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BRIEF COMMUNICATION

Addressing the Physician Mental Health Crisis with Psychoeducation: A Brief Communication

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ABSTRACT: Physician mental health (MH) is in crisis, particularly in high-stress areas of medicine such as the emergency room and the intensive care unit. The high prevalence of burnout and psychiatric illness among critical care physicians, along with delays in seeking psychiatric care, can lead to suicide, ruined careers, damaged relationships, and medical errors. Psychoeducation programs can reduce MH sick leave days, increase empathy, and enhance help-seeking attitudes. The purpose of this brief communication is to demonstrate that physician psychoeducation programs can improve patient care, improve outcomes in physicians with psychiatric illness, and improve burnout rates, and we describe the essential aspects of such a program.

1 Introduction

Physician mental health (MH) is at a breaking point. Physicians are increasingly overworked due to the complexity of care, documentation requirements, and inadequate resources to meet these rising demands [1]. As a result, countless studies demonstrate a high prevalence of burnout and psychiatric illness among physicians who are asked to care for critically ill patients but cannot adequately care for themselves [2].

Psychoeducation is defined as "the provision of systematic, relevant, broad, and up-to-date information about an illness or condition, including its diagnosis and treatment" [3,4]. It communicates information related to psychiatric illnesses and distress, as well as general information about wellness and interventions to support distressed individuals. The purpose of this article is to describe the benefits of physician psychoeducation and to describe the essential elements of a psychoeducation program.

2 Benefits of Psychoeducation: Improved Outcomes among Individuals with Psychiatric Illness

Physicians are prone to psychiatric illness but frequently delay seeking care, and psychoeducation may help to address this critical issue. A study of internal medicine physicians found depressive symptoms in 29% of residents and 33% of faculty physicians [5]. A 2010 prospective cohort study of 740 interns across 13 US hospitals found that the prevalence of depression increased from 3.9% at the beginning of their intern year to 27.1% 3 months into their intern year and that interns' thoughts of death increased by 370% over that period [6]. Despite the high prevalence of psychiatric illness, 40% of physicians have reported being afraid or knowing a colleague who was afraid to seek MH care [7]. Rates of help-seeking among academic physicians with psychiatric illness are between 13% and 36% [8]. As a result of the high prevalence of psychiatric disease among physicians, along with delayed psychiatric care, physicians die by suicide at twice the rate of the

general population, with 1 completed suicide every day, representing a loss of an average medical school class to suicide every year [9]. Strikingly, in a suicide autopsy study, only 60% of physicians who died by suicide had received psychiatric medications in the last year, and only 52% had seen a psychiatrist [10].

Psychoeducation has numerous benefits for individuals with psychiatric diseases. Research demonstrates that psychoeducation for individuals with psychiatric illness and their families can reduce relapse rate by 50%–60%, reduce the severity of relapses, improve treatment adherence, lower self-stigma, improve quality of life, and decrease the cost of care [5]. By incorporating psychoeducation in all levels of physician education, the healthcare system can reach physicians with psychiatric illnesses to engage them in care and improve their outcomes.

3 Benefits of Psychoeducation: Improved Patient Care

Physician MH problems can increase the risk of adverse patient outcomes. Consequences of MH problems among physicians include risk of patient safety incidents, medical errors, lower patient satisfaction, and increased intention to leave practice among those with burnout, which is particularly problematic among critical care physicians for whom a single medical error can lead to a catastrophic patient outcome [11].

Multiple reviews of psychoeducation curricula for medical students found that self-care education and peer-based mindfulness interventions improved patient care [12]. Further, providing medical students with psychoeducation results in greater empathy for their patients, and educational information increases knowledge and positive attitudes and behaviors toward individuals with MH problems [12]. Finally, psychoeducation among nurses has led to improvements in their ability to provide evidence-based psychoeducation to patients with psychiatric illness [13], suggesting that patients may benefit from all members of the healthcare team receiving psychoeducation training.

4 Benefits of Psychoeducation: Reduced Burnout

The prevalence of burnout among physicians varies from 0%–85% in the literature, depending on how burnout is defined and the population of physicians studied [3]. A systematic review of 182 studies of burnout in physicians identified 142 different definitions of burnout [3]. Prevalence of burnout is lowest in studies using the strictest definition requiring abnormal values in all 3 categories (depersonalization, emotional exhaustion, and personal accomplishment) of the Maslach Burnout Inventory (MBI) and highest in studies requiring an abnormal value in only 1 of the 3 categories of the MBI indicating burnout [3]. The population of physicians studied may also affect published burnout rates. A study by Ligibel et al. outlined the prevalence of burnout and professional fulfillment by medical subspecialty, with critical care, pulmonary disease, family medicine, and anesthesia having among the highest burnout and lowest professional fulfillment rates, and neuroradiology and neonatal medicine having among the lowest burnout and highest professional fulfillment rates [2]. Female physicians generally have more burnout than their male counterparts [2], and burnout scores were higher during the pandemic compared to pre- or post-pandemic rates [14]. Commonly cited burnout prevalence rates come from the American Medical Association's organizational biopsy, in which the prevalence of physician burnout peaked at 63% in 2021 during the COVID-19 pandemic and in 2023 was 48% [14]. Data from the *Lancet* suggests that physician burnout is a global problem and not strictly limited to the United States [15].

