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Exploitative Work Relationships in Portuguese Healthcare

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Master's in Health Services Management

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BUSINESS
SCHOOL

Department of Human Resources and Organizational Behavior

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Abstract

Exploitation significantly impacts individuals' mental health, and in people-oriented jobs, it can lead to a decline in the quality of care provided to others. Even so, exploitation in the healthcare sector, particularly within the context of Portugal, remains understudied. Thus, it becomes essential to delve into this subject so that organizations can gain insight into their problems and act appropriately to enhance their workers' mental health and overall well-being, with consequent maintenance of a high standard of care.

Therefore, the main goal of this research was to study how perceived exploitation affects burnout and depressive symptoms levels in healthcare workers. Additionally, it was also studied whether individual differences could moderate this relationship so that the negative effects of exploitation could be mitigated or exacerbated. In order to see if burnout could be identified externally, the perception of others of the HCWs' burnout was also studied.

The data gathered for this research was through a Qualtrics® survey where we obtained 128 valid answers from HCWs and 25 answers from the HCWs' dear ones. This data was later analyzed through the SPSS program. Our analysis revealed a clear positive relationship between the HCWs' perception of being exploited and their levels of burnout and depressive symptoms. However, we did not find evidence of individual differences moderating these relationships.

For future research, it would be beneficial to seek a higher number of respondents and include qualitative data. Additionally, a longitudinal study of these variables could potentially enhance our understanding and aid in developing possible interventions.

Keywords: Healthcare Workers, Exploitation, Depressive Symptoms, Burnout, Resilience, Rumination

JEL Classification System: I19 – Health: Other; I31 – General Welfare, Well-Being

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Resumo

A exploração afeta significativamente a saúde mental dos indivíduos e, em empregos com elevado contacto com público, pode levar a um declínio na qualidade dos serviços prestados. Ainda assim, a exploração no sector da saúde, particularmente no contexto português, continua a ser pouco estudada. Deste modo, torna-se essencial aprofundar este tema para que as organizações possam ter uma visão dos seus problemas e consigam agir adequadamente de forma a contribuir para uma melhoria da saúde mental e do bem-estar dos seus colaboradores.

O principal objetivo desta investigação foi estudar de que forma a perceção da exploração afeta os níveis de burnout e de sintomas depressivos dos profissionais de saúde. Adicionalmente, foi também estudado se diferenças individuais poderiam moderar esta relação.

Os dados recolhidos para esta investigação foram obtidos através de um inquérito Qualtrics® onde obtivemos 128 respostas de profissionais de saúde e 25 respostas de pessoas próximas a estes. Estes dados foram posteriormente analisados no programa de análise estatística SPSS. A nossa análise revelou uma clara relação positiva entre a perceção dos profissionais de saúde de estarem a ser explorados e os seus níveis de burnout e sintomas depressivos. No entanto, não encontramos evidência de diferenças individuais que moderassem estas relações.

No futuro, a utilização de um maior número de respostas e também a inclusão de dados qualitativos acrescentariam valor ao presente estudo. Adicionalmente, um estudo longitudinal destas variáveis poderia potencialmente melhorar a nossa compreensão e ajudar a desenvolver possíveis intervenções.

Palavras-chave: Profissionais de Saúde, Exploração, Sintomas Depressivos, Burnout, Resiliência, Ruminação

Classificação JEL: I19 – Saúde: Outro; I31 – Bem Estar Geral

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Acronyms

BRS – Brief Resilience Scale

CBI – Copenhagen Burnout Inventory

CERQ – Cognitive Emotion Regulation Questionnaire

CES-D Scale – Center for Epidemiologic Studies Depression Scale

CI – Confidence Interval

COR – Conservation of Resources model

COVID-19 – Coronavirus disease 2019

H1, H2, H3, H4 – Hypothesis 1, Hypothesis 2, Hypothesis 3, Hypothesis 4

HCWs – Healthcare Workers

ILO - International Labour Organization

JD-R – Job Demand-Resources model

NAs – Nursing Assistants

SPSS – Statistical Package for the Social Sciences

WHO – World Health Organization

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1. Introduction

Global estimates from the International Labour Organization (ILO) indicate that, in 2021, 50 million people were victims of modern slavery, going from labor exploitation to forced labor to forced marriages (ILO, 2022). Additionally, these modern slavery situations are often long-lasting, going from years in forced labor to even a lifetime in situations of forced marriage (ILO, 2022). Despite the long-held notion that exploitation is a cause of anguish and suffering, as well as a danger to people's health and over-all well-being (Prins et al., 2021), the problem seems to be growing. It was estimated that the number of individuals in these unfortunate circumstances increased by 9.3 million in comparison to 2016 estimates. The recent world crises, spanning from the coronavirus disease 2019 (COVID-19) pandemic to wars and climate change, have exacerbated the hardships faced by individuals, significantly impacting both their social and economic conditions (ILO, 2022).

A situation may be classified as labor exploitation based on different indicators (ILO, 2021). It can begin on the very basis of job recruitment, where workers are misled about job details, working conditions, wages, and type of contract, among others. The conditions in which employees have to work can also be indicators of labor exploitation. A few examples are excessive working hours, low wages, and high exposure to life and health risks without the proper equipment, safety regulations, or guidelines (ILO, 2021). The combination of one or more indicators of labor exploitation and the intentional abuse of a worker's vulnerability is classified as labor exploitation. Additionally, if individuals are being coerced into working against their will in these conditions, then labor exploitation becomes forced labor (ILO, 2021, 2022). In 2021, it was estimated that 27.6 million individuals lived in forced labor. Of these, the labor exploitation indicators that led to this classification were 51.3% due to excessive overtime, 47.8% due to low or inexistence of wages, and 27.4% due to unsafe working conditions. It is important to note that in some exploitative situations, one or more of these indicators can apply (ILO, 2022).

Forced labor is present all around the world, not only in low-income countries. The highest prevalence of forced labor is found in the Asia and Pacific region, followed by Europe and Central Asia (ILO, 2022). Therefore, and contrary to popular belief, the exploitation of workers is not a problem of the past, even in societies where the workforce is vastly protected by the law, it is a widespread phenomenon that goes beyond borders and takes on a wide variety of forms (Livne-Ofer, Coyle-Shapiro, & Pearce, 2019).

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During the COVID-19 pandemic, some countries failed to provide all healthcare workers (HCWs) with proper protective equipment to deal with the pandemic, which put HCWs at high risk of contracting the disease, therefore compromising their health and lives (ILO, 2022). This is a clear indicator of hazardous work conditions in labor exploitation. Additionally, due to the heroization of HCWs during the pandemic, they were also expected to work longer hours, without the proper pay (Stanley, McClelland, Moss, & Kay, 2022). Previously mentioned indicators of labor exploitation such as heavy workloads, insufficient resources, extended shifts, wage theft, and lack of physical or psychological safety are also examples of occurrences in the healthcare sector (Hallett, 2022; Søvold et al., 2021). These situations may often lead to increased stress and consequently increase HCWs' levels of burnout and mental health issues (Søvold et al., 2021).

Thus, the present research is relevant as it seeks to study how perceived exploitation directly influences the well-being of HCWs, who play a crucial role in society's health. Without a comprehensive understanding of how perceived exploitation affects HCWs, it becomes difficult to implement effective strategies for their support. Perceived exploitation might directly affect HCWs' mental health and well-being, which, in turn, can lead to issues such as burnout and depressive symptoms (Guo, Cheng, & Luo, 2021; Livne-Ofer et al., 2019; Prins et al., 2021). Such factors can, in turn, affect their ability to provide patients high-quality care (Cheng, Lyu, & Ye, 2023). The understanding of this phenomenon is also essential for addressing workforce retention challenges, and ensuring public health, especially during critical times like pandemics (Livne-Ofer et al., 2019). Thus far, there are no existing studies on this specific topic in Portugal. This only highlights the relevance of this study and the potential benefits it may bring, not only for the HCWs themselves but also for patient care and healthcare institutions. However, for that to happen, a collective effort between healthcare institutions and lawmakers needs to happen so as to create policies and practices to eradicate exploitation and prioritize the workers' well-being.

Therefore, this research aims to address the gap in the existing literature concerning exploitation in the workplace, and in this case in the healthcare sector specifically. The research question in place is "How are Health Care Workers affected by the perception that they are being exploited?", with a focus on:

1. The impact of perceived exploitation on burnout and depressive symptoms in HCWs;

2. How individual differences, in this case, resilience and rumination, can potentially moderate the relationship between the above-mentioned relationships.

This dissertation comprises seven chapters. Chapter 1 is the present chapter, where we explore the relevance and context that highlights the importance of this research. Chapter 2 is dedicated to the literature review, where it is explained the foundation for this study. This is done by examining the concepts of perceived exploitation, burnout, depressive symptoms, resilience, and rumination, and how these concepts impact the health sector. Chapter 3 presents the conceptual model and research hypotheses. Chapter 4 outlines the methodology, including data collection procedures, sample analysis, questionnaire scales, and data analysis methods. Chapter 5 presents the results of the correlation analysis and hypothesis testing. Chapter 6 delves into the discussion of these results, exploring their implications and potential limitations. Lastly, Chapter 7 provides the conclusion of the dissertation.

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2. Literature Review

2.1 Perceived Exploitation

Traditional definitions of exploitation involve the intentional act of taking advantage of an individual or a situation for personal gain, as well as the unfair treatment of others to profit from their vulnerability or disadvantage (Friedman, 1994; Livne-Ofer et al., 2019; Wood, 1995). In employee-organization relationships, exploitation can manifest in various ways. One common example is when employees are being paid less than the fair amount. In these cases, it is not that workers have the freedom to sell their labor, but economic and social pressures leave them with no other option than to sell it (Prins et al., 2021; Washburn, Diener, Curtis, & Wright, 2022). Another form of organizational exploitation can be seen in situations where workers have to deal with unsafe and unhealthy working conditions, excessive monitoring, lack of benefits and job security, and unreasonable workloads (Cheng et al., 2023; Muntaner et al., 2015). In these situations, employees often feel that their efforts are not being fairly rewarded, as well as that the job demands significantly outweigh their autonomy and control over their work (Prins et al., 2021). Additionally, employee-organization relationships can be exploitative due to limited legal protections for employees, lack of training opportunities, limited mentoring, and opaque decision-making processes (Brocq, Hughes, & Donnelly, 2022). Essentially, exploitation becomes a possibility whenever power imbalances exist within relationships (Livne-Ofer et al., 2019).

