



REVIEW ARTICLES

Systemic Risk Management for Occupational Hazards in the Human Service Professions

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The human service professions have long been known to be associated with elevated risk for occupational stress syndromes, including burnout and compassion fatigue. This paper conceptualizes such syndromes as the result of exposure to occupational hazards that are endemic to human service work. Identifying moral injury (MI) and secondary traumatic stress (STS) as hazards that exist across human service professions, this paper then reviews resilience research from many human service professions. Synthesizing scholarly traditions that have typically remained separate, it identifies organization-level practices that may mitigate the risk of exposure to occupational hazards and build psychological resilience in the work force. It also identifies gaps in the resilience literature, topics that are not fully explained by existing models, and avenues for future research.

The human service professions have a retention problem. From teaching to nursing to social work, people are moving between organizations—and sometimes out of their professions—at high rates. In teaching, for example, Gray, Taei, and O’Rear (2015) found that 17% of the new teachers in their sample were no longer teaching 5 years later. Darling-Hammond, Sutchter, and Carver-Thomas (2018) estimated that about two-thirds of California’s teacher attrition occurred pre-retirement. Meanwhile, Taei, Lewis, and Merlin (2023) found that only 16% of former teachers cited retirement as their primary reason for leaving the profession. Some health care settings have been compared to “a leaky bucket: hospitals can attract nurses, but that can’t keep them” (Suran, 2023, p. 1513). Christianson et al. (2024) found that 21% of nurses in their sample reported an intent to leave the profession, while D’Alessandro-Lowe et al. (2024) found that 67.5% of respondents reported at least a 25% likelihood that they would leave the field. Meanwhile, Aiken et al. (2023) found that over one in five physicians in their sample would leave their current hospital if they could. Moreover, these numbers are not entirely attributable to the pandemic. Clark and Clark (2006), writing 14 years before the pandemic, noted that the number of nurses not working in health care was larger than the total number of nursing vacancies (and, by extension, the nursing shortage of the time). In the social work field, Edwards and Wildeman (2018) estimated that the average child welfare caseworker exited the front-line workforce after only 1.8 years. Even considering that

many undoubtedly transition into other areas of social work, this number is sobering. Given the centrality of human service professions to the well-being of society, this issue of retention cannot be ignored. Yet, existing approaches have proven problematic.

Psychological Occupational Hazards

Since the 1970s, researchers have studied the mental health challenges of human service work under the label of “burnout” (Galek et al., 2011). A fairly representative definition of burnout comes from Swamy et al. (2020), who defined it as “a maladaptive response to chronic work-related stress” (p. 381). This suggests that burnout is both a) an individual response and b) disordered in nature. However, there is a central flaw in this logic. In fields which struggle with turnover and in which mental illness appears to be endemic (Davis et al., 2021; Olfson et al., 2023), it would be surprising if the performance of long-term employees were unaffected. Moreover, burnout has been recorded through five decades (Jackson et al., 1986; Maslach et al., 2001; Maslach & Goldberg, 1998; Pines & Maslach, 1978; Schaufeli & Enzmann, 2020) and around the world (Woo et al., 2020). It has been documented in low-pay, low-status jobs, such as nursing home assisting (Cooper et al., 2016) and in high-pay, high status jobs, such as surgery (Etheridge et al., 2023). It does not appear to respect the usual social divisions—but it is linked to certain professions (Schaufeli & Enzmann, 2020). These patterns suggest the presence of occupational hazards that are present in human service workplaces across a variety of contexts. Because these hazards are psychological, they are easily overlooked. Nevertheless, the persistent (and well-documented) mental health challenges experienced by human service professionals attest to their existence.

Psychological occupational hazards are the mental health analog of physical occupational hazards. Like physical hazards, they are a feature of some professions. Professionals working in asbestos abatement will necessarily encounter asbestos at work. Therapists specializing in trauma treatment will necessarily encounter trauma exposure at work. Some hazards are simply a part of one’s job. Yet, this reality does not diminish the impact of occupational hazards on workers who are repeatedly exposed to them over time. Just as hospitals have robust safety practices regarding blood-borne pathogens, human service workplaces need robust safety practices regarding psychological hazards. Organizations must seek out the psychological equivalent of gloves, bio-hazard bins, and sharps protocols.

