

Wellness Coaching Fosters Quality of Life in Rehabilitation Professionals in Thailand

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The contribution of low quality of life among healthcare professionals has been highlighted in the literature. Still, relatively little attention has been paid to intervention development to improve their quality of life. This paper investigated the effectiveness of a wellness coaching intervention in promoting quality of life and wellness outcomes among healthcare professionals in Thailand. In total, 58 participants in this experimental study work with chronic illness patients. Random assignment allocated participants into two groups, experimental or control group. The study design included randomized control group design given to both groups. Research instruments used in this study include: 1) Five Factor Wellness Inventory (FFWEL) Thai version, and 2) World Health Organization Quality of Life (WHOQOL-BREF) Thai version. Only the 29 participants in the experimental group experienced the 2-day group wellness coaching and 4-week online individual wellness coaching. The findings supported the hypothesis that wellness coaching directly influences rehabilitation professionals' quality of life and wellness perception. The results demonstrated that wellness coaching positively affected rehabilitation professionals' perceptions of wellness and quality of life. Healthcare professionals do not seek help from mental health professionals. The researchers advocate for wellness coaching due to its various positive effects.

Keywords: wellness coaching, rehabilitation professionals, quality of life

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Healthcare professionals worldwide are reported to have significantly high rates of distress (World Health Organization [WHO], 2016), including psychological distress (Whitehead et al., 2015). Healthcare professionals require significant dedication, time, and energy to meet the demands of healthcare services, such as patient management and service delivery. The high stress level and long work hours can adversely affect their own quality of life and the quality of care the professionals provide to their patients. Thus, the WHO calls attention to protecting healthcare professionals from everyday workplace hazards, including stress in the workplace (WHO, 2018). This study investigated the effectiveness of wellness coaching in promoting quality of life and wellness outcomes among healthcare professionals, including healthcare students who work in chronic illness care in Thailand.

Background

The WHO reports that 59 million healthcare professionals worldwide are exposed to various hazards from daily tasks and calls for support to protect healthcare professionals worldwide (WHO, 2016). Hazards include a heavy workload, violence, and stress (WHO, 2016). Providing healthcare in rehabilitation settings to meet the challenge of caring for a growing population is another source of daily stress for healthcare professionals. In Thailand, for instance, healthcare professionals who provide long-term care for patients with chronic illnesses experience high levels of daily stress, negatively impacting the professionals' quality of life (Jiraporncharoen et al., 2016). Chronic illnesses, such as Diabetes Mellitus (DM), Hypertension (HT), and cardiovascular disease (CVD), have a significant long-term impact on both mental and physical health of patients (Mackay & Mensah, 2004).

These chronic illnesses are the costliest health issues in Thailand and worldwide (WHO, 2016). Given the prevalence of these illnesses and the long-term care required for these patients, the healthcare professional's role becomes urgent and demanding. Researchers have found a relationship between healthcare professionals and psychological distress (WHO, 2016). Especially, the healthcare professionals who worked and experienced at the special care departments, including encountering patient's death, heavy patient assignments with a high workload of caring, and a high caseload of traumatized patients (Abendroth & Flannery, 2006; Yoder, 2010), were described as factors that triggered compassion fatigue and burnout among healthcare professionals. These psychological distress among healthcare professionals called an attention with protecting healthcare professionals and promoting the highest competency for healthcare service performance. Indeed, assisting healthcare professionals has added benefits to contributing to quality of life and strengthening the health system, directly impacting patient care. Unfortunately, there is an overall lack of research focused on the impact of rehabilitation work on professionals' quality of life (Quansri & Tadros, 2022).

There is a dearth of studies investigating the current mental health status of healthcare professionals or types of intervention used for quality-of-life promotion, especially in Thailand. Negative societal responses to people who seek help for psychological support may be the single greatest barrier to mental health promotion among healthcare professionals (Lauber & Rossler, 2007). Additionally, as is the case for many countries in Asia, another barrier to mental health care is a lack of personnel and financial resources (Lauber & Rossler, 2007). These factors impact mental healthcare accessibility for Thai people, which is evident for healthcare professionals. In this challenging situation, evidence-based effective intervention to promote the healthcare professional's quality of life is clearly needed.

Statement of the Problem

Evidence-based practice development to improve quality of life has become an important intervention for healthcare professionals' development. Lower quality of life means decreased individual perception of one's position in life concerning their life goals, expectations, standards, and concerns (WHO, 1995). Limited research has examined effective interventions to improve the quality of life among healthcare professionals. Therefore, there is an urgent need to facilitate the use of evidence-based research to identify effective interventions that can improve the quality of life for healthcare professionals in real-world settings.

Quality of Life for Healthcare Professionals & Patients

In Thailand, promoting a positive quality of life in patients is a goal of the multidisciplinary health team. The use of a multidisciplinary team approach in the healthcare system, involving doctors, specialists, nurses, pharmacists, dieticians, health educators, and mental healthcare professionals with the patient at the center of the team, has been demonstrated to improve health outcomes and quality of life (Nitiyanant, 2017). As a multidisciplinary team member, this may be a beneficial role for a counselor's role in quality-of-life promotion. In 1948, the WHO defined quality of life promotion as actions to create relationships and an environment to support mental health and allow health professionals to adopt and maintain healthy lifestyles (WHO, 1997). Promoting quality of life among

multidisciplinary members is challenging for counselors that are part of the team. A counselor is in an ideal setting to enhance wellness as they can develop innovative strategies and tools to strengthen healthcare systems by supporting the multidisciplinary team to promote a more positive quality of life for the team members and the patients.