Perceived exploitation refers to the individual's or group's subjective perception or belief that they are being exploited (Livne-Ofer et al., 2019). It may not always be consistent with objective definitions of exploitation, reflecting instead how each person or group interprets their situation. Livne-Ofer et al. (2019) described perceived exploitation in employee-organization relationships as "employees' perceptions that they have been purposefully taken advantage of in their relationship with the organization, to the benefit of the organization itself" (Livne-Ofer et al., 2019, p.5). Thus, one employee's perception of being exploited may not correspond to their coworker's perception (Cheng et al., 2023). Additionally, the perception of exploitation exists among both men and women, spanning across individuals of different cultures and countries, and with varying levels of education and job prestige (Livne-Ofer et al., 2019).

Numerous alterations to existing legislation, including the introduction of minimum wage regulations, have been implemented to combat exploitative practices in the workplace.

However, companies are constantly seeking original ways to gain leverage over employees and exploit them (Livne-Ofer et al., 2019). In 2017, over 10% of U.S. workers were in alternative employment arrangements, such as on-call work, which leads to increased job insecurity. In the U.K., gig work¹ has increased by over threefold from 2016 to 2022 (Brocq et al., 2022). This long-lasting work uncertainty often leads to anxiety issues and frustration. Some companies even modify traditional employment contracts to sidestep labor laws and cut salaries, or favor temporary contracts so as to reduce salaries and benefits (Brocq et al., 2022; Cheng et al., 2023; Livne-Ofer et al., 2019).

Compared to positive occurrences, negative events, such as perceived exploitation, generally trigger stronger emotional responses (Baumeister, Bratslavsky, Finkenauer, & Vohs, 2001; Livne-Ofer et al., 2019). One's perception of being exploited can lead to a multitude of emotions that can be expressed externally or remain internalized (Livne-Ofer et al., 2019). Exploitation often threatens one's self-respect and dignity, which can lead to emotional distress and its subsequent release through outward emotions, such as anger and hostility. Moreover, these emotions may be involved in partially mediating the relationship between perceived exploitation and certain outcomes. For example, they show a positive relationship with turnover intention, and a negative relationship with work engagement (Livne-Ofer et al., 2019). Shame and guilt are common inward emotions that people experience when they are being exploited. These emotions may originate from a belief that they are somehow responsible for their exploitation, either by not meeting certain expectations or by allowing themselves to be victimized. These feelings may also partially mediate the relationship between perceived exploitation and certain outcomes, such as a positive relation with both burnout and psychological withdrawal (Livne-Ofer et al., 2019). The perception of exploitation may also lead to the depletion of the individual's resources (Cheng et al., 2023; Guo et al., 2021). This, in turn, can contribute to an increase in exhaustion, mental health issues, psychological distress, decreased job satisfaction, and, in jobs that are people-focused, a potential decline in extra-role customer service behaviors or even a reduction in the quality of the service provided (Cheng et al., 2023; Guo et al., 2021; Prins et al., 2021).

The healthcare sector is a clear example of one that is vulnerable to exploitation. This vulnerability manifests in various ways, such as HCWs frequently being denied fair wages or essential resources (Livne-Ofer et al., 2019). According to Hallett (2022), wage theft results in

¹Temporary, often part-time jobs, typically through digital platforms or apps.

HCWs losing millions of dollars in income annually. Additionally, HCWs may also struggle with unhygienic or hazardous working conditions, verbal abuse, unpaid overtime, job insecurity, and irregular schedules (Hallett, 2022). The COVID-19 pandemic has further exacerbated the perception of exploitation among HCWs (Stanley et al., 2022). They were tasked with longer hours, endangered their own lives, and risked contaminating their loved ones, all without any financial or other compensation. As a consequence, there has been a sharp rise in burnout, exhaustion, and stress levels (Stanley et al., 2022). Additionally, HCWs have been acclaimed as heroes since the beginning of the pandemic. However, this new title comes with the belief that HCWs should always appreciate their job, no matter the conditions they are working with and that they should willingly work more hours for the same or even for lower compensation. All of this has, in turn, created a substantial turnover of HCWs, creating a public health concern (Stanley et al., 2022). So far, addressing this issue has been complex due to the high-stakes nature of the field, in which strikes are often seen as morally unacceptable (Livne-Ofer et al., 2019). However, in hand with the increased turnover, labor strikes are also on the rise, as HCWs have grown dissatisfied with their working conditions, highlighted by the COVID-19 pandemic (Hallett, 2022).

2.2 Exploitative Work Relationship and Burnout

Freudenberger (1974) and Maslach and Jackson (1981) defined burnout as a condition of persistent physical and emotional exhaustion. It is frequently brought on by extended periods of stress, excessive personal or work obligations, and the perception of not being able to meet those requirements (Maslach & Leiter, 2016). This phenomenon has a unique interpersonal structure, which has made it stand out from others. Maslach and Jackson (1981) and later Maslach, Schaufeli, and Leiter (2001) describe burnout by three key elements: exhaustion, cynicism, and professional inefficacy (Maslach & Jackson, 1981; Maslach, Schaufeli, & Leiter, 2001).

The term “exhaustion” is a sensation of having one's physical and emotional reserves depleted and being overextended. Workers find themselves drained, with little to no energy (Maslach & Jackson, 1981). It frequently happens due to causes such as excessive workload, extended working hours, stressful situations, and a lack of resources. This lack of energy can have a big influence on people's performance at work, but also on their personal lives. Usually, people who suffer from exhaustion derived from work also lack the energy to spend leisure

time with family and friends. Exhaustion represents the core aspect of personal stress in burnout (Maslach & Leiter, 2016) and has been recognized as the core symptom of burnout (Andersen, Borritz, Christensen, & Diderichsen, 2010; Maslach & Jackson, 1981).

The term “cynicism” is used to describe a pejorative and unfriendly attitude or perspective in which individuals become overly disconnected or indifferent about their work. It frequently entails a lack of idealism, which denotes that people may have started with strong hopes, convictions, or expectations for their profession but over time have grown exhausted or dissatisfied (Maslach & Leiter, 2016). It is believed that cynicism can initially act as a defense mechanism as it serves as an emotional barrier that lets people step back from their work and protect themselves from greater emotional engagement. The element of cynicism stands in for the interpersonal dimension of burnout (Maslach & Leiter, 2016).

Lastly, the term "professional inefficiency" describes a psychological condition in which people feel less competent and productive at work (Maslach & Leiter, 2016). It involves a rising sensation of inadequacy over their capacity to do their jobs effectively, even if there is no concrete evidence to back up these emotions of failure (Maslach & Leiter, 2016). These feelings can lead to an actual decrease in overall performance and reduce one's motivation. The element of professional inefficiency stands in for the self-evaluation dimension of burnout (Maslach & Leiter, 2016).

With this previous theory, it becomes unclear whether burnout is a persistent condition, a coping method, or a consequence (Kristensen, Borritz, Villadsen, & Christensen, 2005). Therefore, Kristensen et al. (2005) created the Copenhagen Burnout Inventory (CBI) which stated that the heart of burnout is fatigue and exhaustion. What constitutes the rest of burnout's body is the attribution of that fatigue and exhaustion to particular sectors of their lives. To study this phenomenon, these investigators divided burnout into three categories: Personal, work-related, and client-related (Kristensen et al., 2005). The first focuses on individual experiences of burnout, including physical and psychological exhaustion, whereas the second examines burnout on work experiences, such as work overload, time pressure, and conflicts. The last dimension explores the burnout related to client or customer interactions and demands. By comparing these three dimensions, it is possible to identify people who are fatigued but attribute their exhaustion to sources other than their jobs (Kristensen et al., 2005). Using these categories, it was discovered that the level of burnout employees experience may change over time. In terms of job-related burnout, in three years, 46% of the respondents reported higher levels while

27% reported lower levels (Kristensen et al., 2005). Relationships at work, whether they be ones with clients, coworkers, or superiors, have long been fundamental to descriptions of burnout (Maslach & Leiter, 2016; Maslach & Jackson, 1981). Thus, job burnout primarily impacts individuals with people-oriented occupations (Kristensen et al., 2005), such as education and health care (Freudenberger, 1974; Maslach & Goldberg, 1998).

Different people respond differently to the same situation, with each person bringing their own personal aspects. These aspects include enduring personality traits, work-related attitudes, and demographic factors (Maslach, Schaufeli, & Leiter, 2001). As for personality traits, individuals with low levels of resilience and self-esteem tend to be prone to higher levels of burnout (Maslach et al., 2001). Regarding work-related attitudes, it is thought that having high expectations about one's job increases the likelihood of burnout, as individuals tend to do excessive amounts of labor, which may not turn into the desired results (Maslach et al., 2001). As for the demographic factors, the one factor that has been consistently linked to burnout is age. According to reports, younger workers are at a higher risk of experiencing burnout compared to those who are 30 years old and above (Maslach et al., 2001). This can lead to the conclusion that burnout is more likely to be a significant risk during the early stages of one's career. However, this may not be the reality as survival bias does exist – i.e., individuals who experienced burnout early in their careers left their jobs, leaving behind those who survived with lower levels of burnout (Maslach et al., 2001).

There are two well-established theoretical frameworks to explain burnout's antecedents and consequences. One is the Job Demand-Resources model (JD-R; Bakker, Demerouti, Nachreiner, & Schaufeli, 2001) which describes job demands and job resources as the key predictors of burnout. The former refers to elements of a job that demands constant effort, whether physical or mental, from individuals. These elements can be, for example, workload, time pressure, shift work, lack of autonomy over their work, emotional demands, and interpersonal conflict (Bakker et al., 2001). In this sense, organizational exploitation can be considered a job demand as it requires constant high effort from employees. Examples of these demands are little to no guidance or training and the feeling of little control over their work, all of which can contribute to exhaustion and it turn burnout (Bakker et al., 2001; Brocq et al., 2022; Prins et al., 2021). Finally, the latter concerns elements of work that aid people in achieving their goals, lessen work pressures, enhance well-being, and are predictors of work engagement (Bakker et al., 2001; Bakker, Demerouti, & Sanz-Vergel, 2014). Some of the available job resources can be autonomy, the feeling of community, rewards, feedback, and

involvement in decision-making (Bakker et al., 2001). According to JD-R, burnout occurs when individuals consistently face high job demands and lack adequate resources to manage and reduce these demands. (Bakker et al., 2001; Maslach & Leiter, 2016). Whereas high job demands and high job resources typically lead to higher levels of work engagement – characterized by energy, commitment, and efficacy (Bakker, Demerouti, & Sanz-vergel, 2023). It is believed that individuals with greater personal resources also have easier access to job resources, and vice versa. Some personal resources are, for example, individual resilience, self-efficacy, and optimism (Bakker et al., 2023).