This paper will focus on two psychological occupational hazards that have been proposed as potential antecedents of burnout (Cain & Gautreaux, 2022; Kulkarni et al., 2013; Phoenix Australia, 2020): secondary traumatic stress (STS) and moral injury (MI). Both STS and MI have clear causes that can be traced to specific conditions in the workplace. It is, therefore, possible to find empirical data on concrete strategies for mitigating their impact. Bringing

together research from a variety of human service fields, this paper will identify strategies for enhancing occupational safety around these common psychological occupational hazards.

Secondary Traumatic Stress

Secondary traumatic stress (STS) has been documented in several human service professions, including chaplaincy (Galek et al., 2011), teaching (Hydon et al., 2015), social work (Choi, 2017), and health care (Cain & Gautreaux, 2022). Risk of STS is higher among individuals who have experienced personal trauma, but it can occur in any individual who is exposed to client trauma in the workplace (Choi, 2017). It can be defined as “repeated or extreme indirect exposure to aversive details of [traumatic] event(s), usually in the course of professional duties” (qtd. in Hydon et al., 2015). STS is often written about simultaneously with the related constructs of compassion fatigue (CF) and vicarious trauma (VT). Many authors use VT and STS interchangeably, while others treat them as related, but distinct, phenomena. When VT and STS are differentiated, the distinction typically lies in the emphasis of the research. Pearlman and Saakvitne (1995), who originated the concept of VT, defined it as a condition that “includes the symptomatology of [STS] in the context of profound changes in the therapist’s sense of meaning, identity, worldview, and beliefs about self and others” (p. 144). This emphasis on a shift in the schema of the practitioner is typical of the literature on VT (Trippany et al., 2004). The literature on STS focuses more on the development of symptoms associated with posttraumatic stress disorder (PTSD) and less on the mental model of the practitioner (Choi, 2017).

Similarly, there is a great deal of construct confusion between compassion fatigue (CF) and STS. The concept of CF is usually credited to Charles Figley, who wrote a chapter on the subject in a 1995 book about STS. Figley has written that CF is synonymous with STS (Figley & Figley, 2017). However, he has also described CF in terms that are much broader than any STS definition. In 2017, for example, Figley and Figley defined CF as “the fatigue from dispensing compassion, day after day, year after year” (p. 387). This conceptualizes CF as a mental health analog to a repetitive stress injury, rather than a synonym for STS. CF therefore has the advantage of encapsulating a broader range of experience, with the corresponding cost of being less precise. This paper primarily relies on the narrower construct of STS, because of its precision. Ultimately, CF must be addressed in its broadest sense: the amount of research CF has inspired suggests that it is a common outcome of psychological injury in the workplace. To address it at the current time, however, would be premature. Psychological occupational hazards are only just beginning to be recognized; early research and practice should focus on constructs that are clear-cut, simple to measure, and for which the corresponding hazard can be easily identified. Future research on

less clear-cut topics can then build on that foundation. For the same reason, this paper will focus on STS, rather than on the more internally-focused and harder to measure (Galek et al., 2011) construct of VT.

Moral Injury

Moral injury (MI) was first identified among veterans returning from the Vietnam War (Dean et al., 2019; Phoenix Australia, 2020). More recently, it has been identified in health care professionals (Grady et al., 2022; Phoenix Australia, 2020; Sheikbahaei et al., 2023) and teachers (Glazer, 2022; Sugrue, 2020). MI can be defined as “the psychological, social and spiritual impact of events involving betrayal or transgression of one’s own deeply held moral beliefs and values occurring in high stakes situations” (Phoenix Australia, 2020, p. 6). There is some construct confusion between MI and burnout, particularly in the medical sector. Sheikbahaei et al. (2023) argue strongly against confusing the two constructs, contending that misidentifying MI as burnout “isolates physicians as being weak and insinuates that they are incapable of coping with the demands of a career in medicine” (p. 1). While it is important to keep the two constructs separate, this positioning of burnout as a personal failing is problematic. Burnout and its related constructs are widely recognized to originate in work-related stressors (Bober & Regehr, 2006; Choi, 2011; Galek et al., 2011; Hydon et al., 2015; Phoenix Australia, 2020; Swamy et al., 2020). Moreover, there is good reason to believe that it is largely—or even primarily—caused by organizational factors (Galek et al., 2011). There may even be a causal relationship between burnout and MI (Phoenix Australia, 2020). To declare this for certain, as Dean et al. (2019) do, is premature. However, the hypothesis that MI mediates the relationship between human service work and burnout is well worth investigating.