Wellness Coaching

Wellness coaching has been defined as a client-centered approach that works with individuals and groups to facilitate and empower the client to achieve self-determined goals related to health and wellness (National Board for Health & Wellness Coaching, 2016). Wellness-based interventions promoting a more positive quality of life among patients is not new; however, using this approach to promote the quality of life among healthcare professionals has not been done (Clark et al., 2014). Wellness coaching is slowly emerging as a topic of interest in Thai society, particularly among those who are well-informed about the current trends in Western psychology (Pelzer, 2010). This approach has had primary application through chronic illness patient coaching to improve quality of life.

Wellness

William Hettler, the father of the modern wellness movement, defined wellness as “an active process through which people become aware of and make choices toward a more successful existence” (Hettler, 1984; p.14). Hettler developed a model of wellness that included six specific dimensions: intellectual, emotional, physical, social, occupational, and spiritual health (Myers & Sweeney, 2007). Several wellness models have been developed that examine wellness from a holistic view (Edlin, 1988). The wellness model is the best perspective for helping people maintain healthy lifestyles, helping clients become as healthy as possible, and helping resolve personal and emotional problems (Remley & Herlihy, 2010).

Healthcare Professionals

In 2009, the number of health professionals was reported as 23,909 doctors (0.37 per 1,000 population), 10,108 dentists (0.156 per 1,000), 24,814 pharmacists (0.38 per 1,000), and 109,797 professional nurses (1.74 per 1,000) (Pagaiya & Noree, 2009). This research study focused on healthcare professionals, including healthcare students that are critical to chronic care, namely doctors, nurses, pharmacists, and other health professionals who identify themselves as full-time rehabilitation professionals. Also, this research focused on the health professional that works at the provincial and district hospital level throughout Thailand, which covered 774 community hospitals at the district level (WHO, 2016).

Quality of Life

Quality of Life has been defined as a condition that involves subjective welfare in physical, psychological, social, and economic areas. This multifaceted concept includes various areas of life: emotional conditions, economics, physical condition, family support, social activities, attitude, and more. In this study, quality of life referred to a state of spiritual, psychological, and social well-being (Theofilou, 2013; WHO, 2018).

Current Study

The aim of this study was to investigate the effectiveness of a wellness coaching intervention on wellness and quality of life for healthcare professionals in Thailand. The research questions and hypotheses were: First, would there be a difference between pretest and posttest scores in the Five Factor Wellness Inventory (FFWEL) score and WHO Quality of Life-BREF (WHOQOL-BREF) for wellness coaching participants? We hypothesized (H1) that there would be a statistically significant difference in FFWEL post-intervention scores in the experimental group compared to their pre-inter-

vention FFWEL scores. Second, (H2) it was hypothesized that there would be a statistically significant difference in WHOQOL-BREF post-intervention scores in the experimental group compared to their pre-intervention WHOQOL-BREF scores. Third, (H3) it was hypothesized that there would not be a statistically significant difference between pretest and posttest scores in the FFWEL score and WHOQOL-BREF score in the control group. It was hypothesized (H4) there would be a statistically significant difference in FFWEL post-intervention scores in the experimental group compared to the control group. Further, (H5) it was hypothesized that there would be a statistically significant difference in WHOQOL-BREF post-intervention scores in the experimental group compared to the control group.

Method

Participants

One province out of 76 provinces of Thailand was randomly selected as the target participant for this study, excluding Bangkok, the capital of Thailand. Participants were recruited who identified themselves as full-time rehabilitation professionals, including healthcare students, who primarily work at district hospitals. There are at least three district hospitals per province. After obtaining institutional review board (IRB) approval, the researchers received permission from the provincial health office director for participant recruitment. This participant recruitment effort was announced in collaboration with the provincial Non-Communicable Diseases system manager. The recruitment announcement was posted at the regional health office. Healthcare professionals who decided to participate in the research attended an engagement meeting at the provincial health office. Simple random sampling was used during the engagement meeting to identify participant candidates. A two-group pretest-posttest design was employed.

In order to protect participant confidentiality, information that would identify the participants was excluded from all research study records. All participants were provided with informed consent for the research study. In this study, the participants ($n=58$) were randomly assigned to either the experimental group ($n=29$) or the control group ($n=29$). The experimental group participated in the 4-week wellness coaching program, while the control group did not participate in the program.

Instruments

Research instruments used in this study included: 1) FFWEL Thai version, and 2) WHOQOL-BREF Thai version which were adopted from the research. The use of pretest and post-test measures for experimental groups was required as the fundamental research question revolved around the within-group change in wellness and quality-of-life outcomes. The use of pretest and post-test measures for the control group was required to examine any confounding variables not likely due to this study. The pretest and post-test for the control and experimental groups were given in the same time frame, on the first day and again, four weeks later.

Five Factor Wellness Inventory (FFWEL)

The FFWEL is also called 5F-Wel (Myers & Sweeney, 2007). This instrument was developed in 2005 and minorly revised by Myers and Sweeney in 2007. The FFWEL was developed to measure wellness based on the principles of the Indivisible Self (IS), a wellness Model (Myers & Sweeney, 2007). The model identifies factors central to healthy living and represents domains of human functioning where accepting personal responsibility and choice will positively affect well-being. The underlying factors in the Wheel model were first identified based on cross-disciplinary research that examined empirical correlates of quality of life, healthy living, and longevity. The FFWEL was developed with three versions: The A version, The T version, and The E version.

