Mental Health Nurse Burnout and Stress: Options for Prevention

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Abstract

The aim of this critical review was to identify prevention strategies that may be effective in the reduction of stress and burnout among mental health nurses. Diminished staff wellbeing, due to high levels of stress and burnout, has significant consequences at both the individual and the service level. Therefore, identifying effective prevention strategies may be beneficial in raising recruitment of mental health nurses, in prolonging retention, and may also have a positive impact on patient care. A search of the literature was undertaken utilising selected systematic review techniques, which identified seven articles as suitable for review. The results of the review found that three main prevention strategies were being utilised: clinical supervision, psychosocial intervention and social support. While all these strategies had the aim of minimising or preventing stress and/or burnout, they were all somewhat different in their focus and in their outcome measures. This factor, coupled with the paucity of high quality randomised intervention studies, makes it difficult to draw definitive conclusions concerning which intervention is most effective. The best currently available evidence suggests that prolonged clinical supervision is probably the best of the three options for the reduction of stress and burnout among mental health nurses, given the lack of high quality evidence and the magnitude and potential impact of this problem.

Keywords: Stress, Burnout, Mental Health Nursing.

INTRODUCTION

Stress and burnout are acknowledged as being both widespread and problematic within nursing (Australian Health Workforce Advisory Committee [AHWAC], 2003, p. 47). Mental health nurses are particularly vulnerable, due a lack of community support, low staffing levels, stigma and client pressures including the risk of violence. Since the prevalence of burnout amongst mental health nurses has reached as high as 59.2% in some settings, the need for intervention is important (Imai, Nakao, Tsuchiya, Kuroda & Katoh, 2004, p. 767).

Burnout can be defined as a psychological condition, resulting in mental or physical energy depletion caused by chronic unresolved job-related stress and ineffective coping strategies (Edward & Hercelinskyj, 2007, p. 240; Robinson, Clements & Land, 2003, p. 34). It can cause significant problems in relation to care provision in mental health care settings, as nurses suffering from burnout may become cynical, lose respect or concern for their patients and have dehumanised perceptions of their patients (Barling, 2001, p. 248).

Stress involves a response by the body to an emotional, mental or physical stimulus or strain, which can disturb or interfere with normal physiological functioning (De Carlo, 2001). Stress can affect mental health nurses in a number of ways, including alcohol and other drug dependence, coronary artery disease, somatic complaints, attempted suicide and efficiency of nursing care provided (Tully, 2004, p. 43).

The increasing number of mental health clients compared to the decreasing number of beds and qualified staff, means that mental health nurses are spending less time per patient and potentially providing a reduced level of care (De Carlo, 2001; Mental Health Council of Australia [MHCA], 2005, p. 2).

In addition, mental health nurses are often confronted with caring for patients in inappropriate settings, with a reduced level of support and increased administrative pressures all leading to an increase in stress and burnout (Barling, 2001, p. 252; MHCA, 2005, p. 3). The mental health sector and its nursing staff are exposed to a unique range of workforce pressures, which are in addition to the pressures affecting the general health industry (MHCA, 2005, p. 2).

The mental health care needs of society are growing, and yet mental health care is currently one of the least chosen career paths of nurses (MHCA, 2005, p. 5). There are also ageing workforce issues, with only 18 per cent of mental health nurses being under the age of 35, compared with 27 per cent in the general clinical sector (MHCA, 2005, p. 5). According to the MHCA (2005, p. 3) low recruitment levels are influenced by not only the stigma associated with mental illness and correspondingly, the profession of mental health nursing, but also by the ‘marginalisation of the speciality within medicine’. Stigma contributes not only to problems in recruitment but also to the complexity of working within the mental health sector, as it impacts greatly on the social engagement, health, wellbeing and recovery of mental health clients and hence on the stress levels and burnout of the mental health nurses (Barling, 2001, p. 249; MHCA, 2005, p. 4).

Therefore, there is an urgent and demonstrable need to identify interventions that are effective in reducing stress and burnout amongst mental health nurses. Some of the factors to be assessed are: what strategies are currently being utilised; which ones are effective; and what impact do they have on the stress levels and coping capacities of mental health nurses.
METHODS

While this was not a systematic review, some of the techniques of systematic reviewing were used, including a defined search strategy, specific inclusion and exclusion criteria, and an assessment of the rigour and quality of the studies that were retrieved.

Search Strategy

The terms used in the review search strategy were burnout OR stress* AND mental health nurse* OR psychiatric nurse*. To identify relevant articles, searches were conducted on nine online databases: AUSTHealth, CINAHL, Cochrane Library, EBMH Online, Internurse, Proquest 5000, Scopus, SpringerLink and Wiley Interscience. In addition, the reference lists of retrieved articles were also examined.