Equating MI with burnout is more an attempt at reframing the problem than a confusion of constructs. While the terms are sometimes equated in the literature, their definitions are clearly distinct. Moreover, burnout describes generalized symptoms: exhaustion, cynicism, and a sense of inefficacy or powerlessness (Kulkarni et al., 2013). “Cynicism” and “a feeling of powerlessness” can have many different causes. MI may eventually be shown to cause these symptoms in some people. However, this idea has not been empirically tested. Furthermore, MI is far from the only plausible cause of these symptoms. STS is another. Depersonalization can be a defense mechanism for processing the trauma narratives of others. Exhaustion, which is included in most definitions of burnout, can clearly be caused by the chronic nightmares and sleeplessness often experienced by individuals with PTSD. For this reason, researchers have hypothesized that the relationship between human service work and burnout is mediated by STS (Kulkarni et al., 2013). Thus, STS and MI have both been proposed as potential antecedents of burnout. Other, currently unidentified factors may also contribute. Further research is needed to investigate the complex causes and mediators of burnout.

Moral Injury in the Human Service Professions

In the military context, MI often results from a single crisis event, such as attacking civilians (Phoenix Australia, 2020). In the human service context, it appears to be rare for MI to be triggered by a single event. Rather, workers experience a series of smaller moral crises that cumulatively add up to MI. Nurses experience MI when they are unable to provide adequate care as a result of high case loads, or when they are required to prioritize one patient's care over another due to staffing constraints (Grady et al., 2022; Phoenix Australia, 2020). As one of Grady et al.'s (2022) participants recalled, "you stand there and watch people die in front of you. Knowing that all they need is a simple procedure that you could do, that isn't available to you" (p. 23). These situations take a collective toll on health care workers over time. The issue of quality patient care is so important to nurses that the *Labor Studies Journal*, a publication dedicated to labor organizing, ran an article on the role of quality care in nurse unionization (Clark & Clark, 2006). The article argued that, if unions want to make progress in organizing nurses, they must prove that unions can be an avenue to better patient care. Baines (also writing in the *Labor Studies Journal*) (2010) documented similar tendencies among nonprofit social service workers. A union organizer's job is to persuade workers that a union would represent the interests of its members. These organizers are making the case that unions can only claim to do that if they are providing avenues for improving client and patient care. Clark and Clark (2006) noted that improved salaries and benefits ranked fifth in a survey of nurse motivations for unionization: improving professional skills, voice in decision-making, and voice in national policy all outranked economic considerations. A union's primary purpose is to advocate for improved working conditions. These results suggest that nurses considered professional development and voice in policy to have a meaningful impact on their working conditions. While these priorities are most striking when encountered in the context of union organizing, Clark and Clark's findings are not unique. Health care providers have reported that quality patient care is more important to their occupational well-being than wellness programs or resilience initiatives (Aiken et al., 2023). In interviews, health care providers consistently mention low-quality patient care as a primary workplace stressor (D'Alessandro-Lowe et al., 2024; Phoenix Australia, 2020). This emphasis on quality patient care illustrates its central importance for people working in health care. In this context, it is easy to see why an inability to provide quality care would cause MI.

While MI in teaching has been much less thoroughly researched, at least one study (Sugrue, 2020) has found high rates of MI in K-12 teachers. MI in educators can result from administrative or district requirements to teach in ways the teacher finds unethical. It can also result from the many ways in which the school system reflects structural injustices (Hydon et al., 2015). Glazer (2022) described the "devil's bargain" facing teachers in difficult-to-staff schools: continue working in an environment that guarantees