Indivisible Self (IS) is an evidence-based wellness model (Myers & Sweeney, 2007). Adler proposed that holism (the indivisibility of self) and purposiveness were central to understanding human behav-

ior and that such understanding required an “emphasis on the whole rather than the elements, the interaction between the whole and parts, and the importance of man’s (sic) social context” (Ansbacher & Ansbacher, 1967, p. 11-12). The IS consists of a single higher-order wellness factor, five second-order factors (creative self, coping self, social self, essential self, and physical self), and contextual factors (local, institutional, global, and chronometrical) (Myers & Sweeney, 2007).

This study used a Thai version of the second edition of FFWEL, Adult (FFWEL-A2) to measure a participant’s wellness. The FFWEL-A2 was developed through structural equation modeling analysis of the database for the instrument that was its precursor, the Wellness Evaluation of Lifestyle (WEL) (Hattie et al., 2004; Myers et al., 1998). Central to the development of the FFWEL-A2 was a unifying definition of wellness, a holistic approach in which mind, body, and spirit are integrated (Myers & Sweeney, 2007). Of the 132 items of the original WEL, 29 items were eliminated because of poor psychometric properties. The FFWEL, a maximum-likelihood exploratory factor analysis, was conducted based on 103 wellness items (Myers & Sweeney, 2007). The FFWEL’s founders specified 17 clear factors based on the original theoretical, circumplex Wheel of Wellness model: five life tasks - spirituality, friendship, love, work, and leisure - as two factors, plus the 12 subtasks of self-direction, but not the composite or sum of the subtasks, self-direction (Hattie et al., 2004). Based on the IS model, all three versions of the FFWEL include 23-factor scores, four context scores, and a one-item validity index.

World Health Organization Quality of Life Assessment (WHOQOL-100)

The WHOQOL-100 assessment was developed in 1998. This instrument is a cross-cultural valid assessment of well-being. The instrument’s purposes are: 1) to extend the dimensions of health measurement beyond traditional health indicators; 2) to develop a more universal instrument for assessing the quality of life (QoL) cross-culturally; and 3) to assess more humanistic elements to promote a holistic approach to health and health care (WHOQOL Group, 1998). The WHOQOL-100 consists of 100 questions that measure 24 quality-of-life facets grouped into four domains: Physical Health, Psychological, Social Relationships, and Environment (Skevington et al., 2004). The instrument was rigorously tested for validity and reliability (WHO, 2018).

World Health Organization Quality of Life (WHOQOL-BREF)

The WHOQOL-BREF is a research instrument used to assess an individual’s quality of life. Based on WHOQOL-100, the WHOQOL-BREF has been developed to provide a short version of WHOQOL-100 that only consists of 26 items (Skevington et al., 2004). The WHOQOL-BREF has been tested and found to have acceptable validity and reliability, as it has been used as a research instrument in many countries (Skevington et al., 2004).

This study used the Thai version of the WHOQOL-BREF. The 26 items consisted of two generic items (i.e., overall quality of life and general health) and 24 other items, which can be classified into four domains, including physical health (7 items), psychological health (6 items), social relationships (3 items), and environmental health (8 items). Each of the 24 items of the four domains was derived from each of the 24 facets in the WHOQOL-100 to ensure a broad and comprehensive assessment (WHO, 1995; WHOQOL Group, 1998). The two generic items ask about individual overall perception of quality of life and individual general perception of participants’ health. The response options of these two items were scored in a positive direction. Likewise, the response options of 21 of the total 24 other items in different domains refer to a favorable direction (i.e., higher scores indicate higher quality of life). For example, to respond to the question “How safe do you feel in your daily life?” the five response options are “1 = Not at all,” “2 = A little,” “3 = A moderate amount,” “4 = Very much,” and “5 = An extreme amount.”

There are three items on the WHOQOL-BREF whose response options are listed in a negative direction. These three items are “To what extent do you feel that physical pain prevents you from doing what you need to do?” and “How much do you need any medical treatment to function in your daily

life?" with endpoints "Not at all" and "An extreme amount"; and "How often do you have negative feelings such as blue mood, despair, anxiety, depression?" with endpoints "Never" and "Always." These items were reversely recoded during the data analysis.

The WHOQOL-BREF is a self-administered instrument with a recommended time frame of two weeks. However, the researchers in this current study suggested a four-week time frame to assess the quality of life in chronic conditions (Skevington et al., 2004).

Demographic Form. The de-identified demographic information was constructed as a set of questions to derive participant characteristics consisting of gender, age, type of profession, education level, whether they were a rehabilitation professional, and the number of years of work.

Procedures

This comparison study aimed to measure the wellness and quality of life outcomes by following experimental group participants in a four-week wellness coaching program. The participants from the control and experiment groups were given a pretest and a post-test, using the FFWEL and WHOQOL-BREF to measure the effectiveness of the wellness coaching program in the experimental group and regular activities in the control group. A half-day of engagement was arranged for each group on the same day. During the half-day engagement, the researcher informed the participants of the research purpose and provided a briefing on the wellness coaching program. The consent forms were signed, and the pre-tests were conducted immediately afterward on the same day.

The researcher conducted a four-week wellness coaching program for the experimental group and began with a two-day workshop in groups followed by weekly individual coaching for four weeks. The individual coaching was performed as a video call via a social media program, LINE application. The individual coaching details, including the schedule, were designed upon the agreement of each participant and the researcher. The post-tests were conducted for both groups, control, and experimental groups at the end of week four.

