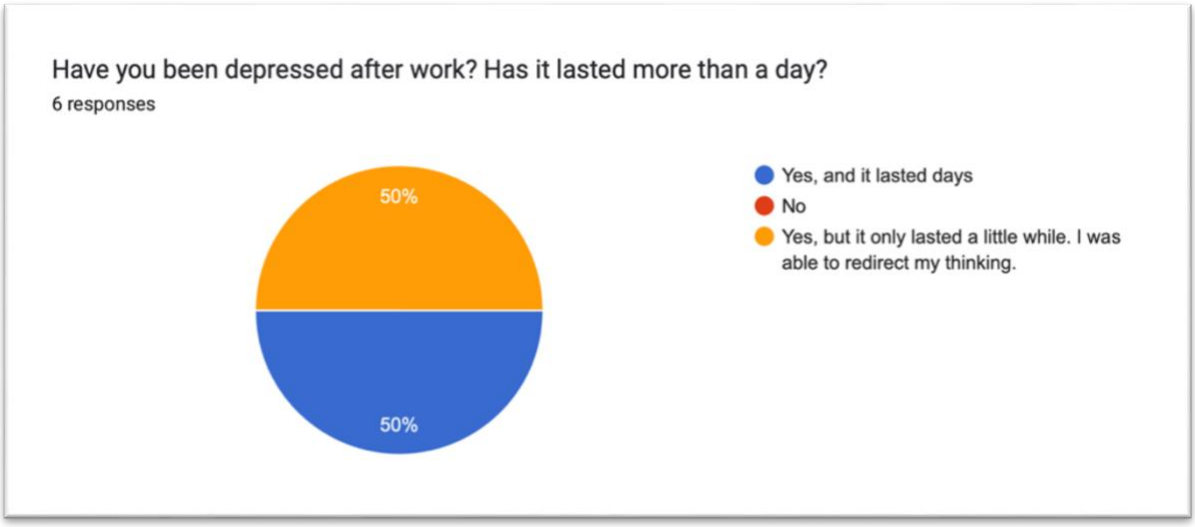

Figure 4.25. Personal depression survey results

The results of the question posed to the participants in figure 4.25 were somewhat surprising. This is because P-7 had originally stated that she had not felt depressed due to work-related issues (refer to fig. 4.2). As stated in the limitations section, not all answers will give a thorough response. Consistency is crucial. However, it's worth noting that the participants

insisted that their answers were accurate and truthful. To help the participants understand the context of depression, it was explained to them that any form of depression, even if it originates from outside the hospital, would be significant.

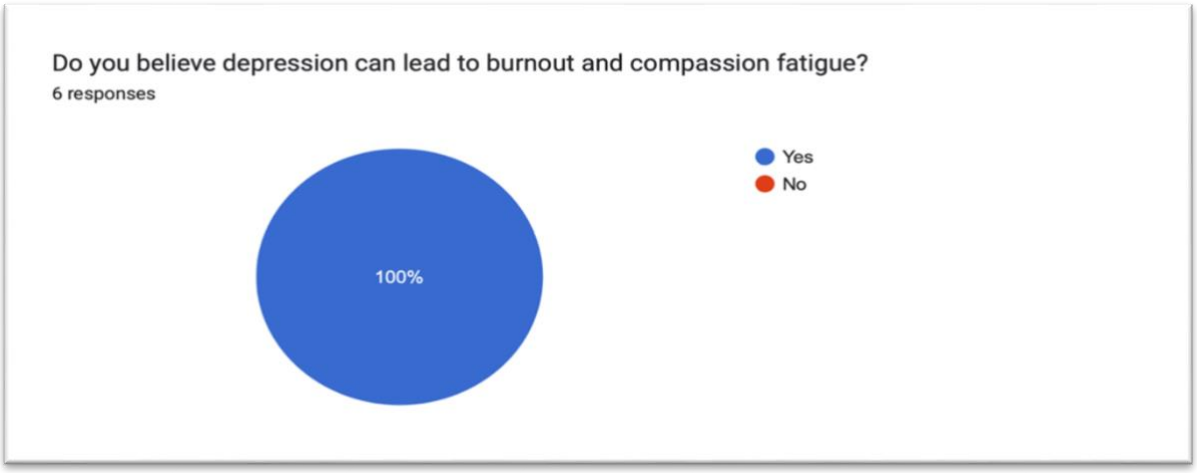

Figure 4.26. Depression burnout and compassion fatigue survey results

During a focus group discussion, the participants talked extensively about the question presented in figure 4.26, which pertains to healthcare workers considering leaving the industry altogether due to depression, burnout, and compassion fatigue. The group agreed that if there were interventions at the depression level, the likelihood of a healthcare worker reaching burnout and compassion fatigue would be reduced. The discussion also revealed that many participants knew of former co-workers who had left the profession altogether due to burnout. All participants in the group agreed with the question in figure 4.26, and six of them completed a survey after the session. The results for this topic lined up with the research and prove that interventions are a possible route to consider for depression in the healthcare worker.

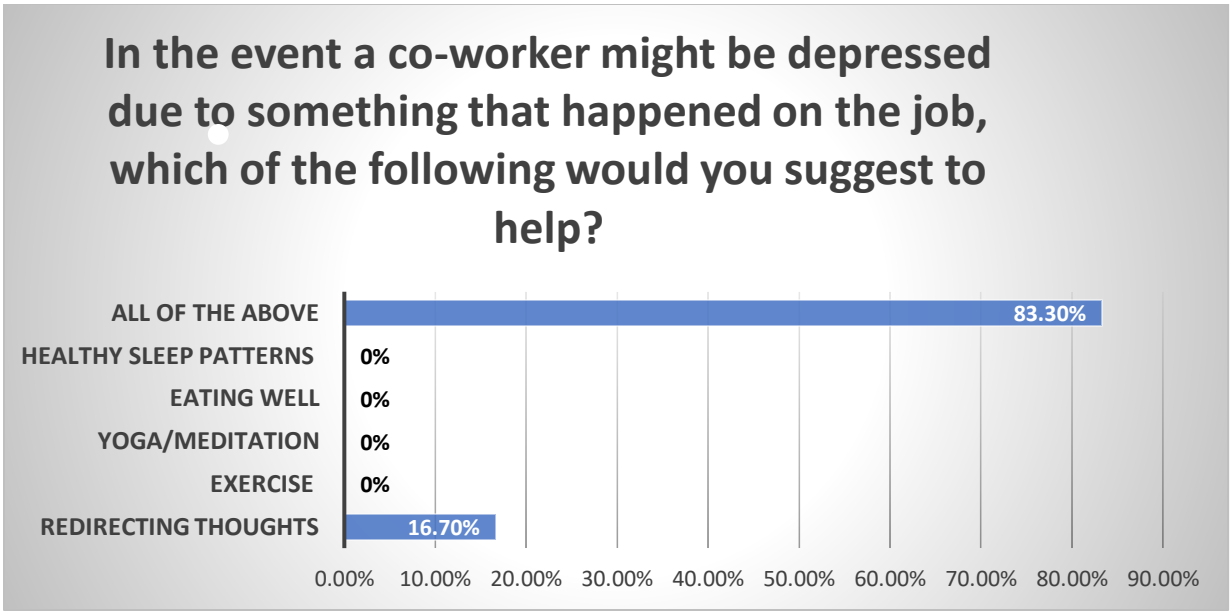

Figure 4.27. Healthy suggestions survey results

During the study, participants were asked about the methods they used in the past to alleviate the symptoms of depression. Figure 4.27 presented various holistic approaches to address these symptoms, and the majority of participants expressed their willingness to try all of them. However, some believed that redirecting their thoughts would be enough to help them cope. The participants were introduced to somatic therapy, which included yoga and meditation, during the week's session as a possible remedy for depression. The importance of sleep was also emphasized, given the long working hours of many healthcare professionals. The majority (83.3%) agreed that any of the choices offered in the study could lead to a healthier outcome, while the rest (16.7%) believed that simply redirecting their thoughts would suffice. During the group discussion, it was unanimously agreed that a drug-free approach is the best method for

healthcare workers. The fact that all participants agreed that a holistic approach is the best way forward adds weight to the findings of this study.

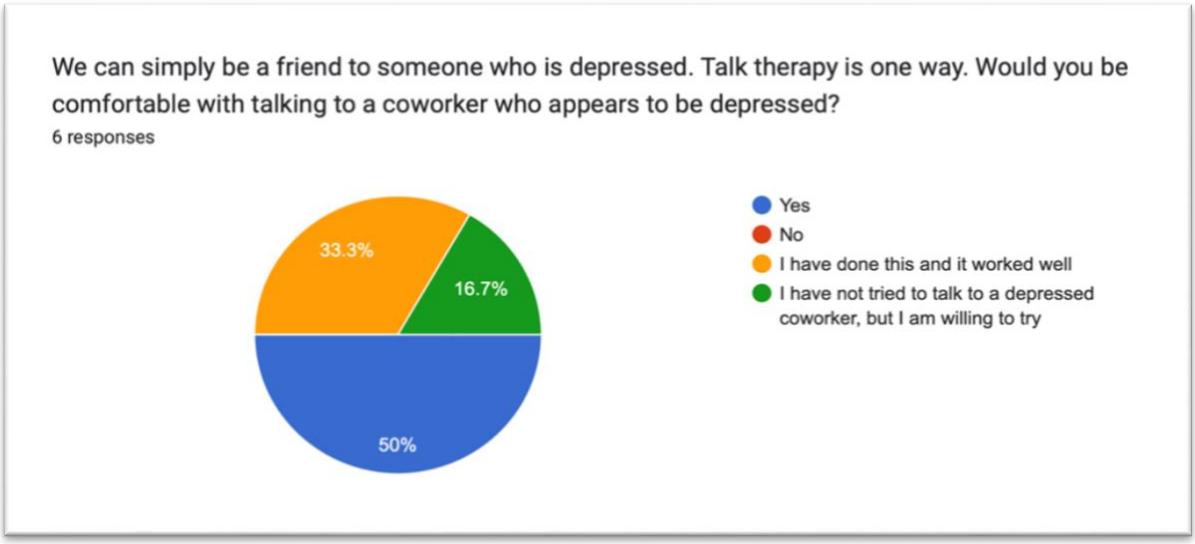

Figure 4.28. Using Talk Therapy with a depressed co-worker Survey results

Along with somatic therapy as an intervention technique, talk therapy is an option that allows the peer to voice their thoughts to another peer. Coming alongside one another and simply listening is appreciated. The focus group as a whole agreed that listening can help in certain situations that bring on depressive feelings. The researcher asked the same question in a survey (fig. 4.28), and the response was respectable. Out of six responses, half stated that talk therapy could be helpful, too. Of the responses, 33.3 percent had expressed that they had used the talk therapy method before with success, and 16.7 percent had not spoken to a depressed co-worker before. Because the majority had some familiarity with speaking with someone who is depressed, this would be a positive sign that the methods will be welcomed. In figure 4.29, the researcher posed the question to the group and later in a survey to see if they had witnessed a co-worker who showed signs of being depressed. All participants in the focus group that week reflected on situations when they had observed a co-worker who displayed typical signs of

depression. Many HCWs have verbalized depressive symptoms to the hospital chaplains in the past. Therefore, the reflections did not come as an astonishment.

In the online survey, the response was astoundingly incredible and noteworthy. One-third of the responses indicated that they had a co-worker who was not only depressed but had developed a chronic condition. The other two-thirds admitted to having a coworker who suffered from depression. These indicators point to the probable need for early intervention to avoid the cross-over to chronic depression and, ultimately, burnout. This research indicates peer-to-peer interventions that can provide the necessary steps to aid a co-worker in an emotionally vulnerable state. The responses to all prompts and discussions in the focus group this week had proven what the research indicates: there are healthcare workers who suffer from depression and need a remedy. The participants agreed that a holistic talk therapy approach is the best method. The next section, week five, discusses burnout and offers suggestions for intervention.