Psychoeducation programs can help to diminish physician distress and burnout. A meta-analysis demonstrated that educational interventions that teach emotional, supportive, and coping mechanisms were associated with improved physician resilience [16]. Resilience is defined as the ability to respond to stress in an adaptive way, and improved resilience may help diminish signs of distress and burnout. Similar benefits have

been seen among psychoeducation programs for nursing leaders [17], suggesting that the multi-professional healthcare team may benefit from these programs.

5 What Is the State of Existing Psychoeducation Curricula?

Few physicians outside of the field of psychiatry receive formal psychoeducation during their training in the United States or abroad. A systematic review demonstrated that self-care education was poorly integrated into medical school curricula [12]. The American Medical Association has developed a Steps Forward series that includes toolkits, playbooks, webinars, and podcasts to improve physician well-being [14], but this education is not a mandatory part of continuing medical education curricula or the Accreditation Council for Graduate Medical Education program requirements. Initiatives such as Schwartz Rounds or facilitated group discussions at the institutional level can also provide psychoeducation, but are not universal or mandatory. Internationally, a need for psychoeducation has been recognized, but it remains voluntary. Organizations such as DocHealth in the United Kingdom provide psychotherapy and psychoeducation for physicians, while organizations such as the Australian Psychological Society promote psychoeducation. Much work remains to be done in building and incorporating psychoeducation programs into medical training for physicians in a uni-professional and multi-professional setting.

6 What Are the Essential Elements of a Psychoeducation Program?

6.1 Distress vs. Psychiatric Illness

Pivotal to a healthcare worker (HCW) psychoeducation program is an appreciation of the role of stressors. A stressor is any actual or threatened source of mental or physical threat or danger [18]. Stressors encompass a wide variety of situations ranging from the mundane to the extreme and can include having an argument with a friend or relative, getting stuck in traffic, or spraining an ankle [18]. Stressors are very common in the intensive care unit (ICU) and may arise from care discussions, codes, medical procedures, or patient deaths. Trauma is a subtype of a stressor with 2 definitional requirements: 1) it is an immediate threat to life or limb; and 2) the exposure is either via direct personal experience or indirect via loved ones [19]. Examples of trauma are being in a severe motor vehicle accident or a gunshot wound to one's spouse. Trauma is defined by the type of stressor, not one's reaction to it, and some stressors (such as a diagnosis of cancer) can be more distressing than incidents defined as trauma (such as falling off a bike and breaking an arm). Another subset of stressors is a disaster, which is defined as a sudden or unexpected event causing significant destruction and/or adverse consequences to a community or society [19]. Disasters usually but not always inflict trauma, but they are stressful. Examples of disasters include Hurricane Katrina (trauma), the Oklahoma City bombing (trauma), and the COVID-19 pandemic (stressors) [19]. A foundation for effective psychoeducation programs to explain the types of stressors to set the stage for describing anticipated reactions to them. This education is particularly important for critical care physicians who often see an increase in patient census in the ICU following disasters and can apply this psychoeducation to both themselves and their patients.

Broadly, stressors can be expected to be followed by two potential personal reactions: psychological distress and psychiatric illness. Psychological distress is a negative emotional reaction to a stressor, manifested, for example, by diminished appetite, feelings of sadness or anger, and chest tightness [19]. Psychological distress is nearly ubiquitous after a significant stressor and can be severe and debilitating [19]. Distress syndromes described in HCWs include burnout, compassion fatigue, and moral distress [18]. Psychological distress is addressed through supportive care, including crisis psychological therapies, time off work, and compassionate gestures [20]. It is important to note that distress is normal and is not necessarily indicative of psychiatric illness. Psychiatric illness, in contrast to psychological distress, occurs in fewer than 50% of

trauma survivors, and many of these illnesses are pre-existing [18]. The most common psychiatric illnesses among disaster trauma survivors include post-traumatic stress disorder, depression, and anxiety disorders [18]. Alcohol and drug use disorders in disaster survivors are almost always pre-existing, although substance use may increase transiently [18].