Individual Sessions

According to Green et al. (2006), coaching has been shown to be beneficial at the individual level. The individual wellness coaching session was provided once a week for 50 minutes to each participant in the experimental group. The individual sessions were divided into four sessions.

First Session

The researcher provided each participant a copy of the FFWEL results and a brief discussion. The discussion focused on helping clients reflect on and interpret their scores. Hattie et al. (2004) indicated that it was useful for participants to provide their scores on the WEL. The score provided information about current levels of functioning in specific areas of their wellness. This session helped participants review their goal(s) and plan for the two-day workshop. It was up to clients to examine their scores and determine which areas they would like to change (Myers et al., 2001).

Second to Fourth Session

These sessions started with "what would you like to accomplish today?" This question allowed the participant to lead the session. The discussions were participant-centered to focus on their goals and plans. The researcher helped the participant to evaluate their goals and plans and discuss skills needed to move forward.

This wellness coaching program, which was utilized in this study, was developed based on basic assumptions of Individual Psychology Theory in both the group and individual approach. The evidence-based instruments used were aimed at examining the effectiveness of the wellness coaching program in the experimental group. The control group, also referred to as the wait-list group, served

as an untreated comparison group during the study. Upon agreement among the participants and the researcher, this group will receive an identical wellness coaching program as the experimental group at a later date (post-research).

Data Analysis

An experimental study evaluated the quality of life and wellness of rehabilitation professionals who participated in the wellness coaching program. A non-equivalent control group design was used, since participants were randomly assigned to the groups and both groups completed a pre-test and post-test (Gall et al., 2007). The research question of this study was considered individually, and the null hypothesis was tested. To increase the strength of this experimental study, the difference within and between the experiment and the control group was examined. This study used parametric statistics, t-tests to test whether the experimental group and control group were significantly different. The pre-test and post-test scores of both the control and experimental groups were input into SPSS for analysis.

Results

The results showed the effectiveness of wellness coaching, which positively contributed to promoting quality of life when conducted through a combination of a face-to-face group workshop and four individual online coaching sessions. Results indicated that the main effect for within-subject variables was significant ($p < .001$), which means there was a significant group difference in perception of quality of life. The results of the mean difference indicated that the increase in scores across the four quality of life domains between pre and post-intervention was significantly greater for post-intervention than pre-intervention. Results also presented significant differences for all individual domains ($p < .001$). Collectively, these results supported the influence of the intervention, the wellness-coaching program.

The study results indicated that the increase of five wellness factors between pre and post-intervention was significantly greater for post-intervention than pre-intervention in the experimental group. That is, there was a significant group difference in perception of wellness.

Demographic Information

Demographic information was collected during the pre-test evaluation. Table 1 presents the participant demographics from the study by group. Table 2 presents the experience levels of the participants by group.

Table 1
Demographic Information

Demographic	Experiment Group (n=29)		Control Group (n=29)	
	<i>n</i>	%	<i>n</i>	%
Gender				
Male	1	3.4	1	3.4
Female	28	96.6	28	96.6
Age (years)				(n=27)
Under 30	3	10.3	8	29.6
31 – 40	8	27.6	3	11.1
41 – 50	10	34.5	14	51.9
51 – 60	8	27.6	2	7.4

Mean	42.621 (<i>SD</i> =9.821)		38.926 (<i>SD</i> =8.9826)	
Min – Max	Min=25, Max=58		Min=24, Max=55	
Marital status				
Single	11	37.9	11	37.9
Married	14	48.3	16	55.2
Separated/divorced/widowed	4	13.8	2	6.9
Educational level				
Lower than bachelor degree	0	0.0	1	3.4
Bachelor degree	17	58.6	25	86.2
Higher than a bachelor degree	12	41.4	3	10.3

Table 2*General Information on Chronic Care Experiences*

	Experiment Group (<i>n</i> =29)		Control Group (<i>n</i> =29)	
	<i>n</i>	%	<i>N</i>	%
Relevant NCDs training/education	<i>(n</i> =21)		<i>(n</i> =22)	
Mini Case Manager	5	23.8	5	22.7
Case Manager	4	19.0	7	31.8
System Manager	2	9.5	0	0.0
More than 1 training/education	2	9.5	2	9.1
Never been training/education	8	38.1	8	36.4
Working in the NCDs clinic	<i>(n</i> =17)		<i>(n</i> =20)	
Mean	7.118 (<i>SD</i> =4.0293)		3.300 (<i>SD</i> =2.8621)	
Min – Max	Min=1, Max=15		Min=0.2, Max=10	

Most (61.9%) participants in the experimental group (*n*=21) reported receiving relevant training or education. However, the majority of them (38.1%) reported never having received relevant training/education related to non-communicable disease (NCD) or chronic illnesses care. There were eight participants who did not report on training/education information. Regarding years of experience working in the NCD clinic (*n*=17) the mean for the experimental group was 7.118 (*SD*=4.0293). The range of years working in the NCD clinic was one to 15 years. Most (63.6%) of the participants in the control group (*n*=22) reported receiving relevant training or education. However, the majority (36.4%) reported never receiving relevant training/education related to NCDs or chronic illnesses care. There were six participants in the group who did not report training/education information. Regarding years of experience working in the NCDs clinic (*n*=20), the mean was 3.300 (*SD*=2.8621). The range of years working in the NCDs clinic was 0.2 to 10 years. Table 3 presents the presence of medical conditions and self-identified by the participants.