The second development model, the Conservation of Resources model (COR), was formulated by Hobfoll in the 1980s (Hobfoll, 1989). This model implies that people are driven to acquire, preserve, and develop resources to improve their well-being. Whereas they will feel tension if those resources are threatened (Hobfoll, 1989; Park, Jacob, Wagner, & Baiden, 2014). Chronic threats to or depletion of an individual's resources can lead to burnout (Park et al., 2014). Organizational exploitation poses a risk to resources due to its potential to result in resource depletion or loss (Cheng et al., 2023). For instance, when an individual is subjected to exploitation in their workplace, they may encounter resource loss such as reduced income, diminished motivation and work engagement, and a decline in self-esteem (Cheng et al., 2023; Hobfoll, Halbesleben, Neveu, & Westman, 2018). This loss of resources can lead to burnout, as the individual is forced to lose additional resources to cope with the loss (Hobfoll et al., 2018).

Resources can be categorized as internal or external to the individual. For instance, hope and self-efficacy are internal locus as they supply the motivation and inspiration to seek out and keep external resources such as a reliable job and helpful connections (Holmgreen, Tirone, Gerhart, & Hobfoll, 2017). The COR theory has 4 principles (Hobfoll et al., 2018). The first – the primacy of loss – is that, compared to resource gain, resource loss is disproportionately more noticeable. The second – resource investment – is based on the investment of resources that individuals need to make to protect or recover from losses and to gain further resources. The third – gain paradox – states that when in a state of resource loss, resource gains become more significant. The fourth – desperation – indicates that individuals may become defensive, aggressive, and even irrational when their resources are slimming (Hobfoll et al., 2018).

This theory expands onto three corollaries (Hobfoll et al., 2018). The first is that those with more resources are better equipped to acquire resources and are less susceptible to losing those

resources. However, those who lack resources face greater difficulties in accumulating them and are at a higher risk of losing what they have (Hobfoll et al., 2018). The second corollary states that resource loss spirals out of control. This connects to the first principle, which leads to stress and to individuals and organizations having fewer resources available to them at each stage of the stress spiral to make up for resource loss. The third corollary is based on resource gain spiraling nature. Those tend to be weak and develop slowly, as gains tend to be slower and less in size when compared to losses (Hobfoll et al., 2018).

Based on previous studies, Hobfoll et al. (2018) also states that resources do not exist alone; rather, they travel in groups, or caravans – resource caravans. Personal resources, such as self-esteem and optimism, are likely to develop in nurturing or supporting social environments, which is probably connected to the presence of supportive families and encouraging work environments. Resources evolution can also change depending on their environment – resource caravans’ passageways. Whether these passageways help or not to create new resources and maintain and foster pre-existing ones, is up to the organization and how they treat their employees (Hobfoll et al., 2018).

As indicated before, HWCs are among the workers who experience burnout the most. Heavy workloads, inadequate resources, long shifts, a rapid work pace, absence of physical or psychological safety, and limited social support are among the factors contributing to higher stress, resulting in burnout among HCWs (Søvold et al., 2021). All in all, burnout can be linked to both job-related outcomes and health-related outcomes (Bakker et al., 2023). Jobwise, when this phenomenon occurs among HCWs, it can lead to a rise in malpractice risk, medical errors, and a decline in patient care and patient satisfaction (Bakker et al., 2023; Søvold et al., 2021). It is also linked to high turnover rates, low commitment to the organization, sick leave absences, and low job satisfaction (Portoghese, Galletta, Coppola, Finco, & Campagna, 2014). A study among nurses, using the CBI, found that job burnout was positively correlated with turnover intentions and negatively correlated with adequate staffing and resources (Montgomery, Azuero, & Patrician, 2021).

Burnout can be visible to others, such as family, friends, or colleagues, through a range of signs and symptoms. Changes in work performance are often one of the most noticeable indicators. Examples are the above-mentioned decline in productivity, and an increase in medical errors and absenteeism (Bakker et al., 2023; Søvold et al., 2021). Additionally, studies found that HCWs suffering from burnout have a higher risk of developing anxiety, depressive

disorders, sleep deprivation, physical pain, and even alcohol dependence (Bakker et al., 2023). The burnout element of cynicism can also be noticeable to others due to the increase in individuals' negativity and indifference towards activities they once enjoyed (Maslach & Leiter, 2016). Furthermore, HCWs suffering from burnout exhibit a higher rate of suicide than other people in general (Bakker et al., 2023).

The COVID-19 pandemic sped up the growing rate of many existing problems, with a special focus on the healthcare sector (Serrão, Duarte, Castro, & Teixeira, 2021; Shanafelt et al., 2022). This prolonged event created a demanding, challenging, and stressful work life, with little to no time for recovering (Søvold et al., 2021). In a study focused on US physicians, it was shown that the percentage of having at least one signal of burnout in 2021 increased when compared to 2020, 2017, and 2014. The numbers being 62.8%, 43.9%, 54.4%, and 45.5%, respectively (Shanafelt et al., 2022). According to a survey conducted on 466 doctors and 1262 nurses between 2011 and 2013, 21.6% of HCWs in Portugal demonstrated moderate burnout, while 47.8% demonstrated high burnout (Marôco et al., 2016). Another study conducted in Portugal stated that 53.1% of HCWs demonstrated high job burnout during the COVID-19 pandemic, specifically in the year 2021 (Serrão et al., 2021).

In 2019, a study by Livne-Ofer, Coyle Shapiro, and Pearce looked into the potential effects of employees' perception of exploitation. As mentioned in the previous chapter, these researchers discovered that there is indeed a positive relationship between perceived exploitation and burnout, which is mediated in part by inward-focused emotions such as shame and guilt. Essentially, individuals who are prone to experiencing shame and guilt may tend to blame themselves for their perceived performance shortcomings or unmet goals, ultimately contributing to burnout (Livne-Ofer et al., 2019).

Hypothesis 1: Perceived exploitation in HCWs is positively related to burnout (self-rated, H1a and other-rated, H1b).

2.3 Exploitative Work Relationship and Depressive Symptoms

There is no health without mental health. According to the World Health Organization (WHO), health is defined as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity” (WHO, 2004, p. 11). The concept of mental health is still not universally defined (Manwell et al., 2015). WHO has provided one of the most often-used definitions of mental health, which is “a state of well-being in which the individual realizes his

or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community” (WHO, 2004, p. 11). In other words, good mental health empowers individuals to successfully manage life's typical challenges and operate effectively (WHO, 2022). It is believed that mental disorders are experienced by approximately 15% of the world's working population. Given the link between productivity and mental health, there could be a significant impact on economic performance and output (WHO, 2022).

Mental health can vary throughout our lives based on the circumstances of our birth, upbringing, and living conditions. This happens due to the interactions of spheres of influence: individual; family and community; and structural elements (WHO, 2022). At the individual level, social and emotional skills, physical activity, and a sense of self-worth and mastery are considered protective factors. Whereas low education, unhealthy diet, alcohol and drug abuse, and sleep disturbances can be considered risk factors. In this case, genetics can be either a protective factor or a risk, depending on the individual's family history (WHO, 2022).

At the family and community level, good parenting and physical security and safety pose as a protective factor while bullying, sudden loss of a loved one, being an ethnic minority, and emotional and physical abuse and neglect pose as risk factors. Structural-wise, economic security, social justice, and gender equality pose as mental health enhancers. In contrast, poor access to services, poor quality infrastructure, injustice, discrimination, and social exclusion pose as underminers (World Health Organization, 2022).

It was estimated that, in 2019, 970 million people suffered from at least one mental disorder. The most common ones were anxiety disorders and depressive disorders, representing 31% and 28,9% of mental disorders respectively (WHO, 2022). In the year 2017, when comparing the European Region, Portugal had the fourth highest prevalence of depressive disorders - 5,7% of their population (WHO, 2017).

Sadness, a loss of interest or pleasure, guilt and low self-worth beliefs, trouble sleeping or eating, fatigue, and difficulty concentrating are all signs of depressive disorders. It can be persistent or recurrent, but it always negatively impacts one or more areas of a person's life. (WHO, 2017). Additionally, depressive disorders are the primary factor associated with suicide deaths. Despite that, most depressed individuals still do not receive proper treatment, and efforts to prevent depression fall short of adequate, which the upward trend in the prevalence of depression worldwide attests to (Moreno-Agostino et al., 2021). Depressive disorders,

including both major depressive disorder and dysthymia², are the most common mental illness among adults, with a slightly higher incidence in women. Due to the COVID-19 pandemic, it is estimated a 28% increase in major depressive disorders (World Health Organization, 2022).

While not the only one, workplace stress is one of the main risk factors responsible for poor mental health and well-being. Similar to what happens with burnout, chronic exposure to work-related stress raises the likelihood of depression and may be a factor in several other disabling conditions and illnesses, such as sleep and anxiety disorders. Depressive disorders can also lead to negative work-related outcomes for both the employee and the organization. The most common consequences workwise are loss of productivity and fewer outputs, absenteeism, job dissatisfaction, and an increase in turnover (Ivandic, Freeman, Birner, Nowak, & Sabariego, 2017). It can also contribute to the exacerbation of cardiovascular diseases and gastrointestinal disorders (World Health Organization, 2004).

Both the JD-R and the COR theories that were discussed in the previous chapter can be applied to understand depressive symptoms in the workplace context. The JD-R model suggests that high job demands tied to low job resources can lead to an increased risk of depressive symptoms. Conversely, high job resources can act as protective factors against depressive symptoms (Bakker et al., 2023; Demerouti & Bakker, 2022; Hatch, Potter, Martus, Rose, & Feude, 2019). The COR theory emphasizes that resource loss and depletion lead to stress, which in turn can lead to an increase in depressive symptoms (Holahan, Moos, Holahan, & Cronkite, 1999; Holmgreen et al., 2017).

HCWs are subjected to a variety of stressors, which can lead to a significant impact on their physical, mental, and emotional well-being. As mentioned in the previous chapter, examples of stressors can be high workloads, long hours, a lack of physical or psychological safety, and a lack of social support. With this in mind, the mental health requirements of these particular occupations have been garnering attention as a substantial public health concern and a potential threat to the delivery of high-quality care (Søvold et al., 2021). The majority of HCWs are taught to prioritize their patients. They feel the need or obligation to do so, not only because of their career choice but sometimes due to fear of others' judgment. However, engaging in self-care is essential for HCWs to balance their responsibilities, workload, and requirements of their line of work. It may also assist them in improving their personal and professional lives and preserving their general well-being (Søvold et al., 2021).

² Persistent low-level depression and a lack of interest or pleasure in daily activities.