they cannot meet student needs (resulting in moral injury), or move to an easier-to-staff school with more resources, better working conditions, and wealthier, whiter students (resulting, again, in moral injury). MI can also result from watching a district or government entity withhold needed services, discriminate against one's students, or fail to follow up on a report of abuse or neglect. In these cases, the boundary between MI and STS can become blurred. All of these situations raise the likelihood that the primary burden of supporting the student will fall on the teacher. This compounds MI (sustained by witnessing others withhold needed care) and STS (through increased exposure to the student's trauma). While all teachers are at risk for MI and STS, these hazards are disproportionately concentrated in underresourced schools serving marginalized students (Sugrue, 2020). This may help explain why such schools experience higher turnover, despite incentive programs (such as student loan forgiveness) designed to improve retention. It also suggests that differences in pay between affluent and underresourced schools may not be as big a driver of urban teacher turnover as is commonly assumed. The research on MI and STS suggests that inequity may be as much an antecedent as a consequence in the area of teacher retention. This insight from the MI literature is well worth further investigation, as it opens up alternative ways for underresourced districts to approach teacher retention.

STS and MI as Psychological Occupational Hazards

Both STS and MI result from hazards that are inherent to the human service workplace. This is particularly true of STS, which results from exposure to the traumatic experiences of others. Professions like chaplaincy, therapy, and social work specialize in helping people who have experienced trauma. Teachers, medical professionals, and shelter staff work less directly with client trauma, but still serve as caring listeners. In the absence of access to adequate mental health care, these professionals may be the only people available to help clients, students and patients process their traumatic experiences. There is no way to eliminate trauma exposure from these professions, nor should it be attempted.

The case of MI is more complex. Many situations leading to MI can be prevented through systems-level interventions, and this should be done whenever possible. However, ethical dilemmas are inherent to human service work. Choices must always be made regarding the allocation of scarce resources. Moreover, professionals working with marginalized populations regularly watch as societal resources are denied to their clients. These risk factors for MI cannot be entirely eliminated from human service work. The endemic nature of these hazards does not, however, mean that organizations are helpless to prevent STS and MI. It is not necessary to say, along with Sheikhabaei et al. (2023), that human service professionals “are used to (and are trained to sustain) great psychologic and physical stress” (p. 1).

Lessons from Manual Labor

The construction and manufacturing sectors can provide a model for the management of occupational hazards. These sectors have several decades of experience mitigating risk within inherently hazardous workplaces. Lead abatement workers, for example, cannot completely eliminate the risk of occupational lead exposure. Nevertheless, hundreds of people work in the industry without developing advanced lead poisoning. This is possible, because the Occupational Safety and Health Administration (OSHA) regulates lead abatement work tightly. Companies are required to fund lead abatement certification for employees. In addition, companies must adhere to detailed regulations on personal protective equipment, environmental mitigation measures, and workplace procedures (OSHA, 2020). The hazard can never be entirely eliminated, and workers accept some level of risk when they choose these jobs. Nonetheless, OSHA's regulations provide baseline protection. Moreover, they place the responsibility for workplace safety squarely on the employer and supervisor, rather than the employee (Henshaw et al., 2007). The human service field can learn much about occupational hazard mitigation from this and other physically hazardous professions.

One key lesson manual labor can offer is its realization that worker responsibility is unlikely to deliver meaningful results. Before the advent of workman's compensation or OSHA, companies took a personal responsibility approach to risk management that resembles the current literature on burnout. Films such as the National Association of Manufacturers' "The Crime of Carelessness" depicted workplace accidents as being largely caused by worker lapses (Films by the Year, 2023). Meanwhile, workers experienced enormously high rates of occupational injury (Henshaw et al., 2007). Occupational injuries decreased more meaningfully after the passage of workman's compensation, which held companies responsible for workplace injuries (Henshaw et al., 2007). Further improvement followed the passage of the Occupational Safety and Health Act, which held companies responsible for maintaining a "safe and healthful" work environment and created OSHA (Henshaw et al., 2007). This history suggests that organization-level and society-level measures are much more effective than individual measures. The history of burnout suggests that personal measures are as unlikely to prevent psychological injury as they are to prevent physical injury. Despite having been identified in the 1970s, burnout appears to be thriving amid all attempts at its eradication (Schaufeli & Enzmann, 2020). It is time to take a systems-level approach to managing psychological hazards in the workplace.