Most participants (75.9%) in the experiment group (*n*=29) reported no medical conditions, while 24.1% had a medical condition such as asthma, breast cancer, dyslipidemia, hypertension, hyperlipidemia, or allergy. Similarly, the majority (79.3%) of participants in the control group (*n*=29) also reported no medical conditions, while 20.7% had a medical condition such as asthma, dyslipidemia, hypertension, allergy, or a thyroid disorder. Table 4 presents participant responses to who they go to ask for help.

Table 3*General Information on Medical Conditions (n=58)*

	Experiment Group (n=29)		Control Group (n=29)	
	<i>n</i>	%	<i>n</i>	%
Medical conditions				
No	22	75.9	23	79.3
Yes	7	24.1	6	20.7

Table 4*General Information on number and percentage of people who participants (n=58) ask for help*

Who you can ask for help when you have a problem that cannot be resolved by yourself		Experiment Group (n=29)		Control Group (n=29)	
		<i>n</i>	%	<i>n</i>	%
Father	No	22	75.9	19	65.5
	Yes	7	24.1	10	34.5
Mother	No	17	58.6	11	37.9
	Yes	12	41.4	18	62.1
Father-in-law	No	29	100.0	29	100.0
	Yes	0	0.0	0	0.0
Mother-in-law	No	28	96.6	27	93.1
	Yes	1	3.4	2	6.9
Spouse	No	17	58.6	13	44.8
	Yes	12	41.4	16	55.2
Children (including) stepchildren	No	24	82.8	27	93.1
	Yes	5	17.2	2	6.9
Brother/sister	No	14	48.3	11	37.9
	Yes	15	51.7	18	62.1
Relative	No	25	86.2	22	75.9
	Yes	4	13.8	7	24.1
Friend/colleague	No	9	31.0	5	17.2
	Yes	20	69.0	24	82.8
Never ask for help	No	29	100.0	29	100.0
	Yes	0	0.0	0	0.0

The majority (69%) of participants in the experimental group ($n=29$) reported that when they have a problem that cannot be resolved independently, they asked for help from friends/colleagues, and 51.7% from a sibling. Following that, 41.4% asked for help from a mother, 24.4% from a father, and none of them stated they never asked for help. The majority (82.8%) of participants in the control group ($n=29$) reported that when they have a problem that cannot be resolved by themselves, they ask for help from a friend /colleague. Beyond that, 62.1% asked for help from a sibling, 62.1% from a mother, 44.8% from a spouse, and none of the participants stated that they never asked for help.

First, the WHOQOL BREF Thai version was employed as a health perceiving measure. Quality of life changes in the four domains were based on the completed pretest and post-tests of both the experi-

mental ($n=29$) and control groups ($n=29$). Second, the Five Factor Wellness (FFWEL) Thai version was employed to assess perceived wellness for participants in both groups ($n=58$). There was no missing data for any items. This assessment used a randomized control-group pre-test/post-test design. A t-test was used to determine any group difference between the experimental group and the control group. The results are presented in Table 5.

Table 5

Equality of Means of Experimental and Control Groups Pre-Test Scores on Quality of life

		Levene's Test for Equality of Variances			t-test for Equality of Means				
		F	Sig.	Sig t	Mean df	Std Error (2 tailed)	Difference	Diff.	95% Confidence Interval of the Difference Lower Upper
Physical									
Equal variances assumed		.078	.781	.392	56	.696	.24138	.61561	-.99183 1.47459
Equal variance not assumed				.392	55.943	.696	.24138	.61561	-.99186 1.47461
Psychological									
Equal variances assumed		.163	.688	.110	56	.913	.06897	.62539	-1.18385 1.32178
Equal variances not assumed				.110	55.695	.913	.06897	.62539	-1.18400 1.32193
Social Relations									
Equal variances assumed		.122	.728	.720	56	.474	.48276	.67004	-.85950 1.82501
Equal variances not assumed				.720	55.990	.474	.48276	.67004	-.85950 1.82502
Environment									
Equal variances assumed		1.248	.269	-.065	56	.949	-.03448	.53349	-1.10319 1.03422
Equal variances not assumed				-.065	55.941	.949	-.03448	.53349	-1.10321 1.03425

Table 5 displays the results from an independent sample t-test, which indicated that there was no significant difference between pre-test achievement scores of the control and experimental groups ($p>0.05$) in all domains. This results indicated that the quality of life for participants in both groups were equal.

Table 6

Mean and Standard Deviation Difference for the Quality of Life in Four Domains of Quality-of-Life Pre-Test and Post-Test in Control Group

Paired Differences								
	Mean	Std Deviation	Std Error Mean	95% Confidence Interval of Difference		T	Df	Sig. (2-tailed)
				Lower	Upper			
Physical	.48276	2.08088	.38641	-.30876	1.27428	1.249	28	.222
Psychological	-.75862	2.61391	.48539	-1.75290	.23566	-1.563	28	.129
Social Relations	.93103	2.46303	.45737	-.00585	1.86792	2.036	28	.051
Environment	.17241	1.81401	.33685	-.51760	.86243	.512	28	.613

The results from an independent sample t-test indicated that there was no significant difference found among pre-test achievement scores of the control and experimental groups ($p>0.05$) in all domains. These results show that the wellness scores of participants in both groups were equal.

The first hypothesis of this study was: (H1) There would be a statistically significant difference in FFWEL post-intervention scores in the experimental group compared to their pre-intervention FFWEL scores. The paired samples t-test was used to test this hypothesis. For each wellness area, a significant difference was shown between pre-test and post-test scores, supporting this hypothesis. The specific results are presented in Table 7.

