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Research Article

Psychological Safety, Confidentiality, and Engagement with Mental Health Support Among Healthcare Providers: A Cross-Sectional Workforce Study

Munira Mahmoud Al Maazmi[1*], Shaban Osman[2], Reda Elsahy[3], Tariq Diab[4]

[1]Consultant Neonatology, Al Jalila Children's Specialty Hospital, Dubai health, UAE.
[2]CICU Nurse Manager, Al Jalila Children's Specialty Hospital, Dubai health, UAE.
[3]CICU Nurse, Al Jalila Children's Specialty Hospital, Dubai health, UAE.
[4]Consultant Child and Adolescent Psychiatry, Al Jalila Children's Specialty Hospital, Dubai health, UAE.

***Corresponding Author:** Munira Mahmoud Al Maazmi, Consultant Neonatology, Al Jalila Children's Specialty Hospital, Dubai health, UAE.

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Abstract

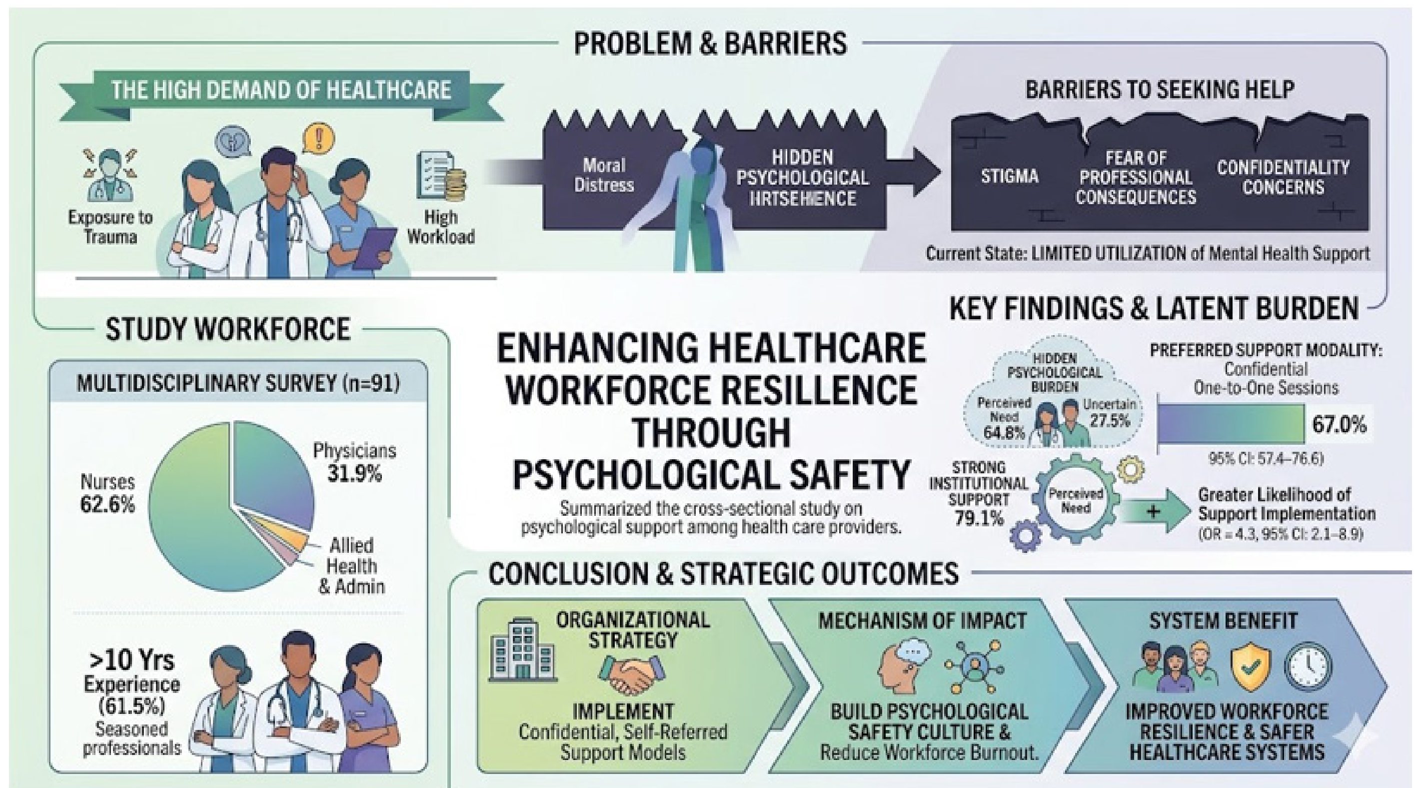
Background: Healthcare professionals work within emotionally demanding environments characterized by sustained exposure to trauma, critical decision-making, moral distress, and high cognitive workload. Despite increasing recognition of burnout and occupational psychological distress, utilization of mental health support services among healthcare workers remains limited due to stigma, confidentiality concerns, fear of professional consequences, and organizational barriers. Objective: To evaluate the acceptability, perceived need, barriers, preferred delivery models, and anticipated impact of confidential one-to-one psychological support among healthcare providers.