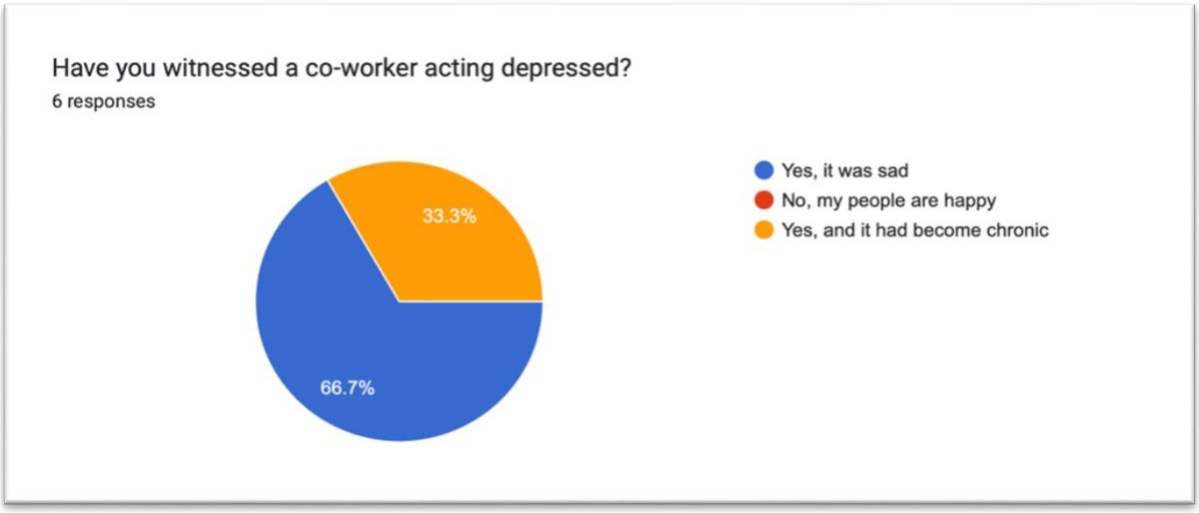

Figure 4.29. Co-worker acting depressed survey results

Week 5: Burnout

In the fifth focus group session held during the week, participants learned how talk therapy can be useful for people who show signs of burnout and how it can be used as an

intervention. The objective of the exercise was to help them understand how to deal with the issue in case they or their colleagues experience burnout and compassion fatigue. During the session, attendees were encouraged to jot down their thoughts and emotions, engage in an open discussion, and respond to a series of questions through Google Forms. The responses were then compiled into graphs to help the participants better understand the prevalence and impact of burnout in their field. The session was informative in addressing burnout and highlighting the advantages of seeking help when necessary. However, the next set of graphs may present some controversial insights in the workplace. Healthcare workers require a reliable source of support in case of a personal mental health crisis. The focus group participants agreed that burnout is becoming a more significant issue, and many of their peers suffer from it. Figures 4.30 to 4.33 detail the survey results on which four employees HCWs feel they can approach for assistance.

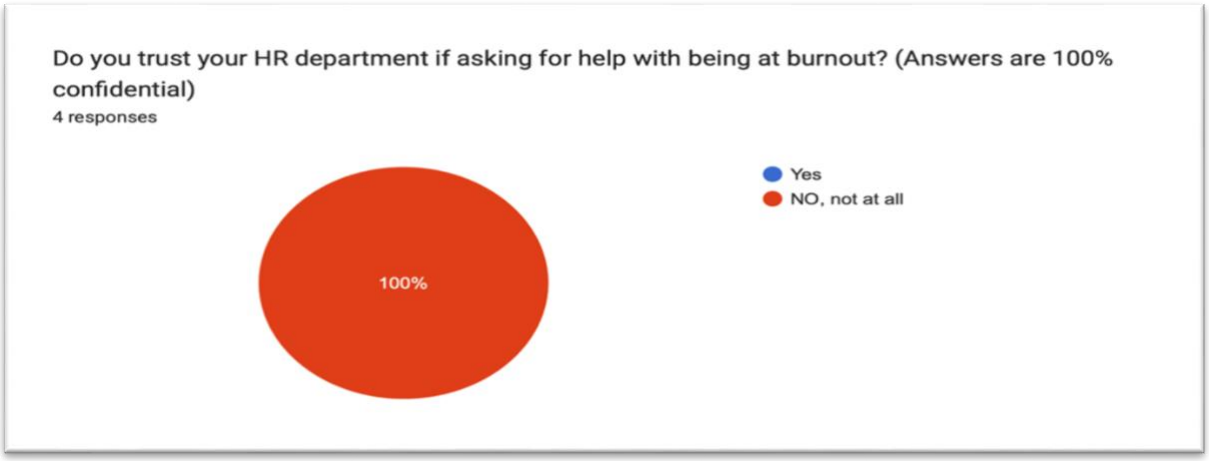

Figure 4.30. HR assistance trust survey results

During the fifth-week focus group, participants were given assurance that their answers would remain anonymous due to the sensitive nature of the questions. Figure 4.30 asked if the participants trusted the current human resources department enough to seek mental health help from them. The research revealed that the participants were reluctant to seek help from HR for mental health crises. The in-person focus group revealed that all participants hesitated to ask for

help due to confidentiality concerns between therapists and HR. Figure 4.30 presents the four responses from the survey after the group met. All participants verbally expressed that they did not trust the HR referrals and that their personal confidential problems would be sent from the EAP to HR. As previously mentioned in Chapter 2, many healthcare workers are concerned about employee assistance programs (EAPs) provided by human resources. An alternative would be peer-to-peer interventions that can express confidentiality. All participants agreed that a peer would be a better choice in most situations. The responses from the participants support the research done in this project in Chapter 2.

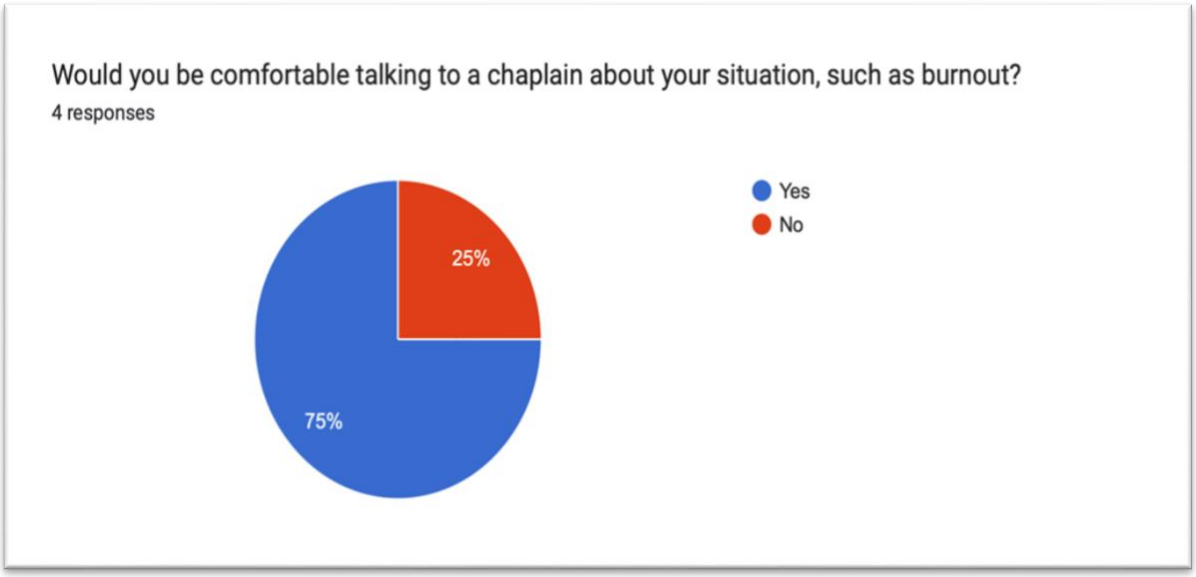

Figure 4.31. HCWs comfortability talking to a chaplain survey results

In week five, a focus group was conducted with the presence of an observer from the hospital chaplaincy. The chaplain was introduced to the group, and they were given the opportunity to ask questions or provide feedback related to the pastoral care department and staff support. The participants were asked if they had any hesitations about confiding in a chaplain during a personal crisis. Interestingly, the group had mixed reactions. Two participants admitted

that they would not approach a chaplain first but were open to considering pastoral support. The rest of the participants felt comfortable speaking to a chaplain or had previously done so. A post-class survey was sent out, and four participants responded to the topic of burnout (see fig. 4.31). One participant was uncomfortable speaking to a chaplain, while the other three were comfortable. This mixed reaction for this part of the research was less than ideal. There was more hope that the chaplains were approachable. Healthcare workers should be reassured that speaking with a chaplain is confidential in case of any mental health crisis. There were only a couple of questions for the staff chaplain from the group. One participant asked if needed, could a priest from my church come talk to me at work? The response was yes, if there is a priest available at that time, it could be made a possibility. One other participant inquired, “Does management ask you what we talk about with a chaplain?” The chaplain reassured the whole group that the conversations were confidential. This concluded this portion of the session.

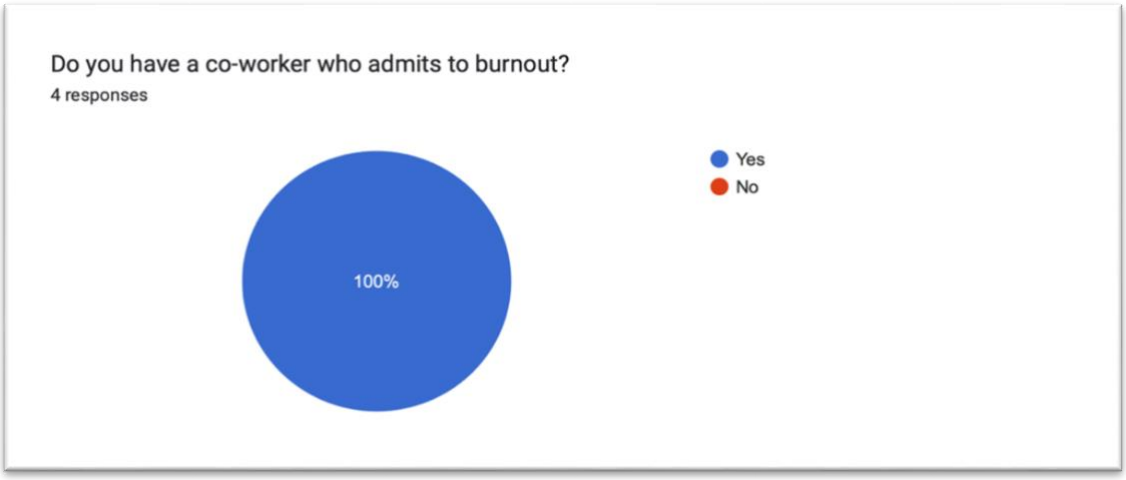

Figure 4.32. Co-worker who admits to burnout survey

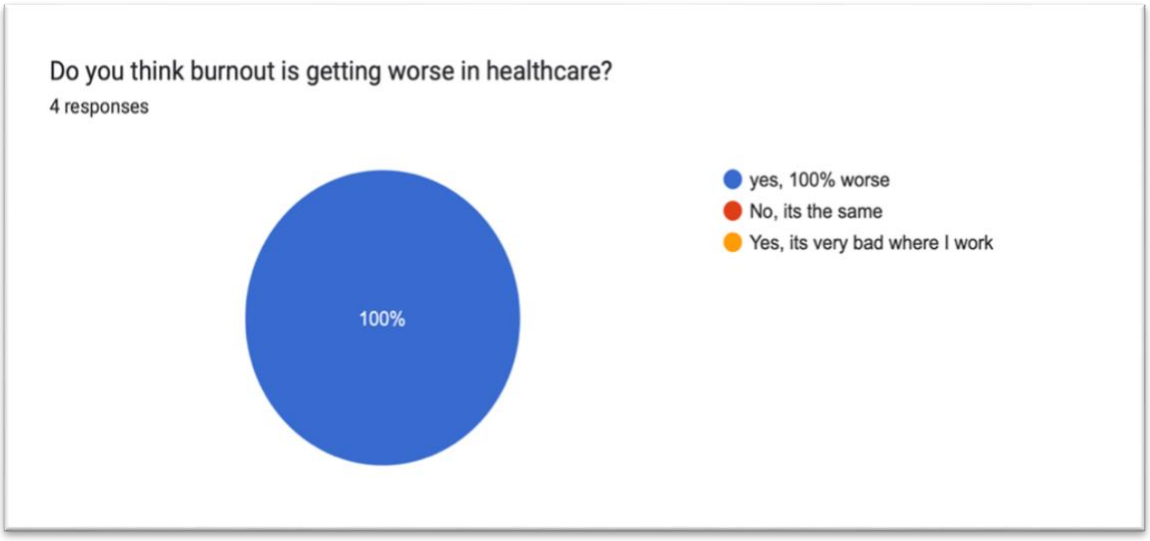

Figure 4.33. Is burnout getting worse in healthcare survey results

In the next part of the focus group session, participants were given mock scenarios that gave them hope. The approach involved a combination of talk therapy and empathetic listening, which all participants believed would be helpful for their immediate needs. The participants were given cards that simulated burnout scenarios in their peers, and they engaged in mock exercises. At the end of the focus group, several participants admitted that having someone listen to them was crucial, especially when they were experiencing burnout. Figures 4.32 and 4.33 provided alarming results for the research on burnout. The researcher expected only a few of the participants to admit to knowing someone experiencing burnout, but in reality, all the participants either knew someone or were experiencing burnout themselves. Most of the participants in the focus group believed that burnout has been increasing since the COVID-19 pandemic started. As it is related to burnout, the topic of compassion fatigue and the intervention necessary will be discussed in week six.