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A study carried out in 2015 among HCWs concluded that positive employee mental health outcomes, such as lower levels of burnout, and depression, were substantially correlated with perceptions of a positive work environment (Bronkhorst, Tummers, Steijn, & Vijverberg, 2015). Numerous studies have revealed a significant prevalence of mental disorders among HCWs (Bronkhorst et al., 2015). In a survey of 1,171 hospital nurses in the United States, Letvak et al. (2012) discovered that 18% of them reported having depression symptoms. This value is twice the rate for the general population. Depressed employees often exhibit persistent low moods, struggle with concentration, and are more susceptible to accidents. When compared to non-depressed workers, they are also considerably less capable of performing mental or interpersonal tasks, have poorer time management skills, and produce less work overall. Moreover, along with negative individual symptoms, nurses who are depressed may also distress their coworkers and lower the quality of care they deliver (Letvak, Ruhm, & McCoy, 2012).

Studies have found that there is a link between mental illness and unconcealed exploitation. Therefore, it is likely that exploitation as a whole is detrimental to individuals' mental health (Prins et al., 2021). Confirming this, it has been revealed that older adults who believe to have been subjected to financial exploitation reported increased rates of medical illnesses, along with anxiety and depressive symptoms, when compared to older adults who had not experienced exploitation (Acierno et al., 2019; Weissberger et al., 2020). One explanation for this is that financial exploitation frequently leads to life-altering outcomes, such as the depletion of personal resources (Acierno et al., 2019) and one's life savings, strained relationships, and a loss of personal independence, thus contributing to symptoms of depression (Weissberger et al., 2020). On the other hand, an alternative explanation could be that older adults experiencing depressive symptoms are more susceptible to financial exploitation or the belief that such exploitation has taken place. This can be attributed to the fact that symptoms of depression have the potential to impair one's decision-making abilities. (Weissberger et al., 2020).

Another study that supports the previous affirmations is regarding Nursing Assistants (NAs). The study sample was constituted by 868 NAs from 50 nursing states. Symptoms of depression among these HWCs in nursing homes were connected to organizational indicators of class exploitation, such as high managerial domination³ and being a for-profit organization. This remained true even after individual-level variables, such as age, gender, and length of

³ Ability of hierarchical superiors to exert strict control on activities.

employment, were accounted for (Muntaner et al., 2015). For-profit healthcare organizations, when compared to nonprofit ones, are characterized by lower staffing and cost-saving strategies that undermine care quality and/or overwork their staff. High managerial domination commonly happens in for-profit organizations, wherein they seek to use as much surplus labor as they can to increase their financial gains. This style of management leads to employees being under rigorous supervision, regular check-ins and reports, and close monitoring with a focus on a negative evaluation (Muntaner et al., 2015). Frequently, NAs also have the chore of supporting the different emotional needs of their patients, commonly characterized by their frail health. All of this contributes to the creation of stressful work settings that have a substantial negative impact on the mental health of NAs (Muntaner et al., 2015). These findings are consistent with previous research that states that occupations characterized by disparities in demand versus autonomy, as well as effort versus reward, are linked to elevated rates of depression, anxiety, and substance use disorders (Prins et al., 2021).

Hypothesis 2 (H2): Perceived exploitation in HCWs is positively related to depressive symptoms.

2.4 The Moderating Role of Resilience

The phenomenon of resilience has been drawing attention since the 1970s when it was studied why some children, although living in challenging circumstances, managed to thrive while others in the same circumstances failed (Masten, 2001). In 2001, Masten referred to resilience as “a class of phenomena characterized by good outcomes in spite of serious threats to adaptation or development” (Masten, 2001, p. 2). Although there is no universally agreed-upon definition, resilience is essentially described as positive adaptability, or the ability to sustain or regain mental health (i.e. the ability to ‘bounce back’) when confronted with adversity (Herrman et al., 2011; Robertson et al., 2016; Zanatta, Maffoni, & Giardini, 2020). One example is that this phenomenon plays a vital role in reducing the intensity of depressive symptoms in individuals who have faced childhood abuse or other traumatic experiences. It acts as a vital moderator influencing their mental health outcomes by affecting their capacity to navigate adversity and adapt to challenging circumstances (Wingo et al., 2010).

It was initially thought to be an innate quality, essentially a stable attribute tied to one's personality. However, in recent years, resilience has been redefined as a result impacted by various factors that protect individuals against the negative effects of stress and adversity (Zanatta et al., 2020). As such, resilience is not a fixed construct; it can change over time. Being

an interactive dynamic process, various factors and sources contribute to building resilience (Herrman et al., 2011; Wu et al., 2013; Zanatta et al., 2020). Some of these can be specific to particular stages of life, while others function throughout the entire life. Studies have shown that one of the sources for building resilience is personal factors, for example, realistic optimism, internal locus of control (like the previously mentioned, hope and self-efficacy), cognitive reappraisal, openness, and even humor (Herrman et al., 2011; Wu et al., 2013). Genetic predispositions, neurological processes, and physiological functions are examples of how biological factors can also affect an individual's resilience. In addition, environmental-systemic factors such as access to support networks, socioeconomic opportunities, and a stable environment can also help build or deteriorate resilience since they shape the external conditions and resources available to individuals. With this, it can be concluded that the factors that impact the growth of resilience can be likened to those that foster mental health (Herrman et al., 2011; Wu et al., 2013).

There are several psychosocial characteristics of resilience. Examples are active coping and high coping self-efficacy, positive risk-taking, self-confidence, altruism, and trust. (Herrman et al., 2011; Wu et al., 2013). If one looks at resilience from the individual's side, this trait may improve their ability to survive and prosper, whereas, from the organization's side, employee resilience may help to sustain productivity or hold on to important employees (Bardoel & Drago, 2021). Given the inherently stressful and demanding nature of the healthcare field, recent recognition has been given to the potential role of resilience as a valuable personal resource for healthcare professionals (Zanatta et al., 2020). Resilience is strongly associated with traits like perseverance, self-directedness, and the ability to confront obstacles head-on. This discovery suggests that resilience can play a protective role, enhancing the adaptability and effectiveness of healthcare personnel (Robertson et al., 2016). Furthermore, research indicates that resilience may help reduce burnout by serving as a protective factor against emotional exhaustion and by improving personal accomplishment. High levels of resilience are also linked to reduced perceived stress and increased hope (Zanatta et al., 2020).

In 2015, a cross-sectional survey of HCWs in the United Kingdom suggested that while there is no indication of a relationship between resilience score and length of service, it does have a clear positive relationship with age. The study also showed a slighter higher resilience score for females (Sull, Harland, & Moore, 2015). The impact of the COVID-19 pandemic and its connection to resilience has also been studied. In a group of nursing students from the

Philippines, it was found that there is a significant moderate inverse relationship between resilience levels and the impact of the pandemic on various key aspects of mental health-related quality of life. This suggests that resilience plays a protective or buffering role in minimizing the adverse impacts of the COVID-19 pandemic (Guillasper, Oducado, & Soriano, 2021). A study of 2008 Portuguese HCWs suggested that HCWs present either a moderate (50.8%) or high level (27.8%) of psychological resilience. It was also concluded that this phenomenon was negatively associated with depression and all burnout dimensions (Serrão et al., 2021).

Based on the aforementioned arguments, we propose that when individuals have high levels of resilience, they are more likely to successfully cope with and mitigate the negative impact of perceived exploitation. Conversely, when they are low in resilience, they may be more susceptible to the adverse effects of perceived exploitation, potentially experiencing heightened levels of burnout and depressive symptoms.

Hypothesis 3: Resilience moderates the positive effect of perceived exploitation on burnout (H3a) and depressive symptoms (H3b) in HCWs, such that workers with high resilience levels will display less burnout and depressive symptoms.

2.5 The Moderating Role of Rumination

Rumination is a cognitive phenomenon characterized by the repetitive and intrusive nature of persistent thoughts. It involves prolonged and often involuntary contemplation of specific issues, emotions, or events, with a tendency to fixate on negative emotions, perceived failures, or unresolved matters (Nolen-Hoeksema, 2000; Nolen-Hoeksema & Jackson, 2001; Watkins & Roberts, 2020), and commonly taking little to no action on resolving the situation (Nolen-Hoeksema, Wisco, & Lyubomirsky, 2008). Individuals who engage in rumination tend to replay and analyze their thoughts in a circular and unproductive manner, often exacerbating and prolonging depressing symptoms, feelings of distress, sadness, anger, or anxiety (Nolen-Hoeksema, 2000; Nolen-Hoeksema et al., 2008; Watkins & Roberts, 2020). Therefore, it can be seen as a cognitive emotion regulation strategy that may lead to a higher vulnerability to emotional problems (Garnefski & Kraaij, 2006). While questioning oneself might be a valuable insight on numerous occasions, those prone to frequent rumination may encounter difficulty in attaining satisfactory answers which then leads to a negative loop of questioning and doubting (Nolen-Hoeksema, 2000).

When individuals ruminate while experiencing a dysphoric⁴ mood, they often recall more unpleasant memories, perceive their current situation in a more negative light, and develop a pessimistic outlook for the future (Nolen-Hoeksema, 2000; Nolen-Hoeksema et al., 2008). Conversely, a brief distraction from rumination can lead to more positive memories, improved perceptions of current events, and more optimistic future expectations (Nolen-Hoeksema, 2000; Watkins & Roberts, 2020). Moreover, people in a dysphoric state who engage in rumination while problem-solving tend to create lower-quality solutions compared to non-ruminative problem-solving (Nolen-Hoeksema et al., 2008). This cognitive phenomenon also dampens one's motivation and initiative, as their negativity may lead them to believe in their lack of efficacy (Nolen-Hoeksema et al., 2008). Interestingly, dysphoric individuals who ruminate tend to have similar life goals, happy events, and aspirations as other individuals. However, their expectations for meeting those goals are set at a lower level (Lyubomirsky & Nolen-Hoeksema, 1995).

Additionally, those who ruminate often report insufficient support from friends and family. This may happen as they may dwell on their distress longer than their loved ones expect, which ultimately leads to a disinterest in the situation (Nolen-Hoeksema, 2000). This can lead to further feelings of isolation and depression (Nolen-Hoeksema et al., 2008). This cognitive process is also linked with insomnia, increased uncertainty, higher work-related fatigue, decreased confidence in one's plans, and a diminished ability to concentrate on the surrounding world (Vandevala et al., 2017; Watkins & Roberts, 2020). In summary, rumination can deplete one's mental resources, exacerbate and prolong negative thought patterns associated with depression, hinder effective problem-solving, disrupt daily functioning, and strain interpersonal relationships. These effects may potentially worsen depressive symptoms over time (Garnefski & Kraaij, 2006; Nolen-Hoeksema, 2000; Watkins & Roberts, 2020).