The field of manual labor demonstrates that it is possible to drastically reduce workplace injury, even in inherently hazardous environments. By identifying occupational hazards, developing evidence-based safety protocols, and enshrining those protocols in policy, the rates of occupational injury in manual labor were significantly lowered (Henshaw et al., 2007). The same approach can be taken to psychological occupational hazards in the human

service workplace. Just as oversight and regulation have been key to improving safety for physical hazards, the same measures are likely required to address psychological occupational hazards. Ultimately, oversight from OSHA or a similar agency would probably afford the highest degree of protection. However, this cannot be expected to happen overnight. Meanwhile, it is possible to initiate voluntary standards such as those implemented before the passage of the Occupational Safety and Health Act.

Organization-Level Safety

Having identified two common occupational injuries (MI and STS), the next step is to identify systemic strategies for risk management. Both STS and MI have their causes written into their definitions. MI results from perpetrating or witnessing an act that one considers immoral. STS results from hearing an emotionally significant individual recount a traumatic experience. This simplicity of causation is the primary reason these constructs have been chosen. This question needs what would be known in Mathematics as a base case: a relatively simple, well-understood case whose solution can illuminate more complex problems (Velleman, 2006). Of the many constructs associated with occupational mental health, these are by far the simplest. Success in mitigating them will provide a useful blueprint for addressing more complex and multifaceted constructs such as compassion fatigue (CF) and burnout. Moreover, there is reason to believe that STS and MI may contribute to both of these conditions; mitigating them may itself provide some relief.

Mitigating MI

One theme that emerges repeatedly in occupational resilience research is the protective role of autonomy and trust in organization. Together, they have been shown to improve perceptions of work-life balance in physicians working for Doctors Without Borders (Visser et al., 2016). Social workers with access to an organization's strategic information experienced lower levels of STS (Choi, 2011). STS was also found to be lower in social workers who experienced higher levels of empowerment (Choi, 2017). Grady et al. (2022) found that hospital workers accepted the risk of moral distress—if they felt their work could make a difference, and they could advocate for change. In contrast, the teachers studied by Sugrue (2020) and Glazer (2022) reported working in unethical environments and being prevented from practicing good teaching. Participants in both studies experienced MI. Because of the apparent connection between trust, autonomy, and improved outcomes, some researchers recommend increasing transparency and employee voice (Choi, 2011, 2017; Grady et al., 2022). Much of the literature reviewed for this paper suggests that, where autonomy and trust in organization are both high, rates of MI will be lower than in organizations where autonomy and trust in organization are low. However, the core hypothesis (that the relationship between human service work and MI is moderated by the combination of autonomy and trust in organization) does not appear to have

been directly tested. Further research is needed to investigate this relationship more thoroughly. Further research is also needed to identify and test concrete interventions for putting this recommendation into practice.

Since the COVID-19 pandemic, there has been increased research interest in organizational factors that contribute to or mitigate MI in hospital settings. Many of these recommendations can easily be adapted to other human service professions. One of these recommendations is the establishment of clear policies for making difficult ethical decisions (Phoenix Australia, 2020). It is proposed that this will reduce the risk of MI, by absolving workers of some of the responsibility for making potentially morally injurious choices when rationing care. Crucially, however, these policies must be made with the input of front-line staff (Phoenix Australia, 2020). This gives doctors and nurses a voice in policy-making—increasing both autonomy and trust in organization. Proactive decision-making could also limit the extent to which workers second-guess the difficult decisions they have made. Grady et al. (2022) also recommend having on-staff ethicists to consult with medical workers on difficult decisions. This again reduces the burden, without compromising employee voice.

While this is a promising approach to emergencies like COVID-19, it oversimplifies the problem of MI in medical professions. The need to ration care in emergencies is inherent to medical work, but many MI triggers lie directly within an organization's control. Nurses and doctors were voicing concerns about the quality of patient care long before the pandemic rendered these issues impossible to ignore (Clark & Clark, 2006). While it is obvious that difficult ethical choices will be part of a global health emergency, this does not address the more common MI triggers found in human service work. Grady et al. (2022) found that fewer than 50% of respondents felt that they worked in an ethical climate. Aiken et al. (2023) found that 42% of physicians and 47% of nurses in their sample reported that they were “not confident management will act to resolve problems in patient care that clinicians identify” (p. 6). The literature on trust and autonomy, as well as the literature on the importance of quality patient care, suggests that this factor alone put workers at an elevated risk for MI.