Week 6: Compassion Fatigue

During the sixth week of the program, the participants attended a session on compassion fatigue in healthcare. They watched a video and then participated in a Q&A session that covered the previous week's activities and what was planned for Week 6. The session discussed the CBT empathetic listening model introduced in the intervention design. Although the session was only 40 minutes long due to scheduling conflicts, the participants wanted to discuss how they would approach a situation involving a peer with CF instead of relying on mock scenarios. Some of the ideas shared by the participants included using open-ended questions, actively listening, and asking directly if the peer was feeling hopeless and drained from their job. The healthy discussion meant that there was no need for any follow-up questions to generate graphics. Weeks seven and eight were primarily for participants to share feedback and ask questions. Few participants attended weeks seven and eight due to schedule conflicts, and those who did attend yielded no further results. All necessary data and results have been gathered for this action research project, and a comprehensive analysis will be provided next.

Data Analysis

The goal of this DMIN action research project is twofold: to increase awareness of the mental health needs of healthcare workers and to create a program that can be combined with other initiatives to offer peer support in hospitals. The data collected during the research confirms what was already suspected: healthcare workers require mental health assistance from time to time. Although the data was only collected from seven HCWs, it indicates the possibility of a broader situation in other hospitals. The data analysis has yielded mixed results, but overall, it is encouraging that a program could be established to assist many HCWs.

During the study, it was found that every participant, except for P-7, had experienced depression at some point in their careers. Out of all the participants, three individuals were open

about their struggles with fear and anxiety in the workplace. Additionally, all participants, except for P-5, had experienced burnout at some point during their careers. These findings are not surprising, as many individuals in high-stress jobs can experience similar challenges. After understanding the data analysis, a summary will be provided to highlight the results.

Summary of Results

Identifying HCWs who are strong leaders and have empathetic emotional well-being has become a vital source in this project. Every participant engaged in the focus groups every week except the last two sessions. The surveys that were sent out after each focus group only reflect the responses of those who chose to answer the questions. Each participant in the focus group asked the same questions. Therefore, the responses for the graphics each week do not reflect all participants. The findings obtained from all participants have proven to be both unexpected and insightful in various ways. In this section, the researcher will summarize the results and share an expert's perspective on the relationship between nursing students and mental health. All stakeholders have contributed high-quality data from interviews with each participant, critical metrics from assessments, and focus groups. The interviews provided an intimate understanding of the healthcare professionals' experiences.

With all participant participation, the study's findings indicate that P-2 has a high level of compassion satisfaction, while P-7 has a low level of compassion satisfaction, leading to compassion fatigue. The Pro-QOL assessment revealed that participants with more years of healthcare experience, such as P-4 and P-7, had a higher level of trauma. The emotional intelligence results of the study are noteworthy, with participants scoring an average of 115.285, which is ten points higher than the national average of 105, as illustrated in figure 4.11. These findings indicate the ability to identify healthcare workers who are capable of attending to the

emotional needs of their peers in crisis, rather than those who have problems. Going forward, it would be ideal to identify other HCWs who have higher E.I.Q. if this program should be utilized at Henry Mayo Hospital. The E.I.Q. is the one assessment that glees the hope of strong leaders who can attend to their peers is essential.

The researcher gained valuable insights from the focus group assessments conducted after each session, which were critical for the success of this project. The questions asked were mostly straightforward and required participants to provide direct answers. During the first week's discussion on stress, the researcher discovered that most units needed to de-escalate stress levels. Participants acknowledged that a stressed healthcare worker can be ineffective and provide poor care, which impacts the patients. Furthermore, it was revealed that every participant had experienced at least one symptom of the problematic mental health issues that healthcare workers face. A personal, professional, and specific perspective can detail important information for this action research project. With more than twenty years of experience as a healthcare professional and nurse educator, the expert interview will contribute to advancing the research for this project.

Interview with Healthcare Expert and Participant

As part of this research, it was vital to have enlisted an expert in the healthcare profession to give a synopsis of the mental health crisis from a personal and professional viewpoint. The following information that the expert provided supports this action research project thesis. The researcher interviewed a healthcare expert via phone who provided crucial information about nursing students and their mental health during the research. The expert, identified as P-7, agreed to participate in the study due to her extensive experience as a nurse in the Emergency Room and the Intensive Care Unit. Currently, she is the assistant director of nursing at the College of the

Canyons in Santa Clarita. The interview occurred before the focus groups had begun, and the researcher asked multiple specific questions about mental health in the healthcare industry.

The expert was a working registered nurse before teaching and becoming the College of the Canyons nursing program co-chair. The researcher asked questions about her past work as an RN in the emergency room and the ICU. The researcher asked if healthcare professionals are supported by management at any hospital where she has worked. The expert referred to a different hospital where she was employed with this response: "No, never did I or my co-workers feel management cared." Additionally, the researcher asked if a program that allowed peers to support other peers was available and if it would benefit those they have worked with. The expert's response was confirmed, "Yes, we work as a team most of the time, but when it comes to supporting one another, it might have kept some nurses and doctors from quitting." The expert provided this information, "The only reason we (healthcare workers) have not helped each other when we are feeling sad, or depressed, possibly filled with anxiety, is because we are so patient-focused. We would not ask if something were wrong, probably because we do not know what to say in return. We often find out about a co-worker having a serious problem after they either quit or take time off." The expert's testimony here confirms that healthcare professionals need a solid peer-to-peer program in the event of a mental health crisis.

With regard to nursing students and their mental health, the following questions were asked. One specific question asked is why nursing students need to prepare for the stress that comes with nursing, as claimed in journal articles and books. The expert responded by saying that students need to be adequately prepared for the emotional challenges they will face. Although they learn to care for the body, they receive minimal training on how to care for the families of patients who have passed away. Unfortunately, some nursing instructors are not comfortable teaching about death and depression, which further limits the students' preparation.

During the interview with the healthcare expert, the topic of the harmful mental health effects on healthcare workers was discussed. The expert mentioned that nursing students are taught about such issues from the BRN (student nursing textbook), which is limited. However, they cannot fully comprehend the full spectrum of mental health issues until they begin working in the clinical setting. When asked about how nursing students cope with stress during their hospital clinics, the expert revealed that, unfortunately, most of them resort to alcohol. The researcher interjected and asked if the alcohol use becomes chronic. The expert stated that it all depends on whether the students stay in a high-stress unit or work in a much lower-stress unit. Somehow, they find ways of coping in the lower-stress units until they gain resilience through experience. According to the expert, nurses cope with a wide range of mental health issues, such as long-term depression, anxiety among new hires, and compassion fatigue.

All of these problems remain the number one problem among healthcare employees all the time. One final question posed to the expert was if she felt this action research project's methods would benefit students before their clinical. The expert believes it would benefit the students tremendously, and knowing it comes from a chaplain makes it that much better. The researcher thanked the expert for the time to be interviewed. The following final conclusive chapter for this Action Crisis Intervention Response project will discuss the research implications, applications, limitations, and further research suggestions.

CHAPTER 5: CONCLUSION

This DMIN action crisis intervention research project has been developed to draw attention to the need for mental health support for healthcare professionals at Henry Mayo Hospital. Chapter 1 provides a ministry context, presents the problem, assumptions, and definitions, and also includes the thesis statement for this research project. Chapter 2 highlighted the conceptual framework that embodies the literary research for this project. Chapter 3 details the methodology that was followed to guide the research. Chapter 4 captures the research and focus group results, detailing the participants' responses to the proposed intervention. Finally, this chapter presents research implications, applications, limitations, and suggestions for further research. The initial section of this conclusion will summarize important findings and discoveries.

Research Implications

At the onset of this research project, it became progressively evident to the researcher that many healthcare professionals needed mental health support. The support mentioned is intended for short-term assistance rather than for chronic issues requiring professional therapy. Unfortunately, the approach to dealing with the mental health crisis at Henry Mayo has been inadequate over the years. While the intention has been present, the practical approach must be re-evaluated. The participants in this action research project have expressed a critical need for a reliable and effective program. Anonymity is crucial for the success of any solution, as demonstrated in this action research intervention. All participants agreed that a peer-to-peer approach and a comprehensive process for each mental health issue would be ideal. Participants

believe that such a program warrants a systematic process to promote well-being in the workplace. Through this research project, participants hope there is a possibility for success if healthcare professionals are willing to engage fully. Whether the participant has experienced a mental health crisis or is aware of a colleague who has, the consensus among the group is that a program addressing stress, anxiety, fear, and depression is likely to be the key factor in preventing burnout and compassion fatigue. All participants agreed that stress is a significant issue for many of their colleagues (see fig. 4.12). Stress is one of the leading causes of burnout and compassion fatigue. While not all participants admitted to experiencing compassion fatigue, they acknowledged experiencing burnout at some point. If left unchecked, stress is a collective problem that can lead to many other issues, such as anxiety, as described in the previous chapters. Figure 4.15 illustrates that the participants in this research believe that stress in healthcare workers can lead to mistakes, possibly harming patients. There are likely consequences to the actions of stressed healthcare workers if mistakes are made.

Depression is a significant problem among healthcare workers nationwide, with 25% of polled workers admitting to experiencing depressive symptoms.[1] During the participant interviews, each either acknowledged having depression or noticing a co-worker with symptoms of depression. All participants agreed that talking to someone would be helpful in this situation. The study found that talk therapy is effective in reducing some depression and anxiety symptoms, and the participants confirmed that they felt better after the sessions conducted in the focus groups. Furthermore, somatic therapy, a relaxation technique, was well-received and showed promise among the participants. After conducting personal interviews and surveys with

[1] Robert P. Lennon et al., "Prevalence of Moral Injury, Burnout, Anxiety, and Depression in Healthcare Workers 2 Years into the COVID-19 Pandemic," *Journal of Nervous & Mental Disease* 211, no. 12 December 2023: 984, https://doi.org/10.1097/NMD.0000000000001705.

all participants, it became evident that each one of the participants has experienced at least one mental health crisis and can relate to the issues presented. This suggests the need for an intervention in the units where these individuals work, if necessary. The research, surveys, and personal interviews indicate that a program of this nature will likely succeed with proper guidance.

The research findings regarding death and dying were surprisingly impactful, particularly for healthcare workers. Witnessing a patient's death can lead to secondary traumatic stress (STS), even for those in the healthcare profession. In one of the focus group sessions, a discussion among the participants on grief was brought up. All participants shared intimate details about their personal experiences. Since they were all healthcare professionals, it seemed more acceptable for them to hug or console a co-worker. The level of compassion displayed by these professionals was truly remarkable. Perhaps their responses were valid and heartfelt because they experience patient deaths more frequently than other professions outside of healthcare.

All participants agreed they had witnessed a co-worker grieve (cf. fig. 4.18). This was essential for the research project, as it aimed to gain insight into healthcare workers who have experienced peers grieving and needing comfort. Figure 4.19 shows all participants were willing to spend time outside the workplace with a grieving peer. This not only demonstrated their caring nature but also presented that one participant had actually done this previously. The only research statistic needed in this section was identifying healthcare workers who had noticed their peers grieving. It would be interesting to see if the statistics change with a different group or with male participants included. This topic was sensitive, and the results showed promise for this research.