Methods: A cross-sectional anonymous workforce survey was conducted among multidisciplinary healthcare providers (n =91) working within a tertiary healthcare environment. Survey domains included perceived psychological need, willingness to engage with support services, preferred support modalities, perceived barriers, and anticipated outcomes. Descriptive statistics, chi-square testing, odds ratio (OR) estimation, and 95% confidence intervals (CI) were utilized for statistical analysis.

Results: Nurses comprised the majority (62.6%, n=57), followed by physicians (31.9%, n=29). Administrators and allied health professionals were minimally represented (≤3.3% each). Additionally, nearly half of respondents worked in PICU (45.1%, n=41), followed by general wards (20.9%), office settings (18.7%), and NICU (15.4%). However, 53.8% of the studied participants had Mixed shifts predominated (53.8%), with day shifts (29.7%) and rotation schedules (15.4%) less common; night-only shifts were rare (1.1%). Regarding the year of experience, most participants had >10 years of experience (61.5%), suggesting a seasoned workforce Perceived psychological support need was reported by 64.8% (59/91) of participants, while 27.5% (25/91) remained uncertain regarding their need, indicating a combined latent psychological burden of 92.3%. Institutional implementation support reached 79.1%. One-to-one confidential sessions were the preferred support modality among 67.0% of participants (95% CI: 57.4–76.6). A significant association was identified between perceived psychological need and support for institutional implementation (χ^2=18.72, $p<0.001$). Participants reporting psychological need demonstrated significantly greater likelihood of supporting implementation of confidential services (OR = 4.3, 95% CI: 2.1–8.9).

Conclusion: Confidential, psychologically safe, self-referred one-to-one support models appear highly acceptable among healthcare providers and may represent an important organizational strategy for improving workforce resilience, reducing hidden psychological burden, enhancing psychological safety culture, and supporting safer healthcare systems.

Keywords: Healthcare workers; Burnout; Psychological safety; Occupational mental health; Confidentiality; Workforce resilience; Counseling; Healthcare systems.



Graphical abstract: for Healthcare Providers participants in the current study.

Introduction

Healthcare professionals operate within environments characterized by sustained emotional demand, repeated exposure to suffering and death, high cognitive workload, workforce shortages, and complex ethical decision-making [1-4]. These cumulative occupational stressors contribute substantially to burnout, emotional exhaustion, anxiety, compassion fatigue, moral distress, and psychological impairment among healthcare workers [5,6].

Burnout among healthcare professionals has increasingly emerged as a global healthcare systems challenge affecting not only workforce well-being but also patient safety, healthcare quality, staff retention, organizational stability, and healthcare sustainability [7,8]. Previous studies have demonstrated associations between healthcare worker burnout and increased medical errors, decreased professionalism, reduced patient satisfaction, and workforce attrition [9.8].

Despite growing awareness of occupational psychological distress within healthcare environments, engagement with psychological support services remains consistently low [10,11]. Multiple barriers contribute to underutilization of mental health services, including fear of stigma, concerns regarding confidentiality, fear of professional repercussions, time constraints, and lack of psychologically safe support environments [12,13].

The concept of psychological safety has become increasingly relevant in healthcare organizations. Psychological safety refers to the perception that individuals can express vulnerability, seek help, disclose distress, or discuss emotional concerns without fear of punishment, humiliation, judgment, or professional harm [14]. In psychologically unsafe systems, healthcare professionals may conceal distress, avoid support services, and continue functioning while emotionally

impaired. Traditional group-based or organizational mental health interventions may fail to adequately address individualized emotional experiences, cumulative grief exposure, or fear-related barriers to engagement. Emerging evidence suggests that confidential, self-referred, individualized psychological support models may improve acceptability and engagement among healthcare professionals by reducing perceived stigma and increasing psychological safety [13].