Inclusion, Exclusion and Assessment

The search strategy was limited by the following criteria: (1) English language, (2) published in or after 2002, (3) specific to mental health nurses, (4) research studies rather than discussion articles, and (4) specifically related to burnout or stress prevention strategies among mental health nurses. Articles were excluded from the review if they did not meet these criteria. They were also excluded if the interventions were not clearly described or defined, and this was a significant issue in many of the studies initially identified for review.

RESULTS

This process resulted in seven articles being selected for review. In terms of study design, four were surveys, two were quasi-experimental pre-test/post-test designs and one was a systematic review. Five of the primary research studies were conducted in the United Kingdom, one in Finland and one in Australia. The systematic review was included because of its rigour, particularly its use of strict inclusion criteria and the appraisal of studies by two independent reviewers prior to inclusion.

The seven articles identified three main strategies for the prevention of stress and burnout in mental health nurses. These were clinical supervision, psychosocial interventions and social support.

Clinical Supervision

Clinical supervision is a formal process of professional support and learning (Edwards et al., 2006, p. 1008). Edwards et al. (2006) conducted a study to assess the effectiveness of clinical supervision involving Community Mental Health Nurses (CMHNs) working in eleven National Health Service (NHS) Trusts in Wales. The authors found that out of 260 respondents surveyed, 73 per cent \((n = 189)\) had experienced six or more sessions of clinical supervision in their present position \((p. 1011)\). Significantly lower levels of emotional exhaustion and depersonalisation were reported among CMHNs who had received six sessions or more of clinical supervision. The authors of this study believe that this indicates a potential correlation between clinical supervision and a reduction in burnout rates.

They also found that CMHNs who were younger, male and who had not experienced six or more sessions of clinical supervision showed higher depersonalisation scores. However, as the response rate was only 32 per cent of the CMHN’s population within Wales, it is unlikely that the participants in this study were a representative sample.

Another study by Hyrkas (2005), in which participants who had undergone a minimum of six months clinical supervision were surveyed, found similar results to Edwards et al. (2006) in terms of factors that influenced the effectiveness of the clinical supervision. Young, male nurses with a varied shift roster showed the least response to clinical supervision and least improvement in burnout scores \((Edwards et al., 2006, p. 1012; Hyrkas, 2005, p. 540)\). This similarity in findings highlights a possible correlation between gender, age, the duration of clinical supervision, and its effectiveness, especially considering the fact that Hyrkas (2005) had an 85 per cent \((n = 569)\) response rate across 14 sites, representing a wide geographical and professional spread \((p. 540)\).

A survey of mental health nurses working in NSW Australia, by White and Roche (2006) and the critical review by Edwards and Burnard (2003) also found that clinical supervision had a positive effect on the levels of stress and overall sense of well being experienced by mental health nurses. The three studies reviewed by Edwards and Burnard (2003) in their systematic review found that one year of clinical supervision significantly decreased the self-reported stress levels of mental health nurses. Furthermore, each of those studies had bias possibilities identified, limitations clearly defined and high response rates \((average 82 per cent)\), thus supporting the findings of Edwards and Burnard (2003, p. 194).

However, the Australian survey conducted by White and Roche (2006) had a very low response rate of 21.2 per cent \((n = 601)\), of which only one third had received clinical supervision for one year on a fortnightly or monthly basis, for between one and two hours per session. Nevertheless, of the respondents who did receive clinical supervision, 65 per cent self reported via questionnaire that they felt more developed professionally and personally, and hence felt less stressed \((White & Roche, 2006, p. 213)\).

Psychosocial Interventions

Psychosocial intervention (PSI) training aims to assist nurses to view patients’ problems in a more empathetic way, whilst providing them with the skills required to intervene effectively in problematic situations \((Edwards & Burnard, 2003, p. 193)\). Some typical components of PSIs are relapse prevention, cognitive behavioural therapy and family interventions \((Doyle, Kelly, Clarke and Braynion, 2007, p. 16)\). The studies conducted by Doyle et al. (2007) and Ewers, Bradshaw, McGovern and Ewers (2002) examined the impact of PSI training on burnout rates in mental health nurses.

Ewers et al. (2002) found that after completing the 20-day PSI training course there were significant positive changes, with the control group showing very little change \((Ewers et al., 2002, p. 474)\). For example, in the intervention group, emotional exhaustion scores decreased by an average of three points and depersonalisation by four points, with personal achievement showing an average increase of four points when measured post-PSI training \((Ewers et al., 2002, p. 475)\). Although these results indicated a correlation between PSI training and a reduction in burnout, the small sample size and potential bias, due to the principal researcher working in the secure unit, delivering most of the training and collecting the
data, need to be taken into account when drawing conclusions from the results (Ewers et al., 2002, p. 475).

Doyle et al. (2007) conducted a similar study to Ewers et al. (2002), with participants representing all areas and disciplines being selected randomly and then allocated to either a control or training group. However, the same positive effects on burnout did not occur when PSI training was implemented, with no significant variation between the control and training groups in pre and post-testing (Doyle et al., 2007, p. 18).