The statistics might appear typical to healthcare workers in a specific area but possibly not to hospital management. Chapter 2 research shows that peers are viewed as non-judgmental, and trust is vital with peer-to-peer counsel. When asked if they trust a referral from human resources to a counselor, specialist, or psychologist, every participant responded, "No, I do not trust HR." Figure 4.30 provides the group's response to the poll question. This is not surprising given the research conducted illustrates the lack of trust for HR in healthcare. This topic was briefly discussed during the group sessions and was not explored further due to its sensitivity. The results provide stability to the implementation of the action crisis intervention project. However, there is a need to investigate further the possibility of human resources defending their views on the topic. The next section will explore the research applications to gain a deeper insight into how the program will be implemented and utilized.

Research Applications

In order to implement the program developed in this action research project, it is important to ensure that every employee is aware of its existence. The first step would involve emailing every employee and the human resources and education departments at Henry Mayo, providing a detailed description of the program and its benefits. This may lead to a variety of questions from the staff, so it would be important to set up a table in a common employee area to address any potential inquiries about the program. Once the intervention program has been introduced, the next logical step would be to train chaplains and staff in the education department to assist in facilitating the agenda.

Hospital chaplains play a crucial role in offering emotional and spiritual support to patients and staff. As Chapter 2 of the literature review indicates, healthcare providers can

leverage the benefits of religion and spirituality to help manage emotions.[2] Most focus group participants value the support hospital chaplains provide. However, chaplains may find it difficult to meet the needs of every staff member. As part of this action research project, it is important to identify individuals in each unit who can offer peer-to-peer mental health support for their fellow healthcare staff. Research indicates a clear demand for interventions based on the feedback from the focus groups in this study. The data collected in this action research project suggests an increasing Chapter 2 need for emotional support for hospital staff. Ana Stefancic's article provided in relates the same sentiment that support is needed in peer-delivered services. All participants in the focus group actively facilitated one or more of the methods used in this research project successfully on a co-worker during the eight-week sessions.

Not every participant experienced a range of issues. All admitted to facing at least one mental health issue in the last few years. The prevalence of stress and burnout among the participants underscores the increasing need for interventions that would benefit the Henry Mayo Hospital, which is the focus of this study. The project also highlights the mental health challenges experienced by healthcare professionals. With the expanding community around Henry Mayo Hospital, the need for more healthcare workers will grow. The ministry of presence of hospital chaplains would be crucial in supporting patients and staff alike. Additionally, healthcare professionals in each department could provide significant support to their colleagues in need, indirectly benefiting patient care. This ACIR was intended to be taught alongside the existing MHFA to support the departments and healthcare workers and to maximize its potential better.

[2] Kostka, Borodzicz, and Krzeminska, "Feelings and Emotions of Nurses Related to Dying and Death of Patients- A Pilot Study," 713.

The Expansion of ACIR

In accordance with the previous program presented to the staff at Henry Mayo Hospital, MHFA would be the initial step in educating the staff if not already done. The MHFA program emphasizes recognizing mental health issues and how to facilitate a referral. To enhance the training, this mental health intervention project would align with MHFA and provide training for the medical and supportive staff to initiate a quick response through holistic therapeutic techniques. The facilitator (researcher) will introduce this program to the MHFA organizers and provide education about it. The research gathered in this project is practical and sufficient to introduce the program's design and critical statistics that have provided some validity to the examination. Much like the participant group sessions in this study, the training will cover the methods used during each mental health crisis.

The initial research surveys given to the participants yielded surprising results. Each participant realized their own levels according to the vicarious trauma, emotional I.Q, and the ProQOL. To ensure the program's standards are met, the researcher and the staff chaplains will seek permission to administer the same three initial surveys used in this project to every healthcare employee at Henry Mayo with an anonymous return to protect the employee's identity. These same surveys address Vicarious Trauma, Compassion Fatigue, and Burnout (see Appendix C), Emotional Intelligence (see Appendix D), and ProQOL (see Appendix E). Once the chaplains process the surveys, they will be discussed among the necessary management. At that point, if the results yield what was learned in the focus groups, management will likely see that there is a need for interventions among the healthcare staff. These surveys will provide statistics that management can use to identify departments needing mental health awareness and preparation for possible interventions.

Henry Mayo Hospital management will be the decider on which unit should receive the initial training. Once established, the team will facilitate the program, starting with MHFA, followed by the action crisis intervention curriculum. As the program advances, the hospital chaplains and the education department will become the facilitators of the intervention program and will be responsible for gathering information from management and scheduling classes for all employees.

ACIR and MHFA Together

The chaplains will have a crucial role in facilitating the program's progress. Ideally, they would collaborate with the Education Department to monitor and oversee MHFA classes and coordinate future courses. Management and human resources will be invited to observe and participate in the initial first-group class. This way, they will become increasingly aware of the process and become advocates for the program. This program will be available to all Henry Mayo Hospital personnel, including medical staff, janitorial, housekeeping, technicians, and other healthcare professionals. The intervention classes will involve initial surveys followed by group sessions used in the focus groups. It would be beneficial to coordinate with other program facilitators of the MHFA for class times and dates, considering the amount of time needed to facilitate this program. The intervention classes will have to be completed without compromise for time to grasp the entirety of the program's benefits. The objective is to gain full approval from management to facilitate this program on an ongoing basis.

Throughout this project, it has been mentioned that the chaplains have numerous tasks to complete on a daily basis. It would be beneficial for the chaplains to seek additional support from the education department to assist with this program. The education department, which has previously assisted with the MHFA, could help by communicating class times and schedules and sending the necessary emails to the staff. Another option could be to train the same staff to run

this ACIR at times. Since this ACIR is meant to complement the MHFA, having the staff from the education department would be very beneficial. Further discussion will be essential to pinpoint the limitations that have been uncovered.

Research Limitations

This thesis project's primary focus is how Henry Mayo Hospital can benefit from acquiring a peer-to-peer intervention program to support fellow staff dealing with mental health crises. Currently, this hospital needs a viable program to meet the needs of its staff in such vulnerable situations. To better understand the limitations, the research conducted was compared with the need for this program. Although there were several limitations, they did not affect the results obligatory to this action research intervention project. All contributors in the project are considered veteran healthcare professionals who have worked in the industry for more than three years.

The data collected provides an accurate understanding of the stresses faced by healthcare workers and the mental health crisis issues they may experience. The research concludes that a significant problem at Henry Mayo Hospital requires urgent attention. This project aimed to gather reliable statistics to develop a working program that ensures mental health stability in each hospital unit. Unfortunately, the number of research participants did not meet the initial expectations, which will be discussed further in this section. It would have benefited this research if participants from other departments had been able to contribute. The behavioral health unit (BHU), emergency room (ER), and surgical healthcare workers could have contributed significantly. The healthcare workers in the mental health unit, endure challenging patients with behavioral issues of their own. The staff in the BHU could have provided insight and possibly benefited from this research project. Given the alarming statistics from the one emergency room participant, additional participants could have provided supplementary insight.

The researcher discovered the fact that there is a great amount of stress and high turnover in the surgical unit, which is often overlooked. Physicians themselves are not exempt from mental health issues that come with a high-stress job. The following will discuss the importance of physicians in further study.

The Need for Physicians

This action research intervention project would have benefited from the participation of one or more physicians from Henry Mayo Hospital. Notably, in the initial literature research, physicians are a part of the healthcare team and are just as susceptible to a mental health crisis. As noted in the literature review, Claire Roger et al. assert that out of 136 healthcare workers studied, 52 physicians admitted to having a mental health crisis at some point. Programs such as Code Lavender and Mental Health First Aid focus on nurses and other supporting staff, but physicians are rarely included (opinion of the author). Physicians have the stigma of having high levels of resilience and thick skin when it comes to trauma, stress, and other mental health problems. The exact way in which physicians at Henry Mayo process their emotions was overlooked. Overall, having physicians in this study would have been a benefit. The author's opinion of this action research project is that the challenge in recruiting physicians for this study was their unpredictable and erratic schedules and the lack of belief in honest answers to the surveys and focus group questions. Other participants that could have brought significant contributions are the critical care and student nurse populations.

Critical Care and Student Participant Needs

The survey responses and focus group discussions provided by the participants representing their respective units were informative and honest. However, the research could have been more substantial if additional healthcare employees from those units had participated. The ICU nurse participant in this study showed high levels of resilience, with low stress and burnout statistics, which contradicted the expert who was interviewed for this project. The expert worked as a critical care nurse in the ICU at one point in her career. The research in Chapter 2 maintains that there are high-stress levels and burnout among ICU healthcare workers. To be more specific in the reference, a study in 2021 identified 136 ICU healthcare workers who were admitted with mental health problems, and 84 were nurses.[3] It would have been beneficial to have another healthcare professional from the same unit involved in this research project. Along with the emergency room technician, having a registered nurse or physician would have been crucial in gathering essential information through a compare-and-contrast approach.

This action research project made several references to nursing students. An expert who was interviewed provided insightful knowledge about the mental health crisis that can affect nurses in their first two years of practice. Although the initial guidelines requested healthcare workers with over five years of experience, it would have been beneficial for the study to include one to two healthcare professionals in their first years of practice. References were made in the literature review regarding student nurses and their emotional inadequacy.[4] These student nurses often sought guidance from the faculty when enduring an emotional on-the-job stressor. Even though some of the survey questions may not have been relevant to newer healthcare

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[3] Roger et al., "Occurrences of Post-Traumatic Stress Disorder, Anxiety, Depression, and Burnout Syndrome in ICU Staff Workers after Two-Year of the COVID-19 Pandemic." The International PSY-CO in ICU Study. *Annals of General Psychology* 23, no 1 January 3, 2024: 14.

[4] Jones, *Grief on the Front Lines*, 86.

professionals, the study could have gained a better understanding of their perspective on the mental health crisis. Beyond the student nurses, another area could have brought additional and significant research information: the men of healthcare.

Male Healthcare Worker's

At Henry Mayo Hospital, when a chaplain is called to minister to a healthcare worker, it often happens after a traumatic event or the patient's death. The chaplain is provided with the unit and healthcare worker's name. All units have men and women healthcare professionals, except for labor and delivery and neonatal intensive care units, which consist of women primarily. For this research project, only female nurses, excluding the critical care nurse in the ICU who is also a nurse practitioner, participated. However, there is a gap in the research as the male counterparts could have provided similar or different results that could have applied to the outcome.

The researcher attempted to include men who were either nurses, physicians, or technicians. Unfortunately, none were available to participate in this action research project. The male counterpart, who also would have had direct patient access, could have contributed to this project with the possibility of a different result in some areas. A male participation would have given balanced insight into this project. The outcome of facilitating an intervention program would not have changed, but some approaches could have had an impact. Engineering a method to include male healthcare workers and physicians will be the responsibility of the hospital chaplains in their communication with management and unit managers. The chaplain's role in this action research project will be crucial moving forward.

The Chaplain's Role

The chaplains will lead the program along with the Education Department at Henry Mayo once it is established. Ideally, involving a group of chaplains in this study would have been very beneficial. However, due to work schedule conflicts, the chaplains at Henry Mayo could only attend one to two focus group sessions. These chaplains will eventually be the main representatives who facilitate the instruction of this crisis intervention model. One of the top goals for this project is to develop relationships with healthcare workers, promote the ministry of presence, and emphasize the importance of hospital chaplains. Additionally, the chaplain will be oversight for this intervention program.

The study's theological aspect was limited and should have been broadened, regardless of the participants' faith backgrounds. Applying biblical principles meaningfully could have advanced the study, benefiting both the participants and the surrounding staff. Much like when chaplains visit patients, understanding the faith or religion of the participants could have enhanced conversations and the understanding of certain theological points. Educating the participants about the fruit of the spirit, such as love, joy, peace, patience, kindness, goodness, faithfulness, gentleness, and self-control (Gal 5:22–23), may have helped them present themselves in the best possible way. All of these attributes are part of everyday lives, although everyone may not possess all of them at the same time. For example, patience, kindness, and gentleness all fit into empathetic listening techniques and talk therapy. A chaplain is trained to attend to the patient's needs, even if they have expressed no faith or belief in God. Displaying a ministry of presence at any given moment is crucial to chaplaincy and programs like this action research project. Further research is required to explore the areas that were not discussed.