This issue may be particularly important in high-intensity pediatric and critical care environments, where healthcare workers are repeatedly exposed to prolonged suffering, chronic illness trajectories, end-of-life care, family distress, and cumulative emotional trauma. The present study aimed to evaluate, a) the perceived need and acceptability of confidential one-to-one psychological support among healthcare providers, b) preferred support modalities and barriers to engagement, c) the relationship between perceived psychological need and institutional support for implementation and d) potential workforce and organizational implications of confidential psychological support systems.

Materials And Methods

Study Design and Participants

A cross-sectional anonymous survey study was conducted among multidisciplinary healthcare providers within a tertiary healthcare environment in the United Arab Emirates. A convenience sample of healthcare professionals (n =91) participated voluntarily in the study. Participants included multidisciplinary healthcare workers from clinical settings associated with high emotional and occupational demands. Participation was voluntary and anonymous. No identifying information was collected.

Survey Instrument

A structured questionnaire was developed to assess, a) perceived need for psychological support, b) acceptability of confidential one-to-one support, c) preferred support modality, d) perceived barriers to engagement, e) anticipated psychological and occupational impact and f) institutional support for implementation. The questionnaire included categorical and Likert-style response domains.

Outcome Measures

The primary outcomes included 1) perceived need for psychological support, 2) institutional support for implementation and 3) preferred support delivery model. However, the secondary outcomes involved 1) perceived barriers to engagement and 2) anticipated emotional and occupational impact.

Statistical Analysis methods

Data were analyzed using descriptive and inferential statistical methods. Categorical variables were summarized using frequencies and percentages. Confidence intervals (95% CI) were calculated for key proportions. Associations between perceived need and institutional support were evaluated using chi-square testing. Odds ratio (OR) analysis with 95% confidence intervals was performed to evaluate the relationship between perceived psychological need and support for implementation of confidential services. Statistical significance was defined as $p<0.05$.

Ethical considerations status

The survey was anonymous and involved no collection of identifiable information. Participation implied consent. The study aligned with institutional standards for minimal-risk anonymous workforce surveys.

Results

Participant characteristics

A total of 91 healthcare professionals completed the survey. Nurses comprised the majority (62.6%, n=57), followed by physicians (31.9%, n=29). Administrators and allied health professionals were minimally represented (≤3.3% each). Additionally, nearly half of respondents worked in PICU (45.1%, n=41), followed by general wards (20.9%), office settings (18.7%), and NICU (15.4%). However, 53.8% of the studied participants had Mixed shifts predominated (53.8%), with day shifts (29.7%) and rotation schedules (15.4%) less common; night-only shifts were rare (1.1%). Regarding the year of experience, most participants had >10 years of experience (61.5%), suggesting a seasoned workforce (Figure 1).