In comparison to men, women frequently report a greater inclination towards rumination (Garnefski & Kraaij, 2006; Nolen-Hoeksema & Jackson, 2001). These gender discrepancies can be credited to numerous aspects, such as differences in socialization, coping methods, and exposure to stressors (Nolen-Hoeksema & Jackson, 2001). Furthermore, contextual elements like persistent stress and a higher incidence of abuse histories among women, relative to men, may also play a role in shaping the observed gender disparities in rumination. This heightened

⁴ State of feeling uneasy, discontented, or emotionally distressed.

propensity appears to contribute to the also higher prevalence of depressive symptoms among women (Nolen-Hoeksema & Jackson, 2001).

As mentioned above, a useful tool to deviate from the negativity that comes along with rumination is seeking distractions (Nolen-Hoeksema et al., 2008). Bakker and Wingerden (2021) found that implementing a playful approach to work tasks can mitigate the adverse impacts of COVID-19-related rumination on employees' overall well-being. When individuals scored lower on the playful approach scale, their COVID-19-related rumination was associated with increased feelings of depression, fatigue, and decreased energy (Bakker & van Wingerden, 2021). However, those employees who repeatedly thought about the pandemic but used their creative imagination, and humor to reshape their job tasks reported lower levels of depressive symptoms and fatigue, coupled with an increase in vitality (Bakker & van Wingerden, 2021). Even so, due to their lack of motivation, dysphoric individuals who tend to ruminate are frequently unwilling to be open to distractions (Nolen-Hoeksema et al., 2008). A 2015 study among teachers revealed that those experiencing frequent burnout symptoms exhibited considerably more ruminative behavior than their colleagues with fewer burnout symptoms (Bianchi & Schonfeld, 2016). Additionally, a study among COVID-19 front-line HCWs reiterated that rumination is positively related to emotional exhaustion, which could ultimately lead to burnout, depression, and other mental health problems (Yan et al., 2022).

Based on the aforementioned arguments, we propose that when individuals have high levels of rumination, they are more likely to amplify the negative impact of perceived exploitation, potentially leading to burnout and depressive symptoms. On the other hand, when they are low in rumination levels, they may be better equipped to mitigate the adverse effects of perceived exploitation, resulting in lower levels of burnout and depressive symptoms.

Hypothesis 4 (H4): Rumination moderates the positive effect of perceived exploitation on burnout (H4a) and depressive symptoms (H4b) in HCWs, such that workers who tend to ruminate will display greater levels of burnout and depressive symptoms.

3. Conceptual Model and Research Hypotheses

The present study aims to explore the relationship between perceived exploitation and the presence of burnout (self-rated or rated by others) and depressive symptoms. Furthermore, it examines if individual differences can buffer the negative impact of perceived exploitation. Specifically, the moderators explored were individual resilience and rumination. With this, it is possible to draw the conceptual research model presented in Figure 3.1.

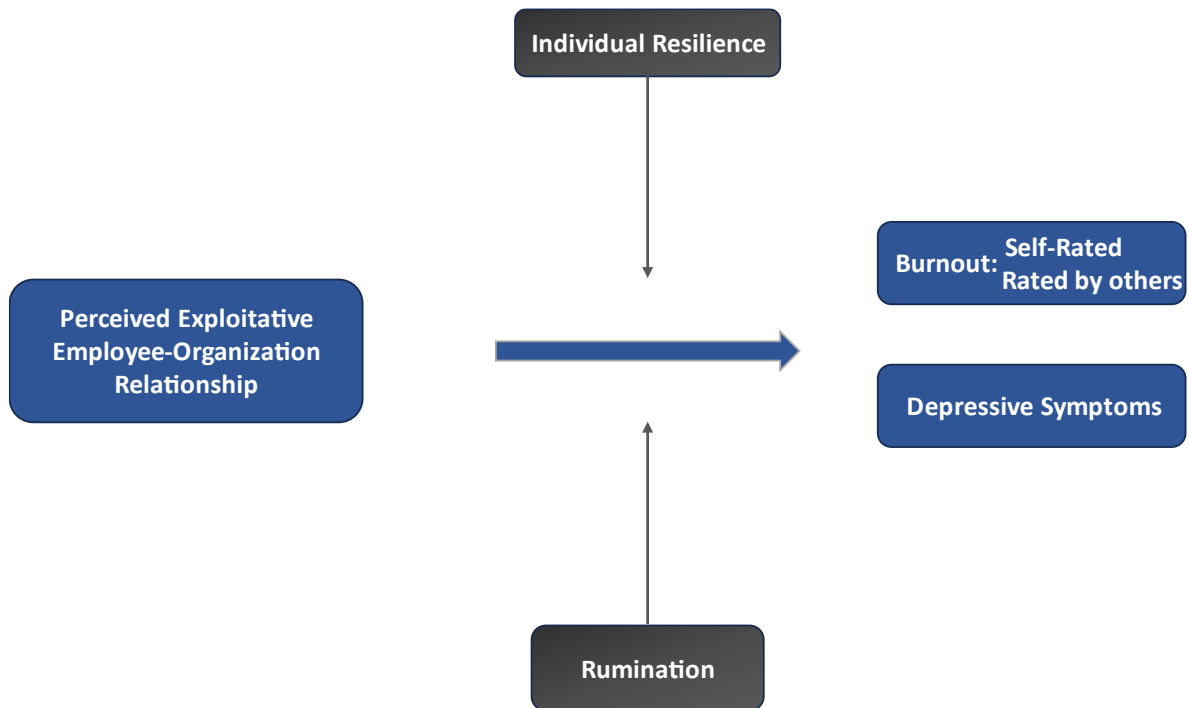


Figure 3.1. Conceptual Research Model

As such, the hypotheses defined in the previous chapter were:

Hypothesis 1: Perceived exploitation in HCWs is positively related to burnout (self-rated, H1a and other-rated, H1b).

Hypothesis 2 (H2): Perceived exploitation in HCWs is positively related to depressive symptoms.

Hypothesis 3: Resilience moderates the positive effect of perceived exploitation on burnout (H3a) and depressive symptoms (H3b) in HCWs, such that workers with high resilience levels will display less burnout and depressive symptoms.

Hypothesis 4 (H4): Rumination moderates the positive effect of perceived exploitation on burnout (H4a) and depressive symptoms (H4b) in HCWs, such that workers who tend to ruminate will display greater levels of burnout and depressive symptoms.

4. Methodology

4.1 Data Collection Procedure

The survey was hosted through Qualtrics® and made accessible to potential participants through a link shared across social media platforms, such as LinkedIn®, Facebook®, and Instagram® using the snowball sampling method.

The first page of the online survey explained the purpose of the study and eligibility requirements – being a health care worker. Anonymity, confidentiality, and voluntariness were also guaranteed. The sociodemographic questions and additional measures would then be made available to the participants who gave their informed consent. The survey was divided into matrix tables, each with approximately 10 items. Two of those tables featured an attention check, where respondents would be asked to select a certain answer. Those who selected answers other than the requested ones were excluded from the data analysis.

A second survey was made available after the completion of the first. However, it was not directed to HCWs *per se*. At the end of the first survey, it was requested for the respondents to share the link present with their dear ones, whether be family, significant others, friends, or colleagues. This second survey aimed to assess the dear ones' perceptions of the burnout experienced by the individual who sent them the survey link.

Quantitative data for both surveys were gathered from April 2023 through July 2023.

4.2 Sample

On the main survey, directed to HCWs, a total of 185 responses were collected. However, during the data cleaning and validation process, it was discovered that 57 of these responses were either incomplete, did not pass the attention check questions, or did not fit the survey's criteria – being a healthcare worker. Consequently, these responses were removed from the dataset. After this thorough screening, the data analysis was based on 128 valid responses.

The second survey, directed to dear ones of the HCWs who responded to the first survey, gathered 29 responses. Yet, only 25 were valid as four of them were either incomplete answers or were eliminated as it was not possible to pinpoint the code provided to only one of the responses of the previous survey.

The 128 HCWs who make up this study's sample are represented by the sociodemographic characteristics shown in Table 4.1. Most of the respondents are women (85.2%) and hold

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permanent contracts (61.7%). The distinction between permanent and temporary contracts plays a crucial role in understanding the job security and stability experienced by employees. Respondents' occupations encompass 23 different jobs. The most common one is Physiotherapists, followed by Nurses, Doctors, and Dentists, representing 28.1%, 24.2%, 10.9%, and 6.3%, respectively. The complete list of respondents' occupations can be found in Appendix A.

Table 4.1.

Sociodemographic Characteristics of the Participants

| Sample Characteristics | | n | % |
|------------------------|----------------|-----|------|
| Gender | Female | 109 | 85.2 |
| | Male | 18 | 14.1 |
| | Rather not say | 1 | 0.8 |
| Type of Contract | Permanent | 79 | 61.7 |
| | Temporary | 49 | 38.3 |

Note. N=128.

The mean age of the respondents is 30.77 years. However, the age distribution exhibits a reasonable spread, as evidenced by the standard deviation of 8.77 years, shown in Table 4.2. The youngest respondent was 22 years old, while the oldest was 67. The complete list of respondents' ages can be found in Appendix B. Additionally, the average number of hours worked is 40.63 hours per week, with a standard deviation of 9.74.

Table 4.2.

Age and Hours Worked Weekly

| | N | Minimum | Maximum | \bar{x} | d.p. |
|---------------------|-----|---------|---------|-----------|------|
| Age | 128 | 22 | 67 | 30.77 | 8.77 |
| Hours worked weekly | 127 | 7 | 70 | 40.63 | 9.74 |

Regarding the 25 participants of the second survey (the dear ones of the first respondents) most of them are also women (64.0%). The mean age of these respondents is 30.12 years old, with the youngest being 23 years old and the oldest being 55.

Significant others were the most common relationship seen with 52.0% of the answers, while friends, relatives, and colleagues represented 28.0%, 12.0%, and 8.0% respectively. The mean time for knowing the HCW who sent them this second survey was 8.60 years. The complete tables with this information can be consulted in Appendix C.

4.3 Measures

All scales mentioned below employed either a seven-point Likert scale that went from 1-"Strongly disagree" to 7-"Strongly Agree", or a five-point Likert scale that went from 1-"Never" to 5-"Always".

4.3.1 Control Variables

In line with Becker's (2016) recommendation regarding the incorporation of significant control variables, we controlled for the type of contract and the number of hours worked per week (Becker et al., 2016). Age and gender were not included as control variables because they were found to be unrelated to our variables of interest, as demonstrated in Table 5.1.

4.3.2 Perceived Exploitation

Perceived exploitation was measured using the scale created by Livne-Ofer et al. (2019). In this study, it was used a Likert Scale from 1 to 7 on all the fourteen items of this scale. Examples of these are "As long as I work in my organization, it will keep taking advantage of me", "My organization uses labor contract loopholes to avoid adequate compensation" and "My organization doesn't provide me with job security as it wants to be able to fire me at its convenience". The scale presented a Cronbach's alpha of 0.92.