Organizations must find a way for their employees to provide quality care in difficult circumstances. This has always been a central challenge for human service professions, which perpetually operate in settings of underfunding, understaffing, and high client need. The research suggests that inability to meet a person's needs can result in MI (Glazer, 2022; Grady et al., 2022; Phoenix Australia, 2020; Sugrue, 2020). It may even be one of the primary sources of MI in some professions. Organizations must ensure that employees can succeed at their jobs. This means maintaining adequate levels of staffing, providing professional development, and aligning administrative expectations with client needs. Human service workers must be able to meet their own standards of care. It is up to organizations to ensure that

workers are not habitually placed in situations where quality care would be impossible. Lessons from manual labor suggest that regulation may be necessary to make that happen.

Mitigating STS

STS has been correlated with the number of trauma survivors on a worker's caseload (Galek et al., 2011). Some researchers have therefore suggested caseload balancing as an organizational protection. However, the research on this is mixed. Choi (2011) found no relationship between trauma caseload and STS. In contrast, Galek et al. (2011) and Bober and Regeher (2006) each found a relationship. These mixed results suggest that existing models do not fully explain the interaction between client trauma and STS.

One possible explanation comes from within the STS definition: STS results from exposure to another person's trauma. Trauma caseload is not a perfect proxy for trauma exposure. Torres et al. (2023), found that therapists practicing Eye Movement Desensitization and Reprocessing Therapy (EMDR) were less likely to experience STS than therapists practicing Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) or Prolonged Exposure Therapy (PE). One of the primary differences between EMDR and the latter two approaches is the therapist's exposure to client trauma. TF-CBT and PE involve the client recounting traumatic experiences to the therapist. In EMDR, the client thinks about a traumatic event, while the therapist leads a variety of eye movement exercises. Because the client recalls the trauma, rather than recounting the trauma, the therapist is less likely to be exposed to the details of the client's experience. This may explain why results on caseload balancing have been mixed. Different therapeutic techniques, as well as different workplace roles, may change the way that trauma caseload impacts trauma exposure. A social worker who connects domestic violence survivors with housing resources may be able to carry a high trauma caseload without much risk. Moreover, not all clients are primarily interested in working through their trauma. Many prefer to focus on quality-of-life issues such as anxiety, substance use, or building a support network. This distinction would be unlikely to show up in a research model relying on surveys and caseload data. Additional research is needed to explore the mediating impact of trauma exposure on the relationship between trauma caseload and STS.

Organizational Factors Impacting Both MI and STS

On-the-job peer support has been recommended for preventing and treating both STS and MI (Choi, 2011; Grady et al., 2022; Phoenix Australia, 2020). Peer support is widely recognized as a promoter of psychological resilience (Galek et al., 2011; Grady et al., 2022; Phoenix Australia, 2020). However, human service professionals cannot discuss the most stressful (and even traumatic) details about their jobs with loved ones: doing so would breach client confidentiality (Grady et al., 2022). This deprives workers of a key trauma resilience tool. Therefore, the workplace itself must provide

outlets which allow workers to engage in this crucial self-care activity. Trippany et al. (2004), Grady et al. (2022), and Phoenix Australia (2020) all recommend that peer support networks be built to mitigate the impact of unshared and unprocessed experiences on workers. Other human service workplaces can implement similar measures. Formal sharing may also promote team morale, which has been shown to promote resilience (Phoenix Australia, 2020).