Evaluation by a trained psychiatric professional is required to diagnose psychiatric illness [20]. Symptom screeners, such as the *Patient Health Questionnaire-9 (PHQ-9)* or *Generalized Anxiety Disorder-7 (GAD-7)*, can suggest risk for psychiatric illness but cannot provide a psychiatric diagnosis [20]. Indications that formal psychiatric evaluation is needed include the inability to function at work or at home, lack of improvement after taking time off or reducing work burden, high scores on psychiatric symptom screeners, prominent avoidance or numbing symptoms, pre-existing history of psychiatric illness or substance use disorder, or suicidal thoughts [20]. Psychiatric illness requires specific treatment based on diagnostic assessment, and most individuals respond well to appropriately chosen and applied treatment [20]. Missing diagnosable psychopathology can lead to morbidity and mortality, including suicide, damaged relationships, and ruined careers [20]. It is therefore essential to educate critical care physicians that psychiatric illness can occur after a significant stressor at work or outside the workplace, that evaluation by a psychiatric professional is essential for diagnosis, and that treatment is effective. Pharmacologic treatment can be provided by a psychiatrist, primary care physician with experience in prescribing psychiatric medications, or a psychiatry advanced care provider; nonpharmacologic treatment, such as psychological therapies can be provided by psychologists, clinical social workers, or licensed professional mental health counselors. Institutions can support critical care physician MH by making psychiatric care easily accessible, timely, and confidential.

6.2 Supportive Interventions for Distress

Although medication and/or psychotherapy are the mainstays of treatment for psychiatric illness, supportive care interventions are indicated for psychological distress [20]. Information about these interventions can be included as a part of a psychoeducation program, but it is important to note that psychoeducation alone, without implementing supportive interventions at the institutional level and addressing systemic factors that contribute to physician burnout, is insufficient to dramatically improve the physician MH crisis.

Supportive interventions can be implemented at both the institutional level and the individual level. During times of significant stressors in the healthcare setting such as pandemics or mass casualty events, institutions can support distressed critical care physicians by listening to their concerns, practicing clear communication, providing flexibility in work schedules, ensuring needed resources, offering compassionate and caring gestures such as meals and recognition of service, instituting buddy systems or personal check-ins, and providing crisis psychological therapies and formal psychiatric services [21]. Institutions can screen their ICU workers for psychiatric illnesses with established symptom screeners such as the PHQ-9 or GAD-7 and can operationalize psychiatry services to meet the rising demand for formal psychiatric evaluation and care expected during a pandemic; while labor-intensive, the feasibility of this approach has been demonstrated in the literature [22]. Even during times of normal operations, institutions can support critical care physicians by reducing workload, improving teamwork, making psychiatric care available, and establishing family leave policies [21]. These supportive measures can be more easily augmented than established *de novo* during times of crisis, and psychoeducation programs can include what sources of professional mental health support physicians can and should access at different times and for different needs.

Individual physicians can support their own MH and that of their colleagues by encouraging the use of mindfulness-based interventions, yoga, gratitude journaling, professional coaching, physical exercise, and social gatherings [20–22]. Additionally, motivated individuals can receive training in psychological first aid (PFA), a form of emotional assistance to address acute distress and re-establish coping and functioning after

critical incidents [21]. PFA may be used with patients and families in the ICU in goals of care discussions or in caring for colleagues following a stressful event such as a code, family meeting, or difficult procedure. PFA is intuitive and is consistent with available scientific evidence, but research to demonstrate efficacy is needed.

A detailed application of PFA to critical care physicians can be found in the literature [21]. Various descriptions of PFA have been published, but they include the same basic elements. The first is being there, or the ministry of presence, which can involve simply sitting attentively with a distressed colleague, patient, or family member. The second is safety and stabilization, which is primarily applicable to trauma or disaster settings, when individuals may need to be removed from exposure to physical harm. Additional elements of PFA include skilled listening, psychoeducation, coping strategies such as self-care and enlistment of social supports, assisting with problem-solving, connecting distressed individuals with sources of care, and acutely managing symptoms with relaxation exercises or crisis psychological therapies, or short-term pharmacotherapy. An easily overlooked component is that of knowing when formal psychiatric help is needed because critical care workers or family members of disaster victims can experience psychological distress or even become MH casualties themselves in difficult critical incident circumstances.

7 Conclusions

Physician MH, particularly among those in high-stress settings such as the ICU, is at a breaking point, but it need not remain so. Psychoeducation can help to de-stigmatize psychiatric illness, encourage physicians to seek needed care and improve patient care outcomes. If we are to effectively address critical care physician MH, we will need to bend and improve the way that we implement psychoeducation before we break.

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