4.3.3 Burnout

A widely known tool for measuring experienced burnout is the CBI. It was created by Kristensen, Borritz, Villadsen, and Christensen in 2005, and it offers a comprehensive assessment of burnout across different areas of life. It assesses all three dimensions: Personal Burnout (six items), Work-related Burnout (seven items), and Client-Related Burnout (six items; Kristensen et al., 2005). For the survey directed to HCWs, it was used all seven items of

the work-related burnout scale, and the participants rated each of them on a Likert Scale from 1 to 5. Examples of these items are questions such as “Is your work emotionally exhausting?”, “Are you exhausted in the morning at the thought of another day at work?” and “Do you have enough energy for family and friends during leisure time?”, with this last item being reverse-coded. The scale presented a Cronbach’s alpha of 0.83.

Based on Fisher, Matthews & Gibbons (2016), the survey directed to the dear ones of the first respondents utilized a single-item approach. This particular item was designed to gauge the level of burnout among HCWs from the perspective of their loved ones. They were asked to rate the item “Your dear one feels burned out” on a Likert Scale from 1 to 5 (Fisher, Matthews, & Gibbons, 2016).

4.3.4 Depressive Symptoms

The Center for Epidemiologic Studies Depression Scale (CES-D Scale) is a popular self-report tool created to gauge the existence and intensity of depressive symptoms among individuals. Developed by Lenore Radloff in 1977, it is amongst the most commonly employed tools for researching and assessing depression in various settings, including academic research (Radloff, 1977). Nonetheless, the CES-D Scale is a screening tool for depressive symptoms and is not a diagnostic instrument for depressive disorders. The scale consists of 20 items, each reflecting a symptom of depression experienced over the past week (Radloff, 1977). In this study, it was used eight items of this scale, where two of them were reverse-coded, and the participants rated each of them on a Likert Scale from 1 to 7. Examples of these items are “You felt depressed”, “You felt everything you did was an effort” and “Your sleep was restless”. The scale presented a Cronbach’s alpha of 0.86.

4.3.5 Resilience

A popular psychological tool for assessing resilience in individuals is the Brief Resilience Scale (BRS). Created in 2008 by Smith, the BRS consists of six simple statements, where three of them are positively worded, and the other three are negatively worded. The scale assesses coping behaviors that are indicative of resilience, with higher scores on the BRS indicating a greater level of resilience (Smith et al., 2008). In this study, it was used all six items of this scale and the participants rated each of them on a Likert Scale from 1 to 7. Examples of these

items are “I tend to bounce back quickly after hard times” and “I have a hard time making it through stressful events”. The scale presented a Cronbach’s alpha of 0.76.

4.3.6 Rumination

The Cognitive Emotion Regulation Questionnaire (CERQ) is a well-known psychological assessment tool designed to measure various cognitive strategies that individuals use to regulate their emotions in response to negative events. It was developed by Garnefski et al. (2001) and consists of nine subscales, each with four items. (Garnefski, Kraaij, & Spinhoven, 2001). These subscales are positive reappraisal, acceptance, rumination, self-blame, catastrophizing, and others. Among these subscales, the "rumination" subscale measures the tendency to engage in repetitive thinking about negative events (Garnefski et al., 2001). In this study, it was used a Likert Scale from 1 to 5 on the four items of the rumination subscale. Examples of these are “I dwell upon the feelings the situation has evoked in me”, and “I want to understand why I feel the way I do about what I have experienced”. The scale presented a Cronbach’s alpha of 0.86.

4.4 Data analysis

The quantitative data analysis was performed using the computer program Statistical Package for the Social Sciences (SPSS, Version 28.0). The internal consistency of the quantitative measures was assessed using Cronbach’s alphas. The internal consistency was interpreted as being adequate (≥ 0.70) or optimal (≥ 0.80 ; Nunnally & Bernstein, 1994).

First, the sociodemographic characterization of the sample was done through descriptive statistics. This was followed by the use of the Pearson correlation coefficient to estimate the relationships between all of the variables. Linear regressions were then applied to model the connection between the dependent variables (specifically, burnout and depressive symptoms) and the independent variable (perceived exploitation). To assess the indirect impact of the moderators and covariates on each of the outcome variables, a moderation analysis was conducted through the PROCESS Macro for SPSS.

5. Findings

5.1 Correlation Analysis and Descriptive Statistics

To evaluate the presence and strength of relationships between variables, it was conducted a correlation analysis using the Pearson Correlation Coefficient. This analysis allowed us to examine whether changes in one variable were linked with changes in another, due to being a measure of the linear relationship between the two variables. If the Pearson correlation is between 0 and ± 0.3 it presents a weak linear relationship if it is between ± 0.3 and ± 0.7 it is considered a moderate linear relationship and when it is between ± 0.7 and ± 1.0 it is considered a strong linear relationship (Ratner, 2009). Then, depending on whether the value is above or below 0, the linear relationship can be positive or negative, respectively. However, for the relationship to be considered significant its p must be smaller than 0.05.

Concerning sociodemographic variables, gender, and age did not present a significant correlation with any of our variables. However, the number of hours worked weekly presented a positive correlation (though a weak association) with depressive symptoms ($r = 0.19, p \leq 0.05$). While with an also weak association, the type of contract (coded 1 for Permanent and 2 for Temporary), presented a positive correlation with perceived exploitation ($r = 0.22, p \leq 0.05$), burnout ($r = 0.18, p \leq 0.05$), and rumination ($r = 0.24, p \leq 0.01$).

Based on Table 5.1., perceived exploitation exhibits a moderately positive correlation with both burnout ($r = 0.62, p \leq 0.01$) and depressive symptoms ($r = 0.54, p \leq 0.01$). Burnout demonstrates a moderately positive correlation with depressive symptoms ($r = 0.59, p \leq 0.01$). In contrast, resilience displays a moderate negative correlation with perceived exploitation ($r = -0.42, p \leq 0.01$), burnout ($r = -0.43, p \leq 0.01$), and depressive symptoms ($r = -0.54, p \leq 0.01$), along with a weak negative correlation with rumination ($r = -0.22, p \leq 0.05$). Rumination has a weakly positive correlation with perceived exploitation ($r = 0.28, p \leq 0.01$) and depressive symptoms ($r = 0.20, p \leq 0.05$), and a moderately positive correlation with burnout ($r = 0.37, p \leq 0.01$).

The perception of burnout by dear ones exhibited a moderate negative correlation with resilience ($r = -0.40, p \leq 0.05$) and a moderate positive correlation with HCWs' perception of exploitation ($r = 0.43, p \leq 0.05$), as well as their own experience of burnout ($r = 0.61, p \leq 0.01$). Additionally, it also presented a strong positive relationship with depressive symptoms ($r = 0.75, p \leq 0.01$). However, it did not exhibit a statistically significant correlation with rumination.

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Table 5.1.

Descriptive Statistics and Correlations

| Variable | M | SD | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|----------------------------|-------|------|---------|---------|---------|--------|--------|-------|-------|---------|------|----|
| 1. Perceived exploitation | 3.42 | 1.19 | | | | | | | | | | |
| 2. Burnout | 3.13 | 0.70 | 0.62** | | | | | | | | | |
| 3. Depressive Symptoms | 3.47 | 1.15 | 0.54** | 0.59** | | | | | | | | |
| 4. Resilience | 4.07 | 1.00 | -0.42** | -0.43** | -0.54** | | | | | | | |
| 5. Rumination | 3.27 | 0.77 | 0.28** | 0.37** | 0.20* | -0.22* | | | | | | |
| 6. Burnout rated by others | 3.24 | 1.01 | 0.43* | 0.61** | 0.75** | -0.40* | 0.08 | | | | | |
| 7. Hours worked weekly | 40.63 | 9.74 | 0.07 | 0.13 | 0.19* | -0.05 | 0.06 | 0.17 | | | | |
| 8. Type of contract | 1.38 | 0.49 | 0.22* | 0.18* | 0.08 | -0.16 | 0.24** | -0.52 | -0.04 | | | |
| 9. Age | 30.77 | 8.77 | -0.03 | -0.10 | -0.08 | 0.03 | 0.02 | -0.13 | -0.07 | -0.39** | | |
| 10. Gender | 1.16 | 0.43 | 0.03 | -0.01 | 0.05 | 0.08 | 0.00 | 0.05 | 0.09 | 0.00 | 0.02 | |

Note. ** $p \leq 0.01$; * $p \leq 0.05$; N= 127 – 128 except in 6 where N=25

5.2 Hypotheses Testing

To confirm Hypothesis 1a, 1b, and 2, linear regression analyses were conducted. These analyses aimed to examine the relationship between perceived exploitation and depressive symptoms as well as burnout (both self-reported and other-rated) while accounting for relevant control variables. Specifically, the control variables considered were the type of contract and the number of hours worked weekly. Thus, for each hypothesis, two models were created, with either burnout (self-reported or rated by others) or depressive symptoms as the dependent variable. In Model 1, the control variables were added as the independent variables. This model examined the influence of the type of contract and weekly hours worked on our dependent variable without accounting for perceived exploitation. In model 2, perceived exploitation was added as a third independent variable, allowing the assessment of its contribution to our dependent variable while controlling for potential influencing variables.

According to Cohen (1988), R^2 values indicate the percentage of the dependent variable variance that can be explained by the independent variable. These values can be classified as having a small effect ($R^2 \geq 0.02$), medium ($R^2 \geq 0.13$), or high ($R^2 \geq 0.26$) effect size (Cohen, 1988).

For H1a, which proposes perceived exploitation to be positively related to self-reported burnout, the latter was used as the dependent variable. Results show that perceived exploitation in HCWs is indeed positively related to burnout ($\beta=0.61$, $p<0.00$), which supports our H1a. Additionally, Model 1, has an R^2 of 0.05 (medium effect size), thus this model explains little of the burnout variance. However, when perceived exploitation is included in Model 2, the R^2 significantly improves to 0.40 (high effect size). This difference shows that perceived exploitation has explanatory power over burnout above and beyond the other variables in the study. Specifically, the higher R^2 value in Model 2 suggests that perceived exploitation, in addition to the control variables, accounts for 40% of the variance. Moreover, Model 2 has a much higher F-change value (71.11) in comparison to Model 1 (3.30), further indicating a significant enhancement achieved by introducing additional predictors.