Sharing the action research intervention project with other hospitals in the area could be beneficial in many ways. As demonstrated in Chapter 2 of the research, mental health problems

among healthcare workers are widespread. Annually, Henry Mayo invites area hospital chaplains and clergy for a ministry breakfast gathering covering a specific topic. The chaplains at Henry Mayo would introduce the program and its potential benefits. During that time, fellow chaplains and clergy would be welcome to ask questions about the program and provide feedback. Providing this program to other hospitals at some point may help improve the mental health of healthcare workers in the area, which has been the goal of this project from the beginning. Healthcare workers are not only professionals but also family members, and it's crucial to recognize the impact of mental health on the entire family.

The Effects on Family

It's important to recognize that when someone is experiencing a mental health crisis, it can affect not only themselves but also their family, friends, and co-workers. Even minor stress can cause strain in relationships. Studies have shown that depression, anxiety, compassion fatigue, and suicidal thoughts can be triggered by stress related to finances, marriage, and children. The literature review provided examples of women in healthcare and birthing children can cause stress. Additionally, the COVID-19 pandemic was extremely stressful on families of healthcare workers, also described in Chapter 2 of the literature review. However, the research conducted for this project only surveyed the participants themselves and did not extend to their family and friends. Therefore, it would have been valuable to include a survey for the family and friends of these individuals to understand their experiences better. There is no telling if the symptoms could have been noticed in the workplace or at home. A firmer understanding from family would have given a broader picture of what others have noticed. The support has been less than perfect for the healthcare workers. They have options, often not taken as addressed in this project. EAPs are not the immediate answer, and nurses are usually a part of a union.

EAPs and Unions

There is strong evidence to suggest that a program at Henry Mayo Hospital would benefit employees and decrease the need for the Employee Assistance Program, except in serious cases that require professional counseling. Participants found the methods used in each mental health crisis episode to be helpful and unanimously agreed that it should be implemented as a program at the hospital. According to figure 4.30, employees would prefer this crisis intervention program over seeking assistance from human resources. Gathering resources from human resources about the EAPs could have aided in the research.

It is worth noting that many healthcare workers in the country belong to unions, but the research did not consider the resources unions may provide for mental health support. None of the participants mentioned seeking help from their union for mental health issues, although this does not necessarily mean that such support is unavailable. Unions typically assist their members with legal and ethical matters, which may also be related to mental health crises. While this project has been successful in many aspects, certain areas require further research and investigation to reach the identified objectives.

Further Research

This action research project was inspired by two tragic events at Henry Mayo Hospital: a high school shooting (known as the Saugus Shooting) that resulted in the deaths of three teens and the emotional toll endured by healthcare workers during the COVID-19 pandemic. It is clear there is a critical need for an intervention program to provide hope and support to healthcare workers. This program is designed to help individuals dealing with stress, anxiety, burnout, compassion fatigue, and depression. In collaboration with MHFA, the ACIR aims to promote mental health wellness for healthcare workers and emphasize the invaluable contributions of Henry Mayo Hospital nurses, doctors, and hospital staff.

The participants in this action research study gave positive feedback on the importance of a program that teaches techniques for aiding those in crisis. When this program takes effect and is used throughout the hospital, the objective is to gain insight into the results. However, it is necessary to gather factual results from individuals who have used these techniques to assist their peers in order to validate the program's effectiveness. The process of collecting real results should take a short time to complete. Therefore, further research is needed to enhance the program's benefits and ensure its success. It's imperative to note that this study had limitations in gathering more healthcare workers to obtain vital information on mental health problems at one hospital. Obtaining more information from healthcare workers at Henry Mayo would have provided a stronger foundation going forward, as discussed in the limitations section.

With Family in Mind

The research in this study has found that healthcare professionals experience stress and anxiety (see fig. 4.23 and 4.24). These mental health issues can also affect their personal lives. Therefore, supporting those involved in crisis intervention, including their family members and affected co-workers is important. It is possible that individuals may experience stress, anxiety, burnout, and compassion fatigue, which can have a significant impact on their well-being at home. The emotions of healthcare workers can also affect their family members. To conduct further research in this area, a survey could be carried out among family members with the permission of the relative healthcare worker. This analysis would mirror the anonymous healthcare survey (see page 156). Such a survey should be completely anonymous for the family members, and the goal would be to gather data that could help develop additional intervention techniques that were not previously considered.

Further Study on Compassion Fatigue and Burnout

Research in Chapter 2, the expert who was interviewed, and the results of just seven healthcare workers collectively show that compassion fatigue and burnout are real problems. As indicated, compassion fatigue and burnout are among the primary reasons why healthcare professionals choose to leave the industry entirely. Multiple factors, including mental health problems, often cause these conditions. However, it is important to conduct further research to determine the likelihood of symptoms leading to burnout or compassion fatigue among healthcare workers. It is imperative for peers who have undergone training to be able to recognize both physical and emotional symptoms in their colleagues. This will enable them to assess the need for an intervention. The likelihood of a healthcare worker resigning could decrease by facilitating an intervention early on.

In the first chapter, it was mentioned that the CDC has concluded that healthcare workers dealing with mental health challenges need immediate attention instead of waiting for further symptoms to manifest. As the program at Henry Mayo Hospital progresses, further research will be necessary to gather the required information on the mental health needs, the timing of the initial intervention, and the possible outcomes. The American Heart Association recommends using the chain of survival as a guide for CPR, with the first link being the most crucial: “Early access to the emergency response system saves lives.” This phrase is well-known in healthcare and should also be effective using an early intervention as a guide. Further research could gather vital information on each response, the timing, and the outcome. No personal information would be necessary for these statistics. A baseline would then be established to determine the average response time and whether any changes are necessary.

Addictions and Coping

An additional topic that requires further research is the use of alcohol and drugs by healthcare workers as a coping mechanism. Studies have shown, and indicated in the research section, that some healthcare workers tend to use alcohol to cope with their work stress. During the focus group sessions, a question was asked if the participants knew of anyone who uses alcohol as a coping mechanism, to which a couple of participants responded affirmatively. In the interview with the expert, it was revealed that nursing students also use alcohol to deal with their stress. Therefore, to assess how many healthcare workers rely on alcohol or drugs as a coping mechanism, more research is needed. The possibility of an honest response to a survey sent to all employees would be adventurous. However trivial, these statistics would be interesting and helpful in the event a healthcare worker falls victim to the grip of addiction. It is believed that some factors led to the stress and depression that caused alcohol to become a crutch. Based on research, COVID-19 has caused an extraordinary amount of stress among healthcare workers. As a result, a temporary fix for a mental health issue can become a long-lasting problem. Chapter 2 of the research indicates that 20 percent of nurses nationwide admitted to misusing narcotics. It is hopeful that healthcare workers find a peer-to-peer intervention as a source to sway such temptations. At this stage of the research, certain topics have been established, and the following will provide a summary of those points.

The Present State

Despite the limitations of the research, it was determined that healthcare workers at Henry Mayo require a program to support their mental health needs and that a holistic approach is valued. The methodology utilized in this project effectively aligned with the thesis's purpose of integrating a program to assist healthcare workers experiencing a mental health crisis. It was not enough to simply recognize a crisis but to act on it through peer-to-peer interventions. The

holistic approach used by the focus group yielded positive results that are expected to have a noticeable impact on the mental health of healthcare workers at Henry Mayo (Author's opinion). Although there were limited participants, the focus groups revealed the mental health struggle of the healthcare workers at Henry Mayo Hospital. The research highlights the importance of mental health awareness training and shows that healthcare professionals prefer peer support. The overall findings confirm the need for a program to support the healthcare team and validate the research thesis. Ongoing training with the staff will be the main objective.

Collaboration with the pastoral care department and management is essential to develop a sustainable program further. With the support of Henry Mayo's management and assistance from the hospital chaplains, implementing a program tailored to the needs of the medical staff could potentially help healthcare workers at Henry Mayo to process and address stress, anxiety, and depression and prevent burnout and compassion fatigue. The author believes that this research project can develop into a successful program with positive outcomes for everyone involved. After additional research has been completed, this ACIR can correspond alongside the MHFA program with the potential to become one program to meet one common goal: to help the healthcare workers in America overcome mental health problems.

Where Should One Go from Here?

Has enough been done in this country to curb the ongoing mental health crisis? Statistically, the answer is no. Mental health in America becomes national headline news only in the shadows of a mass shooting or the sudden suicide of a celebrity. The awareness stops short concerning hospital healthcare workers. There always appears to be a political battle around America's healthcare system, yet there is no attention on the mental health of medical frontline workers. The COVID-19 storm has come and gone, but the mental trauma it left behind still lingers in the minds, souls, and spirits of doctors and nurses. This action research project may be

what is needed to raise awareness and aid in the suffering of healthcare workers at Henry Mayo Hospital through peer-to-peer interventions.

The methodology utilized in this action research project produced variable yet quantifiable results. The evidence assimulated demonstrates that if Henry Mayo Hospital adopts this action research project as part of an ongoing educational program, the hospital, the healthcare workers, and patients will benefit. There is a glimmer of hope for the well-being and mental health of healthcare professionals at Henry Mayo if this program is applied. The healthcare workers who take care of the sick or hold the hand of the dying may feel the stress and anxiety and possibly grow weary. The Bible assures us that the Lord will renew the strength in everyone who has faith and hope; they shall mount up with wings like eagles; they shall run and not be weary; they shall walk and not faint (Isaiah 40:31ESV). Hebrews 11:1 is a reminder that faith is the assurance of things hoped for, the same faith that helped Moses lead the Israelites out of captivity and the same faith that Noah had when he was building the Ark. The same God provides for His people today as He had done then because He wants His children to be successful and not filled with mental anguish. For I know the plans I have for you, declares the Lord, plans to prosper you and not to harm you, plans to give you hope and a future (Jeremiah 29:11 NIV).

APPENDIX A

CONSENT

Title of the Project: Action Crisis Intervention Project

Principal Investigator: Dwayne Pine, Candidate for DMin, Liberty University

Co-investigator(s): Dr. David Martinez

Invitation to be part of a research study

You are invited to participate in a research study. To participate, you must be a healthcare professional, nurse, physician, or technician who is currently employed in an acute hospital setting. Participants must have worked in their field for a minimum of five years. Taking part in this research project is voluntary.

Please read this entire form and ask questions before deciding whether to participate in this research.

What is the study about, and why is it being done?

Many healthcare professionals struggle with mental health crises in the workplace. The problem at Henry Mayo Hospital is that a program called Mental Health First Aid was taught to employees but did not teach staff how to respond immediately to the needs of staff suffering from a mental health crisis. The purpose of this study is to address individual situations, such as acute stress disorder and traumatic stress disorder. Whether it is stress, depression, anxiety, or burnout, the purpose of this program is to evaluate HCWs' mental health and demonstrate that an immediate response is necessary. Those trained to respond will enact one of several techniques, including providing immediate help to the healthcare professional. The techniques include

simple listening, reality testing, problem-solving, empathetic response, and support. Other unique techniques may be utilized depending on the situation.

What will happen if you take part in this study?

If you agree to be in this study, I will ask you to do the following:

1. Fill out an initial questionnaire sent via email. This should only take 20–30 minutes to complete. Questionnaires are protected and not shared with anyone.
2. Participate in a one-on-one conversation. This will be held outside the hospital in a coffee shop to be determined. This will take one hour to complete.
3. Take an evaluation that will be sent via email. All information will not be shared with anyone and will be protected information. This will take between 20–30 minutes to complete.
4. Keep a journal and add an entry at the end of each shift.

How could you or others benefit from this study?

The direct benefits participants should expect from participating in this study include self-awareness of one's mental health while working as a healthcare professional.

What risks might you experience from being in this study?

The expected risks from participating in this study are minimal, meaning they are equal to the risks one encounters in everyday life.

How will personal information be protected?

The records of this study will be kept private. Research records will be stored securely, and only the researchers will have access to the records.

7. Participant responses will be anonymous and will be kept confidential by replacing names with pseudonyms.
8. Interviews will be conducted in a location where others will not easily overhear the conversation.
9. Data will be stored on a password-locked computer/in a locked [drawer/file cabinet]/etc.]. After three/five/seven years, all electronic records will be deleted, and/or all hardcopy records will be shredded.

10. Recordings will be stored [on a password-locked computer/etc. for three/five/seven years/until participants have reviewed and confirmed the accuracy of the transcripts and then deleted/erased. The researcher/the researcher and members of his/her doctoral committee/the study team/etc. will have access to these recordings.