The Convergence of Occupational Safety and Personal Resilience

The challenges of human service work have given rise to an extensive literature on personal resilience. It is beyond the scope of this paper to fully review and summarize that rich literature. However, the often-overlooked role of organizations in promoting personal resilience will be briefly highlighted. Resilience research offers many recommendations to individual practitioners. However, there is often a tension between resilience recommendations and working conditions. Take, for example, the case of sleep. Sufficient sleep is a recognized builder of psychological resilience (Figley & Figley, 2017). Yet, lack of sleep is a known occupational hazard within the medical professions (Aiken et al., 2023). Other human service workers are also at risk of insufficient sleep when they manage excessive caseloads (Figley & Figley, 2017). Workers, then, find themselves in a double bind: resilience literature recommends that they get sufficient sleep, but their schedules and workloads may render this impossible. At first glance, sufficient sleep looks like an individual intervention. Implementation, however, requires working conditions that support sleep hygiene. This theme recurs in other resilience recommendations. Resilience researchers recommend that practitioners maintain a social support network, engage in recreational exercise, and participate in spiritual communities (Figley & Figley, 2017; Trippany et al., 2004). All of these activities require both planning and free time. Meanwhile, Slater et al. (2021) found that high workload was a repeated theme in studies of nursing. Aiken et al. (2023) documented unpredictable hours due to working unscheduled shifts. Nurses, then, are being told to invest planning and free time into their resilience, but may work schedules that interfere with planning and allow for very little free time. Workplaces exercise considerable influence over employees' ability to follow the recommendations of resilience research. Resilience may be an individual phenomenon, but workplaces choose scheduling practices, allot vacation time, set staffing targets, and establish shift work protocols. In order to foster "a safe and healthful work environment" (Henshaw et al., 2007), organizations will need to identify and alleviate any mismatches that may exist between organizational protocol and evidence-based recommendations for individual resilience.

Limitations

No original research was conducted in the process of researching this paper. Instead, it focuses on bringing together insights from a variety of different fields. As a result, this paper cannot offer novel solutions or make value judgments on the recommendations presented by other scholars. It can report that others have recommended “quality patient care,” but it cannot investigate nurses’ understanding of that term or define what “quality patient care” looks like in real hospitals. In addition, depth has been sacrificed for breadth. Rather than going deeply into the literature on a specific profession or a specific construct, this paper has taken a big-picture approach. This necessarily erased some of the detail and nuance found in each literature. Moreover, this paper cannot provide a clear road map for adapting recommendations to a new setting. While hospital responses to MI can undoubtedly inform school responses to MI, this paper does not have a recipe to guide the process of distilling and implementing those insights.

Implications

Interventions such as resilience training have weak evidence of efficacy (Dacar et al., 2019) and fail to address the issues that workers consider most pressing (Aiken et al., 2023). An occupational safety approach offers a different way forward. By developing safety protocols for psychological occupational hazards, workplaces can foster safety, without compromising worker voice (and the psychological protection that comes with it). Moreover, psychological hazards can contextualize worker concerns. Given the role of quality patient care in mitigating MI, for example, it is not surprising that health care providers rated improved staffing as the most important measure for preventing burnout (Aiken et al., 2023). Occupational safety provides an empirically testable mechanism for connections that workers may intuit, but cannot prove. The relationship between burnout and staffing levels is riddled with mediators and moderators that make it almost impossible to meaningfully test causation. The relationship between staffing and quality patient care is much more straightforward to test. An occupational safety approach will require a shift in thinking. It moves the conversation from conceptualizing occupational stress syndromes as the “maladaptive response” (Swamy et al., 2020) of individuals to a problem-solving approach that identifies psychological occupational hazards and seeks appropriate safety protocols. Like the shift to a physically “safe and healthful workplace” (Henshaw et al., 2007) this will likely require regulation and oversight in the future. However, organizations can engage in voluntary measures right now.

Much more research is needed to understand the relationship between psychological hazards and workplace safety. However, enough is known to take immediate action. First, organizations must create workplace procedures that allow employees to follow the recommendations of resilience research. Second, exposure to client trauma appears to be linked to STS. Further research is needed to determine how caseload balancing and similar

techniques can help manage levels of exposure to client trauma. Third, peer support programs can address the need to access peer support without breaking confidentiality. Fourth, MI may be mitigated when difficult decisions are made proactively and with significant worker voice. Fifth, the combination of worker autonomy and trust in organization has been shown to protect against many psychological hazards. Increased employee voice can be a powerful tool in preventing MI and may have promise in other areas as well. Finally, human service professionals care deeply about providing quality care. Organizations that ensure high-quality care will also minimize the risk of MI to their staff. The human service professions present workers and organizations with a unique set of challenges and a unique set of workplace hazards. While these hazards are inherent to the work, risk can be mitigated through organizational measures. By promoting safer and healthier workplaces, we can reduce turnover, keep qualified professionals in their fields, and improve outcomes at both the organizational and societal levels.

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