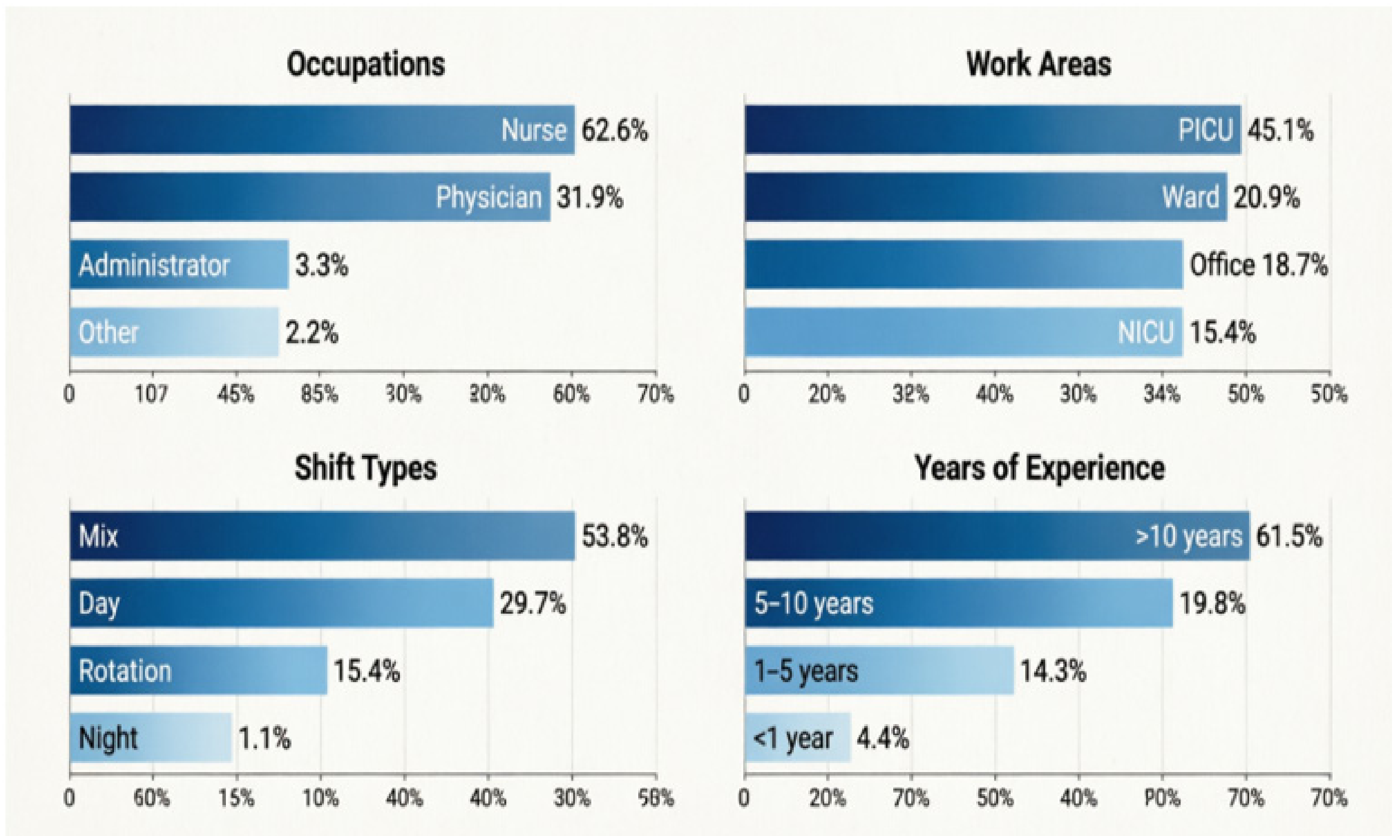


Figure 1. Workforce demographics of healthcare professionals completed the survey.

Perceived need for psychological support

Among participants, 64.8% (59/91) reported a direct need for psychological support, while 27.5% (25/91) remained uncertain regarding their need. Only 6.6% (6/91) reported no perceived need. The combined proportion of participants demonstrating either explicit or latent psychological support need reached 92.3%, suggesting a substantial hidden psychological burden within the healthcare workforce (Figure 2).

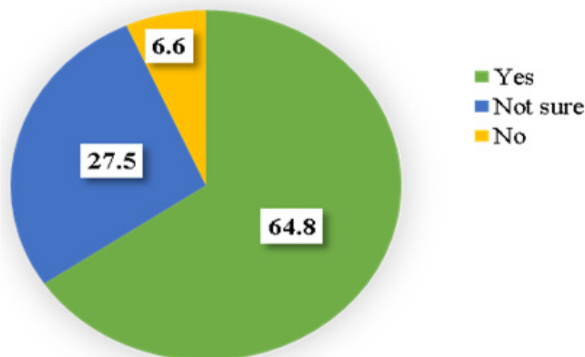


Figure 2. Distribution of the studied participants regarding perceived need for psychological support.

Institutional Support for Implementation

Institutional support for implementing confidential one-to-one psychological services was high. A total of 79.1% of participants either strongly supported or supported implementation (strongly support by 47 participants, 51.6%, support by 25 participants, 27.5%, neutral by 19 participants, 20.9%), (Figure 3).