Table 7

Mean and Standard Deviation Difference for the Quality of Life in Four Domains of Experimental Group (n=29) as Pre- and Post-Intervention (Wellness Coaching)

Domains	Test	T	Df	Sig. (2-tailed)	Mean Difference (Pre & Post)	95% Confidence Interval of the Difference	
						Lower	Upper
Physical	Pretest	35.101	28	0.00	15.03448	14.1571	15.9118
	Posttest	55.078	28	0.00	17.31034	16.6666	17.9541
Psychological	Pretest	33.872	28	0.00	14.41379	13.5421	15.2855
	Posttest	58.959	28	0.00	16.89655	16.3095	17.4836
Social Relations	Pretest	31.880	28	0.00	15.20690	14.2298	16.1840
	Posttest	55.516	28	0.00	16.27586	15.6753	16.8764
Environment	Pretest	39.683	28	0.00	14.72414	13.9641	15.4842
	Posttest	54.783	28	0.00	16.06897	15.4681	16.6698

Table 7 presents t-test results indicating a significant difference among wellness pre-test and post-test scores in the experimental group ($p<0.001$) in all five domains. This result shows that the treatment used on the experimental group dramatically enhanced rehabilitation professionals' wellness. According to this data, it can be concluded that the wellness coaching program positively affected the wellness of rehabilitation health professionals.

The second hypothesis of this study was: (H2) There would be a statistically significant difference in WHOQOL-BREF post-intervention scores in the experimental group compared to their pre-intervention WHOQOL-BREF scores. A paired sample t-test was used to test this hypothesis. In all four domains for the quality of life, the results showed a significant difference between pre-and post-test scores, thereby providing support for this hypothesis. The specific results are presented in Table 8.

Table 8 displays the results from an independent sample t-test, indicating that the within-subject variable's main effect was significant ($p<.005$). Additionally, the post-intervention post-test scores were significantly greater than the pre-intervention scores. The increase was not greater, but all scores increased. The post-test indicates quality of life in all four domains was significantly higher than the pre-test scores of quality of life: Physical ($p<.001$), Psychological ($p<.001$), Social Relations ($p<.001$), and Environment ($p=.002$). The results indicated that the treatment used on the experimental group dramatically enhanced rehabilitation professionals' achievement. According to this data, it can be concluded that the wellness coaching program positively affected the quality of life of rehabilitation health professionals.

Table 8

Mean and Standard Deviation Difference for Between Control and Experimental Groups Post-Test Achievement Scores on Quality of Life

Levene's Test for Equality of Variances			t-test for Equality of Means						
	F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval Difference LowerUpper	
Physical									
Equal Variances assumed	.524	.472	6.195	56	.000	3.00000	.48425	2.02993	3.97007
Equal variances not assumed			6.195	54.644	.000	3.00000	.48425	2.02940	3.97060
Psychological									
Equal variances assumed	.100	.752	4.297	56	.000	1.79310	.41727	.95722	2.62899
Equal variances not assumed			4.297	55.821	.000	1.79310	.41727	.95716	2.62905
Social Relations									
Equal varianced Assumed	7.304	.009	4.400	56	.000	2.48276	.56428	1.35237	3.61315
Equal variances not assumed			4.400	46.216	.000	2.48276	.56428	1.34706	3.61846
Environment									
Equal variances assumed	1.658	.203	3.195	56	.002	1.48276	.46410	.55305	2.41246
Equal variances not assumed			3.195	53.823	.002	1.48276	.46410	.55222	2.41330

The third hypothesis of this study was: (H3) There would not be a statistically significant difference between pre-test and post-test scores in the FFWEL score and WHOQOL-BREF score in the control group. The paired t-test was used to test the hypothesis. Table 9 shows the results from an independent samples t-test which indicated that there was no significant difference ($p > .05$) in all domains between pre-test and post-test scores of rehabilitation professionals' achievement for all domains in the control group.

Table 10 shows that there was no significant difference between the pre-test and post-test scores of rehabilitation professionals in the control group ($p > 0.05$) in the Coping domain, Social domain, Essential domain, and Physical Health domain. Only the Creative domain resulted in a significant difference among pre-test and post-test scores of rehabilitation professionals in the control group ($p < 0.05$).

The fourth hypothesis in this study was, (H4) There would be a statistically significant difference in FFWEL post-intervention scores in the experimental group compared to the control group. The independent samples t-test was used to test this hypothesis. Table 11 displays the mean and SD of participants who perceived wellness in the experimental group ($n=29$) for both the pre-test and post-test, as well as the pre-test and post-test scores for the control group without the wellness coaching program. The post-test of wellness in all five factors for the experimental group was higher than the post-test of wellness in the control group. There was a significant difference in wellness scores among the post-test achievement scores for both the control and experimental groups ($p < .001$) in all domains.

The last hypothesis (H5) stated there would be a statistically significant difference in WHOQOL-BREF post-intervention scores in the experimental group compared to the control group. As presented in Table 12, an independent sample t-test was conducted to compare Quality of Life post-test achievement scores between the experimental group and control group. There was a significant difference among the post-test achievement scores of the control and experimental group ($p < 0.05$) in all domains.