How will you be compensated for being part of the study?

Participants will not be compensated for participating in this study.

What are the costs to you to be part of the study?

There will be no costs to the participant for this study.

Is the researcher in a position of authority over participants, or does the researcher have a financial conflict of interest?

The researcher serves as Chaplain at Henry Mayo Hospital. To limit potential or perceived conflicts, data collection will be anonymous, so the researcher will not know who participated/a research assistant will ensure that all data is stripped of identifiers before the researcher receives it/etc. This disclosure is made so that you can decide if this relationship will affect your willingness to participate in this study. No action will be taken against an individual based on his or her decision to participate or not participate in this study.

Is study participation voluntary?

Participation in this study is voluntary. Your decision on whether to participate will not affect your current or future relations with Henry Mayo Hospital. If you decide to participate, you are

free to not answer any questions or withdraw before submitting the survey without affecting those relationships.

What should you do if you decide to withdraw from the study?

If you choose to withdraw from the study, please exit the survey and close your internet browser. Your responses will not be recorded or included in the study.

Whom do you contact if you have questions or concerns about the study?

The researcher conducting this study is Dwayne Pine. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact him [redacted]. You may also contact the researcher's faculty sponsor.

Whom do you contact if you have questions about your rights as a research participant?

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher[s], **you are encouraged** to contact the IRB. Our physical address is Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA, 24515; our phone number is 434–592–5530 and our email address is irb@liberty.edu.

Disclaimer: The Institutional Review Board (IRB) is tasked with ensuring that human subjects research will be conducted in an ethical manner as defined and required by federal regulations. The topics covered and viewpoints expressed or alluded to by student and faculty researchers are those of the researchers and do not necessarily reflect the official policies or positions of Liberty University.

Your Consent

Before agreeing to be part of the research, please be sure that you understand what the study is about. You will be given a copy of this document for your records/you can print a copy of the

document for your records. If you have any questions about the study later, you can contact the researcher/study team using the information provided above.

I have read and understood the above information. I have asked questions and have received answers. I consent to participate in the study.

The researcher has my permission to audio-record/video-record me as part of my participation in this study.

_____

Printed Subject Name

_____

Signature & Date

APPENDIX B

RECRUITMENT

Dear Potential Participant,

As a doctoral candidate in the DMIN program at The Rawlings School of Divinity at Liberty University, I am conducting research as part of the requirements for a doctoral degree. My research aims to evaluate the potential for crisis intervention for healthcare staff who have experienced the death of a patient or have experienced trauma. The research will indicate how the pastoral care department at Henry Mayo can provide an intervention to help with the mental health and well-being of staff. I am writing to invite you to join my study.

Participants must be 18 years old, a healthcare professional, and have at least five years of experience as a healthcare professional. Participants will be asked to take online surveys, one-on-one interviews, journals, and mental health assessments. It should take approximately 20–30 minutes to complete each listed procedure. Participation will be completely anonymous, and no personal identifying information will be collected.

To participate, do not hesitate to contact me [redacted]. If you meet my participant criteria, I will contact you to schedule an interview/ I will work with you to schedule a time for an interview.

A consent document is provided as the first page of the survey/is attached to this [letter/email]/will be emailed to you if you meet the study criteria/ at the time one week before the interview. The consent document contains additional information about my research.

Because participation is anonymous, you are only required to sign and return the consent document. After you have read the consent form, please proceed to the survey/complete and return the survey. Doing so will indicate that you have read the consent information and would like to participate in the study.

Sincerely,

Dwayne Pine
Chaplain/DMIN. Candidate
[redacted]

APPENDIX C

BURNOUT, COMPASSION FATIGUE, AND VICARIOUS TRAUMA ASSESSMENT

Directions: Using the scale, indicate how these statements reflect your actions and feelings.

5 = Very often; 4 = Often; 3 = Sometimes; 2 = Occasionally; 1 = Seldom; 0 = Rarely

_____ **1.** I am NOT happy and content with my work life.

_____ **2.** I feel drained and exhausted from "giving" so much.

_____ **3.** I am preoccupied with the traumatized stories I have heard.

_____ **4.** I feel apathetic about work.

_____ **5.** I feel down after working with those I help.

_____ **6.** I think about the traumatic experiences of a person I help too much.

_____ **7.** I feel trapped by my work as a caregiver.

_____ **8.** Because of my work as a caregiver, I have been on edge.

_____ **9.** Outside of work, I avoid certain situations because they remind me of the experiences of those I work with.

_____ **10.** I do not like my work anymore.

_____ **11.** Because of my work as a caregiver, I am exhausted.

_____ **12.** I have intrusive thoughts of stories I've heard from those I'm helping.

_____ **13.** I feel overwhelmed with the amount of work I have to do.

_____ **14.** I would like to know if I make a difference through my work.

_____ **15.** I have flashbacks connected to my client.

_____ **16.** I work too hard.

_____ **17.** I become overwhelmed when thinking about working with certain clients.

_____ **18.** I experience troubling thoughts about the events of a client when I'm not working.

_____ **19**. I feel I'm working more for money than for personal fulfillment.

_____ **20.** I have felt trapped by my work as a caregiver.

_____ **21.** I have involuntarily recalled my own traumatic experience while working with a client.

Scoring

Write the number you wrote for each question on the blank below. Total the columns.

BURNOUT

1.____ 4.____ 7.____ 10.____ 13.____ 16.____ 19.____ Total____

COMPASSION FATIGUE

2.____ 5.____ 8.____ 11.____ 14.____ 17.____ 20.____ Total____

VICARIOUS TRAUMA

3.____ 6.____ 9.____ 12.____ 15.____ 18.____ 21.____ Total____

Total Overall Score_____

While no universally applicable cut-off score can be used under all circumstances, in most cases, a higher number of scores indicates a higher level of distress.

0–14	**Low Risk**
15–21	**Moderate Risk**
22–28	**High Risk**
29–35	**Extremely High Risk**

APPENDIX D

EMOTIONAL I.Q. TEST

Each question below asks how you act or feel in certain situations. Answer how often the statement describes your actual (not desired) behavior or attitude.

- **When I feel bad, I'm not sure what is bothering me.**

  Always (3) Usually (5) Sometimes (7) Rarely (9) Never (11)

- **When faced with a disappointment or a loss, I try not to feel sad.**

  Always (3) Usually (5) Sometimes (7) Rarely (9) Never (11)

- **I put a high priority on understanding how I feel when I make an important decision.**

Always (3) Usually (5) Sometimes (7) Rarely (9)

- **When I am upset it takes a long time for me to feel better.**

  Always (3) Usually (5) Sometimes (7) Rarely (9)

- **When someone criticizes me unfairly, I feel bad about myself.**

  Always (3) Usually (5) Sometimes (7) Rarely (9)

- **My emotions are up and down.**

  Always (3) Usually (5) Sometimes (7) Rarely (9)

- **It's hard for me to wait to get what I want, even if I know it's for the best.**

  Always (3) Usually (5) Sometimes (7) Rarely (9) Never (11)

- **When working on a challenge, I struggle to feel hopeful, energetic, and confident.**

  Always (3) Usually (5) Sometimes (7) Rarely (9) Never (11)

- **If I have to do something I do not want to do I put it off till later.**

  Always (3) Usually (5) Sometimes (7) Rarely (9) Never (11)

10. When people share a problem with me, I think more about how they could solve it then about how difficult it feels for them.

Always (3) Usually (5) Sometimes (7) Rarely (9) Never (11)

11. In situations of conflict, I have trouble understanding other people's emotions.

Always (3) Usually (5) Sometimes (7) Rarely (9) Never (11)

12. I am unable to sense other people's unspoken feelings on important issues.

Always (3) Usually (5) Sometimes (7) Rarely (9)

13. I avoid engaging in conversation with people I do not know well.

Always (3) Usually (5) Sometimes (7) Rarely (9)

14. I say things to other people that I regret later.

Always (3) Usually (5) Sometimes (7) Rarely (9)

15. In social situations, it's hard for me to build rapport with others.

Always (3) Usually (5) Sometimes (7) Rarely (9)

Your Total EQ Score _____

EQ scores range from 45 to 165, with 105 being average. A score of 120 and above is exceptional.

SMART Components of EQ

S	**Self-Awareness**	**Questions 1**–3
M	**Managing Emotions**	**Questions 4–6**
A	**Activation (Motivation)**	**Questions 7–9**
R	**Relating with Empathy**	**Questions 10–12**
T	**Teaming with Others (Social Skills)**	**Questions 13–15**

APPENDIX E

Professional Quality of Life Assessment

ProQOL is an assessment that indicates if someone has had negative and positive effects of working with those who have experienced traumatic stress. This assessment will also indicate if there is compassion fatigue, burnout, and compassion satisfaction through analytical scoring.

Use the QR Code provided to enter the website for the Professional Quality of Life Measure (ProQOL 5.0). An option to open and use the PDF (attached) is applicable as well. You will be asked two questions before proceeding. The last question asks if you want your test deleted once you have the results. This is an option if you choose. Your results will be emailed to you. Once they are sent, you can relay them [redacted]. Once again, all information sent to the researcher is confidential and protected. If the QR Code does not work, you may use the form that is attached.

PROFESSIONAL QUALITY OF LIFE SCALE (PROQOL)

COMPASSION SATISFACTION AND COMPASSION FATIGUE
(PROQOL) VERSION 5 (2009)

When you *[help]* people you have direct contact with their lives. As you may have found, your compassion for those you *[help]* can affect you in positive and negative ways. Below are some-questions about your experiences, both positive and negative, as a *[helper]*. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the *last 30 days*.

1=Never 2=Rarely 3=Sometimes 4=Often 5=Very Often

_____ 1. I am happy.
_____ 2. I am preoccupied with more than one person I *[help]*.
_____ 3. I get satisfaction from being able to *[help]* people.
_____ 4. I feel connected to others.
_____ 5. I jump or am startled by unexpected sounds.
_____ 6. I feel invigorated after working with those I *[help]*.
_____ 7. I find it difficult to separate my personal life from my life as a *[helper]*.
_____ 8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I *[help]*.
_____ 9. I think that I might have been affected by the traumatic stress of those I *[help]*.
_____ 10. I feel trapped by my job as a *[helper]*.
_____ 11. Because of my *[helping]*, I have felt "on edge" about various things.
_____ 12. I like my work as a *[helper]*.
_____ 13. I feel depressed because of the traumatic experiences of the people I *[help]*.
_____ 14. I feel as though I am experiencing the trauma of someone I have *[helped]*.
_____ 15. I have beliefs that sustain me.
_____ 16. I am pleased with how I am able to keep up with *[helping]* techniques and protocols.
_____ 17. I am the person I always wanted to be.
_____ 18. My work makes me feel satisfied.
_____ 19. I feel worn out because of my work as a *[helper]*.
_____ 20. I have happy thoughts and feelings about those I *[help]* and how I could help them.
_____ 21. I feel overwhelmed because my case [work] load seems endless.
_____ 22. I believe I can make a difference through my work.
_____ 23. I avoid certain activities or situations because they remind me of frightening experiences of the people I *[help]*.
_____ 24. I am proud of what I can do to *[help]*.
_____ 25. As a result of my *[helping]*, I have intrusive, frightening thoughts.
_____ 26. I feel "bogged down" by the system.
_____ 27. I have thoughts that I am a "success" as a *[helper]*.
_____ 28. I can't recall important parts of my work with trauma victims.
_____ 29. I am a very caring person.
_____ 30. I am happy that I chose to do this work.

WHAT IS MY SCORE AND WHAT DOES IT MEAN?

In this section, you will score your test so you understand the interpretation for you. To find your score on **each section,** total the questions listed on the left and then find your score in the table on the right of the section.

Compassion Satisfaction Scale

Copy your rating on each of these questions on to this table and add them up. When you have added then up you can find your score on the table to the right.