This difference in findings could have been due to the shorter intervention duration in the latter study, or that the Ewers et al. (2002) study sample incorporated both unqualified and qualified staff. Another possible reason is that Doyle et al. (2007) did not have the same representation of gender within each group that Ewers et al. (2002) did. Furthermore, both the studies used sample sizes of fewer than thirty participants, which is another reason to view these findings with caution.

**Social Support**

Jenkins and Elliot (2004) conducted a study in which a convenience sample of nursing staff from eleven acute adult mental health wards at four hospitals in London were assessed to identify the impact of social support on burnout. Social support was defined for the purpose of the study as support from co-workers, supervisors, spouse/partner, relatives and friends. The effectiveness of social support was measured via a questionnaire and using the previously validated House and Wells Social Support Scale (1978) (Jenkins & Elliott, 2004, p. 625). The social support intervention involved substantial assistance and help with either a work task or emotional situation, such as listening sympathetically or the action of caring (Jenkins & Elliott, 2004, p. 623).

This study found a significant inverse correlation between co-worker support and MBI emotional exhaustion scores. Furthermore, support from supervisors was only half as effective in reducing emotional exhaustion as that from co-workers, with support from friends/relatives and spouse/partner showing no significant change in emotional exhaustion scores (Jenkins & Elliott, 2004, p. 626).

These significant differences in outcomes depending on who was delivering the support are notable. They could possibly be attributed to the fact that co-workers are more equipped to deal with work-related problems than people who are more distant from the real life context that mental health nurses are experiencing, or who are in the case of supervisors generally less accessible (Jenkins & Elliott, 2004, p. 628).

However, due to the low response rate of 39 per cent, the use of convenience sampling and self-selection, the findings may not be representative and therefore no definitive statements can yet be made about the relationship between social support and the levels of burnout in mental health nurses (Jenkins & Elliott, 2004, p. 628). In addition, the reviews by Edwards and Burnard (2005) found that social support programs offered no significant advantage in the reduction of burnout. Moreover, a test six months after the intervention found that emotional exhaustion scores had returned to pre-intervention levels, highlighting an obvious need for social support to be ongoing in order to maintain effectiveness (Edwards & Burnard, 2003, p. 191).

**DISCUSSION**

The research into strategies to reduce the stress and burnout being experienced by mental health nurses focuses on three main interventions: clinical supervision, psychosocial interventions and social support. The findings of the studies in this area are conflicting. This is in no small measure due to the fact that interventions, while fitting into broad categorical definitions, differ significantly in the nature of their specifics, their duration, and in the use of both comparison groups and pre and post-testing. The research, apart from a few exceptions, is also characterised by low response rates, so it is difficult to conclude definitively that any one of the interventions is more effective.

However, some findings are suggestive. Of all three interventions, long duration clinical supervision currently has the best available evidence in support of its effectiveness. In order to establish better evidence for this, more studies need to be conducted to assess the exact length, delivery type and content of clinical supervision that is most beneficial. PSI training showed mixed results for reducing burnout. Therefore it would be reasonable to conclude at present that burnout in mental health nurses cannot be addressed effectively by implementing courses of this type until such time as further studies can be undertaken. The relationship between co-worker support and reduced emotional exhaustion indicates that peer social (but not supervisor or family) support could also be influential in alleviating some of the effects of occupational stress, but again the lack of a body of research in this area makes it difficult to draw definitive conclusions about the effectiveness of this intervention.

All of the studies assessed for this review, except for Hyrkas (2005), used convenience sampling to select participants, thus raising the possibility of selection bias. This could operate in two ways. Participants could have chosen to participate as a way of making their feelings known or due to feeling particularly stressed or burnt out, which may have lead to inflated levels of reported stress or burnout. An alternative possibility is that the most stressed or burnt out nurses may have felt too exhausted and dissatisfied to participate, resulting in an underestimation of the real trends. Furthermore, the variance and lack of standardisation in sample sizes, duration of interventions and assessment tools used in the studies all contribute to problems with rigour and ability to generalise from the reported outcomes.

**CONCLUSION**

The most effective strategies for reducing the prevalence of stress and burnout in mental health nurses are yet to be identified. The complexity of the issue, with different clinical environments, different interventions and different outcome measures, makes it difficult to identify a single clearly effective strategy or set of strategies. Given these factors, and the relatively small volume of research in the area, it may be some time before this can be done. Further studies in the area need to address the identified areas of methodological deficiency, particularly lack of defined specificity for interventions and small non-randomly selected sample sizes. Considering the likely impact of individual clinical contexts on findings, the lack of Australian research in this area is a concern. Until these gaps in the evidence are addressed, the current best available evidence is that prolonged clinical supervision may be effective in alleviating the effects of stress and burnout for mental health nurses, and is the best option that we have at present for addressing this significant problem in mental health nursing practice.
References