Table 9

Mean and Standard Deviation Difference for Between Control and Experimental Groups Pre-Test Achievement Scores on Wellness

	Levene's Test for Equality of Variances			t-test for Equality of Means					
	F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval Difference Lower	Upper
Creative									
Equal variances assumed	.057	.812	-.384	56	.702	-.81897	2.13037	-5.08661	3.44868
Equal variances not assumed			-.384	54.947	.702	-.81897	2.13037	-5.08841	3.45048
Coping									
Equal variances assumed	1.526	.222	1.239	56	.220	2.42457	1.95679	-1.49535	6.34449
Equal variances not assumed			1.239	51.128	.221	2.42457	1.95679	-1.50361	6.35275
Social									
Equal variances assumed	2.297	.135	4.555	56	.000	10.68966	2.34678	5.98849	15.39082
Equal variances not assumed			4.555	50.914	.000	10.68966	2.34678	5.97811	15.40120
Essential									
Equal variances assumed	.111	.741	.465	56	.644	.86207	1.85451	-2.85296	4.57710
Equal variances not assumed			.465	55.744	.644	.86207	1.85451	-2.85333	4.57747
Physical Health									
Equal variances assumed	2.327	.133	1.147	56	.256	4.88320	4.25687	-3.64434	13.41074
Equal variances not assumed			1.147	50.300	.257	4.88320	4.25687	-3.66571	13.43212

Wellness Coaching Program Implementation

The 29 experimental group participants successfully completed the two-day workshop and four weekly sessions. By the end of the workshop, all participants had created a goal and a plan related to wellness improvement. The four weekly online sessions were conducted individually and aimed to support the participants in working on their plan for goal achievement. Most (18 out of 29) of the participants created a goal in Physical Health: increase physical activity, healthy diet development, and weight control. Five participants created goals in Essential Self, spirituality, and self-care. The last

five participants created goals in Social Self, and relationship goals. Some of the participant's plans were adjusted as needed.

Table 10

Mean and Standard Deviation Difference FFWEL Pre-Test and Post-Test in Control Group

Std.	Paired Differences							
	Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of Difference		t	Df	Sig. (2-tailed)
				Lower	Upper			
Creative	10.80448	7.07749	1.31426	8.11235	13.49662	8.221	28	.000
Coping	.96983	4.46679	.82946	-.72925	2.66890	1.169	28	.252
Social	-.43103	5.43094	1.00850	-2.49685	1.63478	-.427	28	.672
Essential	1.40086	4.16225	.77291	-.18237	2.98410	1.812	28	.081
Physical health	-.81916	7.19485	1.33605	-3.55594	1.91761	-.613	28	.545

Table 11

Mean and Standard Deviation Difference on Wellness Pre-test and Post-Test in Experimental Group

		T	Df	Sig. (2-tailed)	Mean Difference (Pre-Posttest)	95% Confidence Interval of the Difference	
						Lower	Upper
Creative	Pretest	46.153	28	0.000	70.31897	70.8886	77.4734
	Posttest	62.989	28	0.000	74.18103	68.0322	72.6058
Coping	Pretest	48.608	28	0.000	76.93966	73.6973	80.1820
	Posttest	64.445	28	0.000	83.56681	80.9106	86.2230
Social	Pretest	43.835	28	0.000	83.44828	79.5488	87.3478
	Posttest	56.502	28	0.000	87.41379	84.2447	90.5829
Essential	Pretest	65.960	28	0.000	83.51293	80.9194	86.1065
	Posttest	91.702	28	0.000	88.03879	86.0722	90.0054
Physical Health	Pretest	20.561	28	0.000	71.55172	64.4232	78.6802
	Posttest	30.997	28	0.000	79.31034	74.0692	84.5514

Discussion

The five research hypotheses were tested, and the results supported all hypotheses. The first and second hypotheses were: There was a statistically significant difference in FFWEL and quality of life post-intervention scores in the experimental group compared to their pre-intervention FFWEL scores. These results aligned with previous research, which indicated the effectiveness of wellness coaching in improving various areas, including quality of life (Clark et al., 2014). The third hypothesis did not show a statistically significant difference between pre-test and post-test scores in the FFWEL scores and WHOQOL-BREF scores for the control group. These results confirmed the effectiveness of

the intervention, which supported that there was no change in wellness and quality of life perceptions among rehabilitation professionals who did not participate in the wellness coaching program.

There was a statistically significant difference in FFWEL post-intervention scores and WHOQOL-BREF post-intervention scores in the experimental group compared to the control group.

Table 12

Mean and Standard Deviation Difference on Wellness Post-Test Achievement Score Between Groups

	Levene's Test for Equality of Variances			t-test for Equality of Means					
	F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval Difference	
								Lower	Upper
<u>Creative</u>									
Equal variances assumed	2.565	.115	3.144	56	.003	6.12345	1.94737	2.22240	10.02450
Equal variances not assumed			3.144	50.114	.003	6.12345	1.94737	2.21226	10.03464
<u>Coping</u>									
Equal variances assumed	4.032	.049	6.287	56	.000	10.02155	1.59403	6.82832	13.21478
Equal variances not assumed			6.287	50.695	.000	10.02155	1.59403	6.82093	13.22217
<u>Social</u>									
Equal variances assumed	.012	.914	6.775	56	.000	14.22414	2.09965	10.01802	18.43025
Equal variances not assumed			6.775	55.590	.000	14.22414	2.09965	10.01734	18.43094
<u>Essential</u>									
Equal variances assumed	.248	.621	4.711	56	.000	6.78879	1.44092	3.90228	9.67530
Equal variances not assumed			4.711	55.304	.000	6.78879	1.44092	3.90148	9.67611
<u>Physical Health</u>									
Health variances assumed	.261	.612	3.474	56	.001	11.82266	3.40353	5.00457	18.64075
Equal variances not assumed			3.474	55.065	.001	11.82266	3.40353	5.00201	18.64331

The results of hypothesis testing confirmed that wellness coaching intervention resulted in higher perceptions of wellness and quality of life in rehabilitation professionals. The wellness and quality of life outcomes supported significant changes from baseline to week four, indicating that the 4-week wellness coaching was an effective intervention.