3. _____
6. _____
12. _____
16. _____
18. _____
20. _____
22. _____
24. _____
27. _____
30. _____

Total: _____

The sum of my Compassion Satisfaction questions is	And my Compassion Satisfaction level is
22 or less	Low
Between 23 and 41	Moderate
42 or more	High

Burnout Scale

On the burnout scale you will need to take an extra step. Starred items are "reverse scored." If you scored the item 1, write a 5 beside it. The reason we ask you to reverse the scores is because scientifically the measure works better when these questions are asked in a positive way though they can tell us more about their negative form. For example, question 1. "I am happy" tells us more about the effects of helping when you are *not* happy so you reverse the score

You Wrote	Change to
	5
2	4
3	3
4	2
5	1

*1. _____ = _____
*4. _____ = _____
8. _____
10. _____
*15. _____ = _____
*17. _____ = _____
19. _____
21. _____
26. _____
*29. _____ = _____

Total: _____

The sum of my Burnout Questions is	And my Burnout level is
22 or less	Low
Between 23 and 41	Moderate
42 or more	High

Secondary Traumatic Stress Scale

Just like you did on Compassion Satisfaction, copy your rating on each of these questions on to this table and add them up. When you have added then up you can find your score on the table to the right.

2. _____
5. _____
7. _____
9. _____
11. _____
13. _____
14. _____
23. _____
25. _____
28. _____

Total: _____

The sum of my Secondary Trauma questions is	And my Secondary Traumatic Stress level is
22 or less	Low
Between 23 and 41	Moderate
42 or more	High

YOUR SCORES ON THE PROQOL: PROFESSIONAL QUALITY OF LIFE SCREENING

Based on your responses, place your personal scores below. If you have any concerns, you should discuss them with a physical or mental health care professional.

Compassion Satisfaction _____

Compassion satisfaction is about the pleasure you derive from being able to do your work well. For example, you may feel like it is a pleasure to help others through your work. You may feel positively about your colleagues or your ability to contribute to the work setting or even the greater good of society. Higher scores on this scale represent a greater satisfaction related to your ability to be an effective caregiver in your job.

If you are in the higher range, you probably derive a good deal of professional satisfaction from your position. If your scores are below 23, you may either find problems with your job, or there may be some other reason—for example, you might derive your satisfaction from activities other than your job. (Alpha scale reliability 0.88)

Burnout_____

Most people have an intuitive idea of what burnout is. From the research perspective, burnout is one of the elements of Compassion Fatigue (CF). It is associated with feelings of hopelessness and difficulties in dealing with work or in doing your job effectively. These negative feelings usually have a gradual onset. They can reflect the feeling that your efforts make no difference, or they can be associated with a very high workload or a non-supportive work environment. Higher scores on this scale mean that you are at higher risk for burnout.

If your score is below 23, this probably reflects positive feelings about your ability to be effective in your work. If you score above 41, you may wish to think about what at work makes you feel like you are not effective in your position. Your score may reflect your mood; perhaps you were having a "bad day" or are in need of some time off. If the high score persists or if it is reflective of other worries, it may be a cause for concern. (Alpha scale reliability 0.75)

Secondary Traumatic Stress_____

The second component of Compassion Fatigue (CF) is secondary traumatic stress (STS). It is about your work related, secondary exposure to extremely or traumatically stressful events. Developing problems due to exposure to other's trauma is somewhat rare but does happen to many people who care for those who have experienced extremely or traumatically stressful events. For example, you may repeatedly hear stories about the traumatic things that happen to other people, commonly called Vicarious Traumatization. If your work puts you directly in the path of danger, for example, field work in a war or area of civil violence, this is not secondary exposure; your exposure is primary. However, if you are exposed to others' traumatic events as a result of your work, for example, as a therapist or an emergency worker, this is secondary exposure. The symptoms of STS are usually rapid in onset and associated with a particular event. They may include being afraid, having difficulty sleeping, having images of the upsetting event pop into your mind, or avoiding things that remind you of the event.

If your score is above 41, you may want to take some time to think about what at work may be frightening to you or if there is some other reason for the elevated score. While higher scores do not mean that you do have a problem, they are an indication that you may want to examine how you feel about your work and your work environment. You may wish to discuss this with your supervisor, a colleague, or a health care professional. (Alpha scale reliability 0.81)

APPENDIX F

Initial Interview Questions

1. How long have you been a healthcare professional?
2. What is your specific license in healthcare?
3. What department do you currently work in?
4. Have you ever worked in ICU, ER, or L&D?
5. Have you ever treated a patient who died? Please explain.
6. How did you feel after a patient died? Please explain.
7. Have you experienced depression after a shift? Please explain.
8. Prior to the Covid pandemic, did you ever feel depressed or have feeling of anxiety after working a shift?
9. Have you ever experienced anxiety while working? Please explain.
10. Do you recall a time when you felt fear while working? Please explain.
11. How would you define burnout?
12. Have you ever felt you were at burnout?
13. How do you cope when feeling any of the symptoms you have answered yes to?
14. In what specific ways have you coped with a stressful situation at work when you have returned home?
15. Have you ever observed a peer or co-worker who may have been suffering from depression, anxiety, stress, burnout, or had verbalized thoughts of suicide?

APPENDIX G

Lesson Plan: Week 1
Lesson Title: Acute Traumatic Stress (ATS)
Length of Time: 1 Hour

Objectives:

- How to recognize an acute traumatic stress episode
- How to approach a person with care in the ATS
- How to assess the person with compassion
- How to provide support to anyone with ATS

Materials: Video Monitor (TV) for videos; pen or pencil, journal.

What is Acute Traumatic Stress? 1. Definition and history 2. Who is susceptible? 3. Symptoms	Video: 1. 5 Minute video describing ATS 2. 5 Minute Class Discussion 3. 5 Minutes to Journal Thoughts
How to recognize Acute Traumatic Stress 1. How a co-worker might appear to have ATS 2. Physical appearance 3. Mantel reaction at work	Visual Aids: 10 Minutes 1. Pictures of someone who might have ATS or might not. Students discern the difference.
Risk Factors 2. Work related problems. 3. Relationships 4. Anger 5. Depression 6. Anxiety	Role play: 10 Minutes 1. Students will pair up and read a scenario. The scenarios will be how a person with ATS would react at work. 5 Minutes 2. Discussion about risk factors.
Assess, Approach and Support 3. How to quickly assess a person with ATS 4. How to Approach with care 5. How to Support a person with ATS **Conclusion and Recap**	Lesson: PowerPoint 15 Minutes 1. Assessment of the person with ATS 2. Reducing the symptoms through compassion 3. Peer-to-peer support-making a difference

	Open Discussion: 10 Minutes

Learning Outcome At the end of this week's course, the participants should know how to recognize a co-worker exhibiting traumatic stress. Participants will know how to assess, approach, and provide support to the HCW peer.

Lesson Plan: Week 2
Lesson Title: Peers and Grief & Suffering
Length of Time: 1 Hour

Objectives:

- How to recognize a peer suffering from grief
- How to approach a person with care who is grieving
- How to assess the person with compassion
- How to provide support to anyone who is grieving

Materials: Video Monitor (TV) for videos; pen or pencil, journal.

What is Grief? 4. Definition and history 5. Who is susceptible? 6. Symptoms	Video: 4. 5 Minute video describing grief 5. 5 Minute Class Discussion 6. 5 Minutes to Journal Thoughts
How to recognize Grief 7. How a co-worker might appear suffering in grief 8. Physical appearance 9. Mantel reaction at work	Visual Aids: 10 Minutes 6. Pictures of someone who might be suffering from grief or might not. Students discern the difference.
Risk Factors 7. Work related problems. 8. Relationships 9. Anger	Role play: 10 Minutes

10. Depression 11. Anxiety	12. Students will pair up and read a scenario. The scenarios will be how a person appearing to have grief would react at work. 5 Minutes 13. Discussion about risk factors
Assess, Approach and Support 14. How to quickly assess a person with grief 15. How to Approach with care 16. How to Support a person who is grieving **Conclusion and Recap**	Lesson: PowerPoint 15 Minutes 4. Assessment of the person with grief 5. Reducing the symptoms through compassion 6. Peer-to-peer support makes a difference Open Discussion: 10 Minutes

Learning Outcome

At the end of this week's course, the participants should know how to recognize a co-worker exhibiting grief. Participants will know how to assess, approach, and support the HCW peer.

Lesson Plan: Week 3
Lesson Title: Peers and Acute Anxiety
Length of Time: 1 Hour

Objectives:

- How to recognize a peer suffering from acute anxiety
- How to approach a person with care who has anxiety
- How to assess the person with compassion
- How to provide support to anyone who displays anxiety

Materials: Video Monitor (TV) for videos; pen or pencil, journal.

What is Acute Anxiety? 7. Definition and history 8. Who is susceptible? 9. Symptoms	Video: 10. 5 Minute video describing anxiety. 11. 5 Minute Class Discussion 12. 5 Minutes to Journal Thoughts
How to recognize anxiety 13. How a co-worker might appear suffering in anxiety 14. Physical appearance 15. Mantel reaction at work	Visual Aids: 10 Minutes 17. Pictures of someone who might be suffering from anxiety or might not. Students discern the difference.
Risk Factors 18. Work related problems. 19. Relationships 20. Anger 21. Depression 22. Anxiety	Role play: 10 Minutes 23. Students will pair up and read a scenario. The scenarios will be how a person appearing to have anxiety would react at work. 5 Minutes 24. Discussion about risk factors
Assess, Approach and Support 25. How to quickly assess a person with anxiety 26. How to Approach with care 27. How to Support a person who is anxiety **Conclusion and Recap**	Lesson: PowerPoint 15 Minutes 7. Assessment of the person with anxiety 8. Reducing the symptoms through compassion 9. Peer-to-peer support makes a difference Open Discussion: 10 Minutes

Learning Outcome At the end of this week's course, the participants should know how to recognize a co-worker exhibiting anxiety. Participants will know how to assess, approach, and support the HCW peer.

Lesson Plan: Week 4
Lesson Title: Acute Depression
Length of Time: 1 Hour

Objectives:

- How to recognize a peer suffering from depression
- How to approach a person with care who is depressed
- How to assess the person with compassion
- How to provide support to anyone who is depressed

Materials: Video Monitor (TV) for videos; pen or pencil, journal.

What is Depression? 10. Definition and history 11. Who is susceptible? 12. Symptoms	Video: 16. 5 Minute video describing depression. 17. 5 Minute Class Discussion 18. 5 Minutes to Journal Thoughts
How to recognize Depression 19. How a co-worker might appear to be depressed 20. Physical appearance 21. Mantel reaction at work	Visual Aids: 10 Minutes 28. Pictures of someone who might be suffering from depression. 29. Students discern the difference
Risk Factors 30. Work related problems. 31. Relationships 32. Anger 33. Depression 34. Anxiety	Role play: Chapter 5 35. 10 Minutes 36. Students will pair up and read a scenario. The scenarios will be how a person appearing to be depressed. 37. 5 Minutes 38. Discussion about risk factors
Assess, Approach and Support 39. How to quickly assess a person with depression 40. How to Approach with care 41. How to Support a person who is depressed **Conclusion and Recap**	Lesson: PowerPoint 15 Minutes 10. Assessment of the person who is depressed. 11. Reducing the symptoms through compassion 12. Peer-to-peer support makes a difference

	Open Discussion: 10 Minutes

Learning Outcome At the end of this week's course, the participants should know how to recognize a co-worker exhibiting depression. Participants will know how to assess, approach, and support the HCW peer.

Lesson Plan: Week 5
Lesson Title: Burnout
Length of Time: 1 Hour

Objectives:

- How to recognize a peer experiencing burnout
- How to approach a person with care who might be at burnout
- How to assess the person with compassion
- How to provide support to anyone who displays burnout

Materials: Video Monitor (TV) for videos; pen or pencil, journal.

What is Burnout? 13. Definition and history 14. Who is susceptible? 15. Symptoms	Video: 22. 5 Minute video describing burnout 23. 5 Minute Class Discussion 24. 5 Minutes to Journal Thoughts
How to Recognize Burnout 25. How a co-worker might appear suffering in anxiety 26. Physical appearance 27. Mantel reaction at work	Visual Aids: 10 Minutes 42. Pictures of someone who might be suffering from anxiety or might not. Students discern the difference

Risk Factors 43. Work-related problems. 44. Relationships 45. Distancing 46. Depression 47. Lack of Motivation	Role play: 10 Minutes 48. Students will pair up and read a scenario. The scenarios will be how a person appearing to have burnout would react at work. 49. 5 Minutes 50. Discussion about risk factors
Assess, Approach and Support 51. How to quickly assess a person with anxiety 52. How to Approach with care 53. How to Support a person who has burnout **Conclusion and Recap**	Lesson: PowerPoint 15 Minutes 13. Assessment of the person with burnout 14. Reducing the symptoms through compassion 15. Peer-to-peer support makes a difference Open Discussion: 10 Minutes

Learning Outcome At the end of this week's course, the participants should know how to recognize a co-worker exhibiting burnout. Participants will know how to assess, approach, and support the HCW peer.