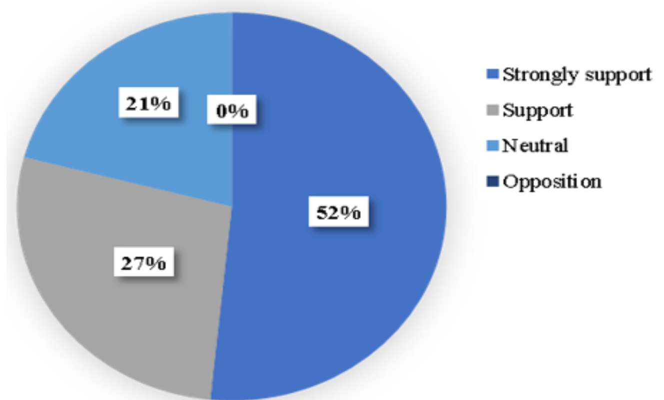


Figure 3. Distribution of the studied participants regarding the institutional support for implementation.

Preferred support delivery model
One-to-one confidential sessions were identified as the preferred support modality among 67.0% of participants (95% CI: 57.4–76.6). Hybrid models combining individual and group approaches were preferred by 26.4%, while only 5.5% preferred group-only interventions (Figure 4).

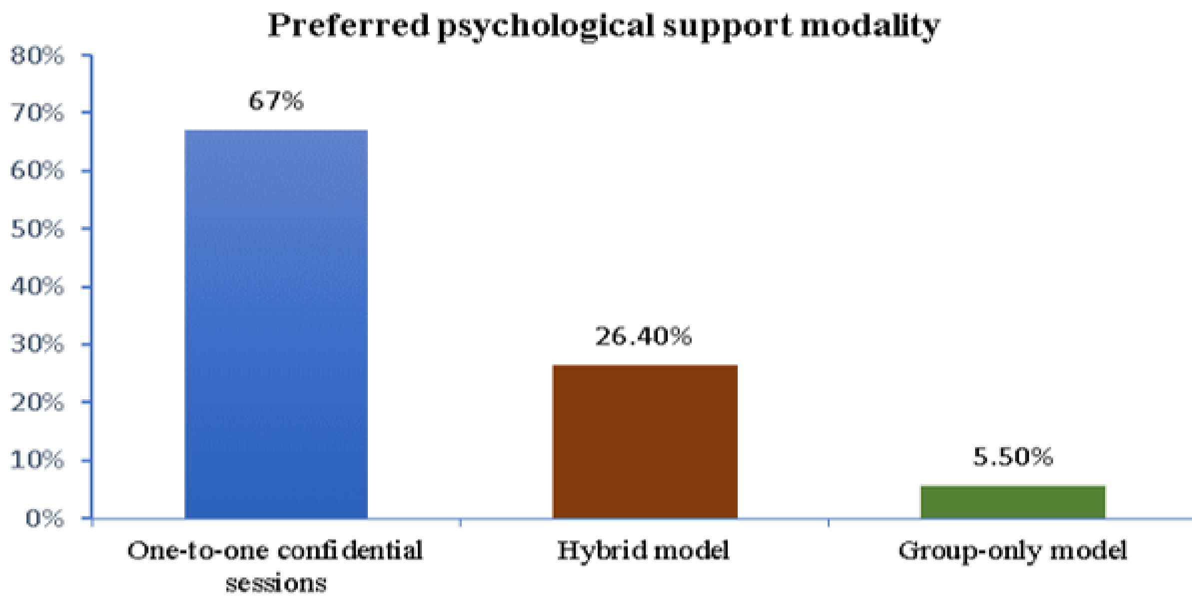


Figure 4. Distribution of the studied participants regarding preferred psychological support modality.

Association between psychological need and institutional support
A statistically significant association was identified between perceived psychological support need and institutional support for implementation of confidential psychological services (χ^2=18.72, $p<0.001$). Participants reporting psychological need demonstrated significantly greater likelihood of supporting implementation compared with participants not reporting need (Table 1).

Analysis	Statistic	Result
Need vs institutional support	χ^2	18.72
Statistical significance	p-value	<0.001*
Support likelihood	OR	4.3
Confidence interval	95% CI	2.1–8.9

Confidence interval (CI), *Significant
Table 1. Inferential Statistical Analysis.

Barriers to engagement
Thematic analysis identified confidentiality concerns as the dominant barrier influencing engagement with psychological support services. Additional barriers included fear of judgment, fear of professional consequences, time constraints, stigma-related concerns and uncertainty regarding effectiveness (Table 2).