The same procedure was used to evaluate our Hypothesis 1b, which states that perceived exploitation is positively related to burnout seen by others. In this case, “burnout rated by others” was used as the dependent variable. Results show a positive association between perceived exploitation among HCWs, and burnout rated by others ($\beta=0.45$, $p<0.05$), which supports our H1b. Besides, when perceived exploitation is added to the analysis (in model 2)

the R^2 goes from 0.04 to 0.24 (medium effect size), which is an improvement in the model's ability to explain the variance in burnout rated by others. This implies that perceived exploitation, in conjunction with the control variables, contributes 24% to how others perceive burnout among HCWs. Furthermore, Model 2 exhibits a higher F-change statistic (5.51) compared to Model 1 (0.50), emphasizing once again the improvement achieved by incorporating perceived exploitation.

Then, to confirm H2, which suggests perceived exploitation is positively related to depressive symptoms, a similar approach to that described for H1a and H1b was followed. Hence, the two models were created, but with depressive symptoms as the dependent variable. The findings of the linear regression analysis support our Hypothesis 2, showing a positive association between perceived exploitation among HCWs and depressive symptoms ($\beta=0.53$, $p<0.00$). The R^2 for Model 1 is 0.04 and for Model 2 is 0.31 (high effect size). This difference highlights the higher explanatory power of perceived exploitation in predicting depressive symptoms, surpassing the contributions of the other variables in the study. It also indicates that perceived exploitation, in combination with the control variables, accounts for 31% of the variance in depressive symptoms, against the 4% when just accounting for the control variables. Model 2's F-change value (47.75) also demonstrated a significant improvement, compared to Model 1's F-change value (2.86). This, along with the previous analysis, further emphasizes the enhancement achieved by incorporating the additional predictor in Model 2.

To test hypotheses 3a, 3b, 4a, and 4b, which involved moderation analysis, it was used model 2 of the PROCESS macro for SPSS (Hayes, 2013). These hypotheses suggested that individual differences, respectively resilience and rumination, moderate the effect of perceived exploitation on burnout and depressive symptoms. The predictors were mean-centered (Aiken & West, 1991). A 95% confidence interval (CI) was applied in all analyses as well as 10,000 bootstraps resamples (Preacher & Hayes, 2008). Contrary to our predictions, the results do not support either of the four hypotheses tested. This is evident in Table 5.2. The relationship between perceived exploitation and self-rated burnout is not moderated by resilience or rumination, as both 95% confidence intervals include zero (resilience, $B=0.04$, 95% CI = [-0.04; 0.11]; rumination, $B=0.03$, 95% CI = [-0.07; 0.12]). Similar results were found for burnout rated by others (resilience, $B= -0.60$, 95% CI = [-1.58; 0.37]; rumination, $B= -0.38$, 95% CI = [-1.13; 0.37]) and depressive symptoms (resilience, $B=0.05$, 95% CI = [-0.08; 0.17]; rumination, $B= -0.03$, 95% CI = [-0.19; 0.14]). Therefore, these findings indicate that in this

study there is no statistically significant interaction effect between perceived exploitation and the moderators on any of the outcome variables.

Table 5.2. also shows that there is a direct negative relationship between resilience and self-rated burnout ($B=-0.13$; $p<0.02$; 95% IC = $[-0.23; -0.02]$) and depressive symptoms ($B=-0.44$; $p<0.00$; 95% IC = $[-0.61; -0.27]$). However, there is no direct relationship between resilience and burnout rated by others, as the 95% confidence interval includes a zero and the p-value is not statistically significant ($B=0.05$; $p<0.92$; 95% IC = $[-0.89; 0.99]$). Regarding rumination, it is only possible to observe a direct positive relationship between burnout ($B=0.18$; $p<0.01$; 95% IC = $[0.04; 0.31]$). Both burnout rated by others ($B=0.07$; $p<0.88$; 95% IC = $[-0.82; 0.95]$) and depressive symptoms ($B=0.01$; $p<0.92$; 95% IC = $[-0.22; 0.24]$) do not have a direct relationship with rumination as they have a zero in their 95% confidence interval and the p-values were not statistically significant.

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Table 5.2.

Bootstrapping Results

| Model/Predictor | Outcomes | | | | | | | | |
|---------------------|----------|--------|----------------|-------------------------|--------|---------------|---------------------|--------|----------------|
| | Burnout | | | Burnout rated by others | | | Depressive Symptoms | | |
| | B | SE (B) | 95% CI | B | SE (B) | 95% CI | B | SE (B) | 95% CI |
| Type of contract | 0.00 | 0.10 | [-0.20; 0.21] | -0.09 | 0.66 | [-1.48; 1.30] | -0.12 | 0.17 | [-0.47; 0.22] |
| Hours worked weekly | 0.01 | 0.01 | [0.00; 0.02] | 0.02 | 0.04 | [-0.06; 0.09] | 0.02 | 0.01 | [0.00; 0.03] |
| PEx | 0.29 | 0.05 | [0.20; 0.38] | 0.63 | 0.37 | [-0.14; 1.41] | 0.37 | 0.08 | [0.22; 0.52] |
| Res | -0.13 | 0.05 | [-0.23; -0.02] | 0.05 | 0.45 | [-0.89; 0.99] | -0.44 | 0.09 | [-0.61; -0.27] |
| Rum | 0.18 | 0.07 | [0.04; 0.31] | 0.07 | 0.42 | [-0.82; 0.95] | 0.01 | 0.11 | [-0.22; 0.24] |
| PEx x Res | 0.04 | 0.04 | [-0.04; 0.11] | -0.60 | 0.46 | [-1.58; 0.37] | 0.05 | 0.06 | [-0.08; 0.17] |
| PEx x Rum | 0.03 | 0.05 | [-0.07; 0.12] | -0.38 | 0.35 | [-1.13; 0.37] | -0.03 | 0.08 | [-0.19; 0.14] |

Note. PEx = Perceived Exploitation; Res = Resilience; Rum = Rumination

6. Discussion

The central focus of this study was to understand how the perception of being exploited affects Portuguese HCWs' burnout and depressive symptoms. In addition, we aimed to assess whether individual differences, specifically resilience, and rumination, could moderate these relationships. To test our hypotheses, we gathered data from 128 different HCWs. Even though Physiotherapists, Nurses, and Doctors represent slightly more than half of our sample, we still assembled a diverse number of different occupations belonging to the healthcare sector. We can infer that the healthcare sector mainly consists of women, as they amounted to almost the totality of our respondents. This is in agreement with 2021 statistics that state the high feminization of HCWs in Portugal (Instituto Nacional de Estatística, 2023). The ages of our respondents vary from 22 to 67 years old, which also showcases a wide and diverse range of experience and perspectives within the healthcare sector.

Additionally, a significant number of HCWs in this study have temporary contracts. This may result in a vulnerable workforce that is more susceptible to exploitation and less willing to raise issues or report abuse, in fear of potential repercussions (Bellè, Carreri, Miele, & Murgia, 2014). Usually, individuals with temporary contracts are known to have heavier workloads and fewer training opportunities within their organization (Bellè et al., 2014), which can lead to an even further perception of exploitation (Brocq et al., 2022) when compared to individuals with permanent contracts. In agreement, our results indicate a statistical relationship between having a temporary contract and experiencing higher levels of perceived exploitation and burnout. Additionally, the number of hours worked weekly may be linked to a slight increase in depressive symptoms as it presents a positive correlation, which is in agreement with Søvold et al. (2021). However, all of these are weak correlations, so further research is needed to explore the nature of these relationships.

Our findings suggest that perceived exploitation plays a significant role in explaining burnout (self-reported and rated by others) and depressive symptoms among HCWs, with all of them presenting a positive relationship. This remains true even when controlling for other relevant variables, in this case, the type of contract and hours worked weekly. Additionally, the study did not find evidence to support the hypotheses regarding the moderating effects of resilience and rumination. This lack of moderation evidence could be due to the sample size, as it may be too small to detect moderation effects. It can also be because we measure these moderators as traits, as opposed to states. This indicates that they were considered to be

somewhat constant characteristics of an individual. However, these variables can fluctuate in response to external circumstances, such as perceived exploitation (Herrman et al., 2011; Nolen-Hoeksema et al., 2008; Zanatta et al., 2020). Even so, and in agreement with Zanatta et al. (2020), resilience shows a direct, negative relationship with self-rated burnout and depressive symptoms, meaning that higher resilience may be associated with lower levels of these outcomes. Whereas rumination has a direct positive relationship with burnout, meaning that higher rumination can lead to higher levels of burnout, consistent with the results from Bianchi & Schonfeld (2016) and Yan et al. (2022).

It is also possible to notice that individuals close to HCWs can indeed observe burnout in them as their perception of burnout is positively correlated with HCWs' own perception of being burned out as well as with them feeling exploited and having depressive symptoms. This result further supports the importance of social support as a job resource in the JD-R model and as a mechanism in the development of personal resources in the COR theory (Bakker et al., 2001; Hobfoll et al., 2018), which can lead to better support and timely help in times of need.

6.1 Theoretical Implications

The results observed in this research are in line with the JD-R model and the COR theory. It is evident that perceived exploitation is positively related to depressive symptoms, and to both self-reported and other-rated burnout. These findings align with the JDR theory, as perceived exploitation can be considered a job demand that requires significant physical, psychological, and emotional effort from employees (Bakker et al., 2001; Maslach & Leiter, 2016). As mentioned before, even though resilience does not appear to moderate the relationship between perceived exploitation and outcomes, it does have a direct negative relationship with them. This is in line with the JD-R model that states that job resources, including individual resilience, may act as factors that aid employees in reducing the negative consequences of high job demands (Bakker et al., 2023) and in line with COR theory as it seems it protects from further negative impact to our outcomes. Furthermore, these findings also align with the COR theory as perceived exploitation can be seen as a resource loss, which can then trigger a cycle of resource loss, that may lead to burnout and depressive symptoms (Hobfoll et al., 2018). While in this study, rumination does not moderate the relationship between perceived exploitation and outcomes, it does have a direct positive relationship with them. This means that rumination in

the face of negative events can indeed contribute to further resource loss and increase depressive symptoms and burnout.

The fact that perceived exploitation contributes to explaining a significant portion of the variance in burnout (self-rated and other-rated) and depressive symptoms further strengthens this relationship with both the JD-R model and the COR theory. The confirmation of both of these theories' predictions reinforces their applicability in the context of HCWs and exploitation. Additionally, the inclusion of the type of contract as a control variable adds depth to the JD-R theory by acknowledging that different employment conditions can have an impact on employee well-being and mental health. In the context of this theory, the type of contract can be considered a job resource or demand. Permanent contracts may offer more stability and therefore be considered a job resource, while temporary employment may be associated with job insecurity, and lack of training, thus associated with higher job demands (Bellè et al., 2014). Similarly, the number of hours worked weekly can be a significant job demand or resource. Longer working hours may increase job demands and contribute to burnout, while reduced hours could be seen as a job resource in terms of work-life balance. Furthermore, it also indirectly adds to the COR theory, as the type of contract can affect the job-related resources that are available.