This study focused on improving wellness and quality of life in rehabilitation professionals working with patients with chronic illnesses. Some participants focused on developing goals related to health service performance improvement, in which health service knowledge was needed to support their ability to achieve the goal. Other participants developed weight control goals, which only needed a nutrition coach's expertise. In this study, the key success factors in participant recruitment and no drop-

outs were influenced by the needs of participants and the research design that arranged for the control group to be wait-listed to receive the wellness coaching program at a later date.

The wellness models are the best ways to resolve personal and emotional issues (Remley & Herlihy, 2010). Additionally, it is the ethical responsibility of professional counselors to use evidence-based practices (American Counseling Association, 2014). This research finding confirmed that wellness coaching significantly affects healthcare professionals in promoting wellness and quality of life. Wellness is the universal goal for clients and professionals alike. Sharing this goal by strengthening the healthcare system through promoting wellness among the healthcare multidisciplinary team is an important aspect of counselor identity development.

Clinical Implications

This wellness coaching program was designed as an innovative strategy to promote quality of life in a particular target group. This intervention was developed based on a concern to protect healthcare professionals. The previous research acknowledged that healthcare professionals who provide care to chronic illness patients experience high levels of stress, which can negatively impact their quality of life (Quansri & Tadros, 2022, WHO, 2016), particularly healthcare professionals in Thailand (Jiraporncharoen et al., 2016). However, there is a stigma associated with seeking help from other healthcare professionals. This study's findings presented evidence that healthcare professionals do not seek help from mental health professionals. Accordingly, the wellness coaching program was designed to fill this gap to serve healthcare professionals' needs. To some extent, healthcare professionals' desire for such a program was evident in the high enrollment number for this study, which was higher than the researcher's expectation.

Compared to the previous research, results indicated that the four-week wellness coaching intervention positively affected wellness and quality of life in rehabilitation professionals. Similarly, DeJesus et al. (2018) found that a 12-week wellness coaching program delivered in a healthcare setting to make behavior change in pre-diabetes clients was also effective. The intervention duration and intensity allowed for implementation in two settings - in-group and in an individual online context. Further, this study indicated that wellness coaching effectively addresses current health challenges and goal attainment in a limited time.

In understanding the coaching-counseling conundrum, coaching is a specific goal-focused approach (Spence & Grant, 2007). This approach is a series of coaching sessions typically engaging in three main typologies: skill development, performance improvement, or personal /professional development (Grant & Green, 2018). Counselors must consider expertise in particular areas and the limited time to coach in coaching practice.

Limitations

A potential limitation is the interpretation of self-report inventories when using the WHOQOL-BREF to measure the quality of life and FFWEL to measure wellness level. These self-report inventories required the participants to recall their perception ratings. The effect of human memory in terms of responding to a self-report questionnaire has been a concern of research methodology for many years. Reliance on memory is subject to memory error, which can negatively affect the accuracy of the participant's true feelings.

The sample size can influence research outcomes. Faber and Fonseca (2014) stated that researchers who examine the differences between groups must ensure sufficient power to be able to generalize the statistical analysis results to the overall population. This research needed 60 participants total. However, this research had only 29 participants in the experimental group and 29 in the control group, totaling 58 participants. Given that the number of participants is near but less than the recommended 60 for this type of research, generalizations about the overall population must be done cautiously.

In order to research wellness coaching that promotes quality of life among healthcare professionals who work for rehabilitation in Thailand, the researchers must acknowledge the study's limitations. In Thailand, identifying multidisciplinary members who work as full-time healthcare professionals for patients with chronic illnesses is difficult. Healthcare professionals are assigned multiple tasks in the healthcare system; therefore, individuals may not be devoted full-time to patients with chronic illnesses. This issue was addressed using demographic questions in which the participants were asked to identify themselves as full-time rehabilitation providers. This study intended to use wellness coaching as an approach that instructed proper assessment, tailoring interventions, and monitoring progress and outcome with evidenced-based assessment for clients to continue to promote quality of life.

The second limitation was that the participant's experience of being evaluated might change one's behavior, the Hawthorne effect (Schanzenbach, 2012). The participant in the experiment group may exert extra effort to make the difference of post evaluation because they know they were measured. This extra effort will affect post-intervention scores. The last limitation was the possibility of non-equivalent groups, even with random assignment and a control group (Schanzenbach, 2012). The fourth limitation was the social desirability bias. Collecting data through self-report measures may be influenced from participants' bias from social desirability. They may report experiences that were considered to be socially acceptable.

Conclusion

Wellness coaching significantly affects and promotes wellness and quality of life in healthcare professional participants. Given the positive outcomes, this program can be a viable option to promote quality of life in Thai society. Most importantly, quality of life has played a central role in promoting health and preventing chronic diseases, which are key strategies in successfully battling chronic illnesses. The rise in chronic illness significantly impacts both patients and rehabilitation professionals. It is critical that high-quality, low-cost, and effective intervention programs, such as the wellness program described in this study, be implemented and expanded for their collective benefit and well-being.

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