Lesson Plan: Week 6
Lesson Title: Compassion Fatigue
Length of Time: 1 Hour

Objectives:

- How to recognize a peer suffering from compassion fatigue
- How to approach a person with care who has compassion fatigue
- How to assess the person with compassion and concern
- How to provide support to anyone who displays compassion fatigue

Materials: Video Monitor (TV) for videos; pen or pencil, journal.

What is Compassion Fatigue (CF)? 16. Definition and history 17. Who is susceptible? 18. Symptoms	Video: 1. 5 Minute video describing compassion fatigue 2. 5 Minute Class Discussion 3. 5 Minutes to Journal Thoughts
How to recognize compassion fatigue 28. How a co-worker might appear suffering from compassion fatigue 29. Physical appearance 30. Mantel reaction at work	Visual Aids: 10 Minutes 54. Pictures of someone who might be suffering from compassion fatigue or might not. Students discern the difference.
Risk Factors 55. Work related problems. 56. Relationships 57. Anger 58. Irritation 59. Lack of interest in work 60. Disconnect from emotions with patients.	Role play: 10 Minutes 61. Students will pair up and read a scenario. The scenarios will be how a person appearing to have compassion fatigue would react at work. 5 Minutes 62. Discussion about risk factors

Assess, Approach and Support 63. How to quickly assess a person with anxiety 64. How to Approach with care 65. How to Support a person who has compassion Fatigue **Conclusion and Recap**	Lesson: PowerPoint 15 Minutes 4. Assessment of the person with compassion fatigue 5. Reducing the symptoms through compassion 6. Peer-to-peer support makes a difference Open Discussion: 10 Minutes

Learning Outcome

At the end of this week's course, the participants should know how to recognize a co-worker exhibiting anxiety. Participants will know how to assess, approach, and support the HCW peer.

Lesson Plan: Week 7
Lesson Title: Recap & Review/Mental Health in HCW's
Length of Time: 1 Hour

Objectives:

- How to recognize a peer in all situations above
- How to approach a person with care
- How to assess the person with compassion
- How to provide support to peers

Materials: Video Monitor (TV) for videos; pen or pencil, journal.

Review 19. Week 1–5 20. What stood out? Open Discussion 21. What can be improved?	Video: 31. How peer-to-peer support can bring a positive outcome

How to Help a Co-Worker 32. Review all intervention techniques from weeks 1–5	Visual Aids: 10 Minutes 66. Journal read (Participation is voluntary)

Lesson Plan: Week 8
Lesson Title: Review and Dismissal
Length of Time: 30 Minutes

Objectives: Open discussion about the interventions and the process

Did you see a co-worker with any of the mental health problems discussed in weeks 1–5? 22. Did you approach? 23. What did you do?	All material will be collected such as journals and any other handouts. Final Questions will be allowed.

APPENDIX H

Action Research Classroom Modules Eight Weeks

Week 1	**Topic: Traumatic Stress Disorder (TSD & PTSD)** • Recognition • Approach • Assisting • Assessing • Supporting **1 Hour** **HMH Education Center Annex Building.**
Week 2	**Topic: Healthcare Worker Suffering from Grief** • Recognition • Approach • Assisting • Assessing • Supporting **1 Hour** **HMH Education Center Annex Building.**
Week 3	**Topic: Healthcare Worker Anxiety** • Recognition • Approach • Assisting • Assessing • Supporting **1 Hour** **HMH Education Center Annex Building**
Week 4	**Topic: Healthcare Worker Depression** • Recognition • Approach • Assisting • Assessing • Supporting

	1 Hour
Week 5	**Topic: Healthcare Worker Burnout** • Recognition • Approach • Assisting • Assessing • Supporting • Burnout Evaluation/Questionnaire **1 Hour** **HMH Education Center Annex Building**
Week 6	**Topic: Healthcare Worker Compassion Fatigue** • Recognition • Approach • Assisting • Assessing • Supporting • Compassion Fatigue Scale Self-Evaluation **1 Hour** **HMH Education Center Annex Building**
Week 7	**Topic: Mental Health and the Healthcare Worker** • Recap • Q&A • Review Assessments from week 1 • Role Play **1 Hour**
Week 8	**Topic: Final Session** • Recap • Q&A • Role Play • Review of Program **1 Hour**

APPENDIX I

Addendum

Christian Formation and Human Development

Moral responsibilities should be an innate trait in those who are HCWs; doctors take an oath that declares that they will uphold all moral behavior to its highest degree. Whether they believe in God or not, human beings have a moral sense and moral responsibility. Ravi Zacharias admitted that he struggled with the concept of a moral law giver (God). Zacharias believed that if evil exists in the world, there must be good. If it is good, then a moral law is given to humankind by a moral lawgiver. [1] Therefore, everyone can have a moral responsibility, whether they use it or not.

This is not to discuss evil vs. good but to point to the fact that moral decisions are possible in all people. In healthcare, moral decisions are made rapidly, depending on the department. This does not mean that moral decisions are always correct. James Estep Jr. and Jonathan Kim provide the theories from several well-known authors and the view they believe is correct.

According to Sigmund Freud, moral development conflicts with the human ego, superego, and id. Additionally, it is believed to be a process of creating a mental balance.[2] Scholars need clarification about the correct theory for moral development. Kohlberg believed (later retracted) that moral decisions rely on reasoning. Jean Piaget believed that morality consists of a set of rules. Moral decisions can be sought through the biblical scriptures.

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[1] Ravi Zacharias, "Moral Laws Must Imply Moral Law Givers," n.d., https://www.youtube.com/watch?v=JmNeo_vwKtM.

[2] James Riley Estep and Jonathan H. Kim, eds., *Christian Formation: Integrating Theology & Human Development* Nashville, TN: B & H Academic, 2010. 5.

The moral formation is connected by cognition, affect, and action.[3] Biblically speaking, moral development and its framework can be found in the New Testament (1 Corinthians, Hebrews, Philippians, and Ephesians). Estep and Kim emphasize that moral formation comes from dependence on the Holy Spirit. The intertwined spiritual and moral decisions bring light to the notion that all moral decisions can be made through the power of counsel from the Holy Spirit.[4] The formation of all moral decisions must have certain elements to become a moral process. Moral effect and behavior must complement cognitive-mental reasoning.[5]

Growth and Formation

Hospitals thrive on ethical decision-making, and exploring moral choices will be the focus. Scott B. Rae clarifies the two, which many would consider interchangeable. Morals refer to the actual content of right and wrong. In contrast, ethics refers to the process of right and wrong.[6] At Henry Mayo Hospital, an ethics committee will determine if someone should be taken off life support if there is no family to be found. Nevertheless, a finer focus would be on moral decisions at this hospital. Many of which would have to be a split second. As noted above, moral decision-making would require cognitive, moral effect, and mental reasoning.

When applied in the context of this action research project, moral decision development will help the participants understand that moral behavior is the key to moral actions. The three-dimension paradigm for morality will assist in understanding the dilemma. Morality is a matter of ethical cognition, affect, and behavior that is sound scripturally and in the social sciences.[7]

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[3] Estep and Kim, *Christian Formation*, 7.

[4] Ibid., 8.

[5] Ibid., 9.

[6] Scott B. Rae, *Moral Choices: An Introduction to Ethics*, 3rd ed. (Grand Rapids, and Mich: Zondervan, 2009), 15.

[7] Estep and Kim, *Christian Formation*,11.

This should be easy to grasp if the medical staff have good reasoning and have processed the ethical teaching they received in medical school.

Once the moral behavior theory is implemented, the participants will better understand cognitive and moral processing to arrive at decisions they can live with. An example of how this could help or at least assist the participants is that moral decisions can be made ethically when dealing with the death of a patient. This could be a better example: a patient has been given an end-of-life diagnosis, and the family will be approached with the news. The participants will be equipped to use moral judgment through cognitive decisions to care for the patient and family. Delivering news as such is difficult, but through moral formation, the participants will be able to give a just understanding of end-of-life decisions. The participants will be able to process the decision much better, satisfying them that they did the right thing.

Scripturally speaking, the participants will understand that God is the source of moral decisions. Estep and Kim have provided a basis for scripture in the approach to moral development. All the following apply to the healthcare participants in one way or another– conflict, action, knowledge, and potential because of the imago Dei.[8] God is the center of moral formation. The participants will understand what was taught by the apostle Paul in Romans 12:2, "Do not be conformed to this world, but be transformed by the renewal of your mind, that by testing you may discern what is the will of God, what is good and acceptable and perfect." Participants will learn through the media methods described below often, and they will have to think through the situation and make moral decisions that align with God's will.

[8] Estep and Kim, *Christian Formation*, 18.

Methods

In the classroom modules, scenarios will be presented as a series of moral models, which will be shown via YouTube videos. The first video is Moral Awareness. The second is Moral Decision Making, followed by Moral Intent, and lastly, Moral Action. The series was developed by The University of Texas at Austin. Following each video, there will be a time for a discussion session. Each participant can share their points of view on the video and provide any feedback necessary. The participants can only provide a single comment to avoid a debate. After each participant has shared, the floor will open to discussion about the rules in place that will not tolerate arguing. The topic of moral intent and moral action can transpire into an argument far too quickly.

At the end of the videos, the participants can share a real-life testimony of moral decisions if they choose to, but no participant is required to contribute. The testimonies can have a negative or positive outcome. This will open the discussion to mediate the problem they may have faced in the workforce or at home. More importantly, the discussion will be opened on how the hospital will benefit from moral decision-making through the lens of the Bible. This measurement will come in the form of a personal questionnaire that will be anonymous. The questions will include “Have you ever thought you made a moral decision to discover you regretted it? Have you been in a situation where moral decisions were made well?” These questionnaires will help when the data details how the participants experience moral decisions.

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Henry Mayo Authorization

Henry Mayo Newhall Hospital
23845 McBean Parkway, Valencia, CA 91355 661/253-8000

September 22, 2023

RE: Letter of Authorization

To whom it may concern:

Henry Mayo Newhall Hospital gives Dwayne Pine permission to conduct an anonymous study with staff as part of his doctoral program. Dwayne will provide willing staff with surveys and conduct an in-person training/study. Dwayne must work with/through Human Resources who will assist him with employee contact(s).

Please contact me with any questions at 661/200-1571 or puleoma@henrymayo.com.

Thank you.

Sincerely,

[redacted]

Mark A. Puleo
Vice President, Human Resources

Liberty University IRB Approval Letter

LIBERTY UNIVERSITY.
INSTITUTIONAL REVIEW BOARD

October 12, 2023

Dwayne Pine
David Martinez

Re: IRB Application - IRB-FY23-24-466 Action Crisis Intervention Response

Dear Dwayne Pine and David Martinez,

The Liberty University Institutional Review Board (IRB) has reviewed your application in accordance with the Office for Human Research Protections (OHRP) and Food and Drug Administration (FDA) regulations and finds that your study does not meet the definition of human subjects research. This means you may begin your project with the data safeguarding methods mentioned in your IRB application.

Decision: No Human Subjects Research

Explanation: Your project is not considered human subjects research because it will consist of quality improvement activities, which are not "designed to develop or contribute to generalizable knowledge" according to 45 CFR 46. 102(l).

Please note that this decision only applies to your current application. Any modifications to your protocol must be reported to the Liberty University IRB for verification of continued non-human subjects research status. You may report these changes by completing a modification submission through your Cayuse IRB account.

For a PDF of your IRB letter, click on your study number in the My Studies card on your Cayuse dashboard. Next, click the Submissions bar beside the Study Details bar on the Study Details page. Finally, click Initial under Submission Type and choose the Letters tab toward the bottom of the Submission Details page.

Also, although you are welcome to use our recruitment and consent templates, you are not required to do so. **If you choose to use our documents, please replace the word *research* with the word *project* throughout both documents.**

If you have any questions about this determination or need assistance in determining whether possible modifications to your protocol would change your application's status, please email us at irb@liberty.edu.

Sincerely,

G. Michele Baker, PhD, CIP
Administrative Chair
Research Ethics Office