6.2 Practical Implications

This study has revealed significant practical implications for healthcare organizations, employees, and policymakers. It highlights the pressing need for healthcare institutions to acknowledge and address perceived exploitation among their employees (Livne-Ofer et al., 2019). This includes but is not limited to ensuring fair workload distribution and compensation, adequate work resources, and providing job security (Hallett, 2022). Furthermore, given the positive significant relationship between perceived exploitation, burnout, and depressive symptoms, healthcare institutions must prioritize mental health support (Prins et al., 2021). According to the JD-R, job demands and resources can change over time (Bakker et al., 2001). Thus, it is crucial for organizations to regularly evaluate and adapt their work environments to ensure an equilibrium between work demands and resources. This research suggests that interventions should take place not only to reduce job demands but also to provide additional resources, such as training, social support, and power of decision. According to the COR theory, those who have more resources can better cope with stressors, and resource loss can lead to a

spiral of additional losses (Hobfoll et al., 2018). As such, healthcare organizations and policymakers should implement policies that protect from resource loss as well as help create new resources. This may involve offering counseling, stress management resources, and promoting a culture of well-being (Cheng et al., 2023; Guo et al., 2021). The present study also highlights the importance of occasional measurement of well-being metrics. The use of these can be beneficial to understand the situation that is being faced (Livne-Ofer et al., 2019), which can lead to timely interventions and support. Examples could include the metrics used in this study, job satisfaction, and even patient outcomes as it can directly link to employees' well-being and state of mind.

Additionally, healthcare organizations and policymakers should reassess workplace policies to ensure that employees are not exploited and have access to the resources they need to cope with stress, depressive symptoms, and burnout (Cheng et al., 2023; Hallett, 2022). Even if rumination and resilience did not significantly moderate the relationship in this study, it does not diminish their importance. Further research should explore whether interventions tailored to these, or other individual differences can help healthcare workers cope with their challenges. This study also makes clear the importance of communication. HCWs should be encouraged to provide feedback about their working conditions and concerns. This feedback can help guide healthcare organizations in making organizational changes and improvements to prevent exploitation. For this to happen, it is essential to establish effective communication channels. This could happen through regular meetings between HCWs and their management. Thus, managers and leaders in healthcare organizations should have an open line of communication and be prepared to receive feedback, whether positive or negative (Montano, Reeske, Franke, & Hüffmeier, 2016). They should also receive training in recognizing and addressing issues related to perceived exploitation, burnout, depressive symptoms, and other mental health issues (Guo et al., 2021; Montano et al., 2016). However, some HCWs might not feel comfortable giving honest negative feedback to their hierarchical superiors. Therefore, healthcare organizations should also ensure clear and confidential pathways for reporting exploitation, mistreatment, or other concerns HCWs deem important.

6.3 Ethical Aspects and Other Limitations

So as to minimize respondent burden, participants were informed how long they should expect to take to complete the survey before it even started. Considering the length of it, a survey

segmentation technique was utilized to enhance the overall participant experience. In doing so, participants could complete the survey throughout several sessions by breaking it up into smaller, more manageable sections. This approach was used in an effort to minimize potential respondent fatigue while maximizing participant involvement and data completeness. Even so, several constraints had an impact on the current investigation. The limited sample size, which might not accurately represent the reality of HCWs, is one of the primary limitations. One potential reason for the low number of respondents is that, even with the aforementioned steps, the majority of feedback indicated that the survey was too time-consuming and lengthy. Additionally, because data was gathered through an online platform, people without internet access or adequate digital literacy were unable to participate in the study.

Another potential drawback is the exclusive use of self-report measures. Reliance on self-report measures for variables might introduce response biases. Participants may be influenced by social desirability, where they provide answers that align with what they think is socially acceptable or expected. The emotional complexity surrounding subjects such as burnout and depressive symptoms may make respondents hesitant to openly express their thoughts and feelings. Alternatively, participants might have difficulties accurately recalling past experiences or emotions, leading to recall bias. These biases can distort the true relationship between variables, potentially leading to inaccuracies in their responses. However, considering our focus on variables such as perceived exploitation and emotional exhaustion, which inherently rely on self-reports, we view this as a minor concern. Prior studies have also found strong relationships between self-report and unbiased assessments of the demands and control of the job (Muntaner et al., 2015). Despite the second survey's low response rate, the use of alternative data sources, in this case, the dear ones' perception of the HCWs' burnout, also helped to improve the impartiality. Nevertheless, the use of additional data sources for the remaining variables could similarly enhance the overall credibility and value of our data. Further, another limitation of this study is its cross-sectional design, therefore caution is advised when interpreting the results. In the future, a longitudinal study might give another insight into the study at hand. The results could also gain strength with the use of qualitative data, collected through interviews.

The underrepresentation of males in the responses also poses a study's limitation as it might affect the generalizability of the findings. To draw meaningful conclusions, it's crucial to have a diverse and representative sample that reflects the broader population under investigation. However, this representation is most likely due to the high amount of feminization of HCWs in

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Portugal. In 2021, women represented 56.9% of doctors, 63.2% of dentists, 82.4% of nurses, and 79.4% of pharmacists (Instituto Nacional de Estatística, 2023).

Lastly, another limitation of this study is that we did not account for stressors in HCWs' personal lives. These outside-of-work stressors might have affected their responses, making it challenging to attribute all negative answers solely to work-related factors. In future research, it would be valuable to consider these broader life stressors to gain a deeper comprehension of how perceived exploitation affects burnout and depressive symptoms.

7. Conclusion

This research has explored how Portuguese HCWs' feelings of being exploited can lead to adverse effects, namely burnout and depressive symptoms. Our findings have established that perceived exploitation is significantly and positively related to burnout (self-reported and other-rated) and depressive symptoms among HCWs. This relationship remains clear even after accounting for relevant control variables. This emphasizes the critical impact that perceived exploitation has on the mental health of HCWs, urging the need for healthcare organizations and policymakers to address this issue. Our results also show that the dear ones of HCWs can indeed recognize burnout in them, as the two variables of burnout presented a positive correlation, as well as with the perceived exploitation and depressive symptoms variables. This highlights the importance of social support for early intervention.

Additionally, our study examined the potential moderating effects of individual differences, specifically resilience, and rumination, on the relationship between perceived exploitation and burnout or depressive symptoms. The results did not support the hypotheses related to moderation. However, it is essential to recognize the direct impact of resilience and rumination on burnout and depressive levels of HCWs. Higher resilience was associated with lower levels of self-rated burnout and depressive symptoms, while increased rumination was linked to higher levels of burnout. These findings suggest the importance of fostering resilience and addressing rumination as part of interventions aimed at enhancing the mental health of HCWs.

Lastly, this dissertation provides insights into the challenges faced by HCWs in the healthcare sector and offers a foundation for future research and practical interventions aimed at improving their mental health. To achieve equality, justice, and human dignity, we must work together to eliminate exploitation and build a more just and equitable society, based on justice, respect, and empowerment.

8. References

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9. Appendix

Appendix A: Complete list of Respondents' Occupation

Table 9.1.

Respondents' Occupation

| Occupation | n | % |
|--|----|------|
| Physiotherapist | 36 | 28.1 |
| Nurse | 31 | 24.2 |
| Doctor | 14 | 10.9 |
| Dentist | 8 | 6.3 |
| Psychologist | 6 | 4.7 |
| Clinical and Public Health Analysis Technician | 3 | 2.3 |
| Medical Assistant | 3 | 2.3 |
| Nutritionist | 3 | 2.3 |
| Pharmacy Assistant | 3 | 2.3 |
| Senior Diagnostic and Therapeutic Technician | 3 | 2.3 |
| Clinical Research Associate | 2 | 1.6 |
| Oral Hygienist | 2 | 1.6 |
| Pharmacist | 2 | 1.6 |
| Senior Radiology Technician | 2 | 1.6 |
| Veterinarian | 2 | 1.6 |
| Clinical and Public Health Analysis Senior Technician | 1 | .8 |
| Clinical Secretary | 1 | .8 |
| Dental Assistant | 1 | .8 |
| Dental Prosthesis Technician | 1 | .8 |
| Laboratory Technician | 1 | .8 |
| Orthoptist | 1 | .8 |
| Orthotics Specialist | 1 | .8 |
| Podiatrist | 1 | .8 |

Note. N=128.

Appendix B: Complete list of Respondents' age**Table 9.2.***Age of the Respondents*

| Age | n | % |
|-----|----|------|
| 22 | 5 | 3,9 |
| 23 | 21 | 16,4 |
| 24 | 14 | 10,9 |
| 25 | 6 | 4,7 |
| 26 | 11 | 8,6 |
| 27 | 4 | 3,1 |
| 28 | 1 | 0,8 |
| 29 | 8 | 6,3 |
| 30 | 4 | 3,1 |
| 31 | 6 | 4,7 |
| 32 | 3 | 2,3 |
| 33 | 9 | 7,0 |
| 34 | 3 | 2,3 |
| 35 | 5 | 3,9 |
| 36 | 5 | 3,9 |
| 37 | 3 | 2,3 |
| 38 | 3 | 2,3 |
| 40 | 2 | 1,6 |
| 41 | 3 | 2,3 |
| 43 | 1 | 0,8 |
| 45 | 1 | 0,8 |
| 47 | 2 | 1,6 |
| 48 | 2 | 1,6 |
| 49 | 1 | 0,8 |
| 53 | 1 | 0,8 |
| 55 | 1 | 0,8 |
| 57 | 1 | 0,8 |
| 62 | 1 | 0,8 |
| 67 | 1 | 0,8 |

Note. N=128.

Appendix C: Second Survey Respondents' Information

Table 9.3.

Second Survey Respondents' Gender, Type of Relationship, and Role in their organization

| Sample Characteristics | | n | % |
|--------------------------|-------------------|----|------|
| Gender | Female | 16 | 64.0 |
| | Male | 9 | 36.0 |
| Type of Relationship | Significant Other | 13 | 52.0 |
| | Friend | 7 | 28.0 |
| | Family | 3 | 12.0 |
| | Colleagues | 2 | 8.0 |
| Role in the organization | Collaborator | 24 | 96.0 |
| | Supervisor | 1 | 4.0 |
| | Senior Manager | 0 | 0.0 |

Note. N=25

Table 9.4.

Respondents' age and time knowing the HCW who sent them the survey.

| | Minimum | Maximum | \bar{x} | d.p. |
|--------------------------|---------|---------|-----------|------|
| Age | 23 | 55 | 30.12 | 7.81 |
| Years of knowing the HCW | 0 | 23 | 8.60 | 6.91 |

Note. N=25