Barrier	Interpretation
Confidentiality concerns	Primary determinant of engagement
Fear of judgment	Stigma-related barrier
Time constraints	Structural barrier
Fear of professional impact	Organizational barrier
Uncertainty of benefit	Knowledge-related barrier

Table 2. Reported barriers to psychological support engagement.

Perceived impact of confidential psychological support
Participants anticipated multiple benefits associated with confidential support systems, including, emotional relief, improved coping capacity, reduced emotional exhaustion, reduced burnout risk, enhanced resilience, improved professional performance, improved workplace functioning.

Discussion

This study identified a substantial and largely unmet psychological support need among healthcare professionals working within emotionally demanding healthcare environments. More than 90% of participants demonstrated either explicit psychological support need or latent vulnerability, suggesting the presence of significant hidden psychological burden within the workforce. These findings align with international

evidence demonstrating increasing rates of burnout, emotional exhaustion, moral distress, and occupational psychological impairment among healthcare professionals [5,6].

Importantly, the study extends beyond traditional burnout prevalence reporting by examining determinants of engagement with psychological support systems. Confidentiality emerged as both the dominant barrier and the principal facilitator influencing engagement. This finding supports the growing importance of psychological safety within healthcare organizations. Healthcare professionals may avoid support services when emotional disclosure is perceived as professionally unsafe or potentially stigmatizing. Fear-based silence within healthcare systems may contribute to concealed distress, delayed intervention, emotional deterioration, and occupational impairment.

The strong preference for individualized confidential support suggests that healthcare workers may perceive one-to-one psychological interventions as safer, more private, and more emotionally appropriate than generalized group-based models. The findings may be particularly relevant within pediatric and critical care environments, where clinicians are exposed to cumulative grief, chronic suffering, prolonged family distress, and repeated emotionally traumatic experiences [15,16,4].

The substantial “uncertain” subgroup identified in this study represents a clinically important finding. Individuals uncertain regarding their need for support may represent healthcare professionals experiencing unrecognized, normalized, minimized, or partially suppressed psychological distress. This hidden vulnerability subgroup may be especially important for early intervention strategies because individuals experiencing latent distress frequently remain functionally active while emotionally deteriorating [17-19]. The organizational implications of these findings extend beyond individual well-being. Previous evidence has linked healthcare worker psychological impairment with reduced cognitive performance, impaired decision-making, increased medical errors, reduced patient safety, and workforce attrition [7,8].

Accordingly, implementation of psychologically safe, confidential, self-referred support systems may contribute not only to workforce well-being but also to healthcare system resilience, retention, workforce sustainability, and patient safety culture. The present findings support increasing recognition that workforce mental health should not be viewed solely as an individual issue but rather as a strategic healthcare systems priority.

Strengths and Limitations

The strengths of the current study were real-world multidisciplinary healthcare workforce data, Strong acceptability signal for confidential support models, Practical and implementable organizational intervention concept, Inclusion of inferential statistical analysis, Workforce resilience and healthcare systems relevance. However, several limitations should be acknowledged, first, the study utilized a single-center convenience sample, which may limit generalizability. Second, the cross-sectional design prevents causal inference. Third, findings were based on self-reported perceptions and may be influenced by response bias or social desirability bias. Additionally, detailed subgroup analysis according to profession, seniority, and specialty was not performed. Future multicenter longitudinal studies are needed to evaluate objective outcomes including burnout reduction, retention, absenteeism, workforce stability, and patient safety outcomes following implementation of confidential support systems.

Future Directions

Future research should evaluate, a) longitudinal impact of confidential psychological support, b) burnout reduction outcomes, c) workforce retention outcomes, d) impact on sick leave and absenteeism, e) patient safety indicators, f) healthcare organizational culture outcomes, g) psychological safety culture development and h) implementation science models for workforce mental health programs.

Conclusion

Healthcare professionals experience substantial psychological burden within modern healthcare environments, yet engagement with support systems remains limited by confidentiality concerns, stigma, and fear-related barriers. This study demonstrates high acceptability for confidential one-to-one psychological support models among healthcare providers and highlights the critical importance of psychological safety in workforce mental health engagement. Confidential, self-referred, psychologically safe support systems may represent an important organizational strategy for improving workforce resilience, reducing hidden psychological burden, supporting retention, strengthening patient safety culture, and enhancing healthcare system sustainability.

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