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STRESS, COPING AND BURNOUT IN MENTAL HEALTH NURSES: FINDINGS FROM THREE RESEARCH STUDIES

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SUMMARY

In this paper we present data from three research studies on stress, coping and burnout in mental health nurses. All three studies used a range of self report questionnaires. Measures included a demographic checklist, the General Health Questionnaire (GHQ-28), the Maslach Burnout Inventory, the DCL Stress Scale and the Cooper Coping Skills Scale. In all, 648 ward based mental health nurses were surveyed. There were no significant differences between levels of psychological distress on GHQ Total Score, but there were differences in caseness rates. In Study 3, some 38% of nurses were found to score at or above the criterion for caseness. The main stressors for ward staff were to do with staff shortages, health service changes, poor morale and not being notified of changes before they occurred. Differences in coping skills were found across studies. The study group with the highest stress scores also had the lowest coping skills scores. This was also associated with significantly higher alcohol consumption and greater self reported sickness absence. Scores on the Maslach Burnout Inventory showed higher levels of burnout amongst nurses in Study 3. These three studies have confirmed that stress is a problem for ward based mental health nurses. Two main implications arise from this work. Firstly we need models of the stress process that are empirically based, and which help us identify the moderating variables that reduce the impact of stressors on nurses. Secondly, we need to utilise this knowledge to deliver stress management interventions for staff. We end by outlining a model which may help us both understand the process of stress causation, and move towards our goal of stress reduction.

INTRODUCTION

Of all the mental health professions, nursing has had to undergo the most dramatic changes in the last 20 years (Nolan, 1993). In America, Britain and elsewhere in the world, the closure of large asylums and the transfer of care of the mentally ill into the community, has led to radical changes in the role of mental health nurses (Weller, 1993; DOH, 1994). As asylum nursing has declined, there has been a rapid development in community mental health nursing (McNamee, 1993). From only 226 nurses working in the community in 1966 in Britain, the number had risen to around 5000 by the end of the 1980s (White, 1990). Such major changes in both the location and nature of mental

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health nursing might be expected to lead to greater occupational stress. In our previous work we demonstrated that community mental health nurses experienced significantly higher levels of stress than their ward based counterparts (Carson *et al.* 1995; Fagin *et al.* 1995). In this paper we focus our attention on ward based mental health nurses.

In contrast to the relatively large number of studies of stress in general nurses (Grey-Toft & Anderson, 1981; Hipwell *et al.* 1989), there have been fewer studies of stress in mental health nurses. Jones (1987), reviewing the literature, could only identify five studies worldwide. Of the research that has been conducted to date, methodological shortcomings limit the generalisations that can be made from the findings. There are three main problems with this research. Firstly, many studies have utilised small samples, and it is often difficult to establish to what extent those surveyed may be representative of the total population of nurses (Dawkins *et al.* 1985; Trygstad, 1986; Dolan, 1987; Landeweerd and Boumans, 1988). Secondly, several studies have used insufficient measures to be able to say anything meaningful about the samples. Reeves (1994), in a comparative study of general and psychiatric nurses, used only a brief demographic questionnaire and the General Health Questionnaire (GHQ-28). Unsurprisingly she found few differences between both samples. Thirdly, some of the measures used in previous research are of questionable reliability and validity. While Sullivan (1993), claimed to have developed a measure for assessing stress in mental health nurses, he presented no evidence on the measure's reliability or validity. As part of the process of running down large mental hospitals, the British Health Service started to establish psychiatric units within district general hospitals (Murphy, 1991). The process of reproviding care in the community, led to the development of smaller residential units (Wainwright, 1992). It is in the context of such changes that we examine stress in ward based mental health nurses.

To date we have conducted three separate studies. The first, the Claybury CPN Stress Study, was a Regional comparison of stress and coping in both ward and community based mental health nurses. In this paper we focus only on the ward staff, n = 317. The second study examined qualified nurses from two large asylums, n = 145. The third, focussed on staff from two mental hospitals in a different region. The combined sample of 648 ward based nurses is to our knowledge the largest yet reported.

METHODS

All three studies used self report questionnaires. In the first study sampling was done on an opportunistic basis. The researcher spent between one and five days in hospitals throughout the region, and persuaded as many staff as possible on duty to participate in the study. The nurses were drawn from two district general hospital psychiatric units, and five mental hospitals. For study 2 and 3, separate research workers surveyed all nursing staff within the hospitals and obtained response rates of 46% and 47% respectively. Of the total sample, 20.2% were unqualified, 55.5% were staff nurses, while 23.2% were charge nurse grade or above. The remainder were state enrolled nurses. The same questionnaires were used in all studies. These were:

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Demographic Questionnaire

This was a 23 item measure developed by the authors. It covered issues such as sex, age, experience, absence etc. (Brown & Leary, 1995).

The General Health Questionnaire

We used the GHQ-28 (Goldberg & Williams, 1988). Two main scores are obtained from this, a Total Score and a Caseness Score. The latter refers to the number of participants scoring above a criterion level of 5 or more. This measure assesses level of psychological distress, and is the most used psychiatric screening instrument worldwide (Bowling, 1995). Extensive data are available on the measure's reliability and validity.

The Maslach Burnout Inventory

This is generally recognised as the most valid and reliable indicator of occupational burnout syndrome (Schaufeli *et al.* 1993). Again two types of score are obtained, on each of the three subscales. A Total Score for the subscale, and also a categorical rating coding the score as High, Moderate or Low in burnout. The subscales are, Emotional Exhaustion, Depersonalisation and Personal Accomplishment (Maslach and Jackson, 1986).

The DeVilliers Carson Leary Stress Scale (DCL)

This is a 30 item measure of occupational stress developed specifically for ward based mental health nurses (Carson *et al.* 1996a). The measure has good internal and test-retest reliability, and satisfactory face, content and concurrent correlational validity.

The Cooper Coping Skills Scale

This is a 28 item measure of coping skills, taken from the Occupational Stress Indicator (Cooper *et al.* 1988). It has six subscales covering Social Support, Task Strategies, Logic, Home and Work Relationships, Time Management and Involvement. We also report a Total Coping Skills Score, as other researchers have found this to be the most useful indicator of coping skills (Cooper, personal communication). The reliability and validity of this measure are not as well established as the other measures. The studies also used the Minnesota Job Satisfaction Scale (Weiss, 1967), and the Rosenberg Self-Esteem Scale (Rosenberg, 1965). Findings from these two measures will not be reported here.

RESULTS

Characteristics of samples

Table 1 below gives the sex distribution for the three studies, the percentage of each that were married or cohabiting, their average age, their average time spent in nursing, as well as the amount of time they had spent in their present job. The sample in Study 2 contained the highest proportion of married staff, was the oldest and had the most experience and most time in their present job.

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Table 1
Characteristics of study samples

	Study 1 (n = 315)	Study 2 (n = 144)	Study 3 (n = 182)	Significance
Male	43%	44%	37%	Chi-square = 0.2554
Female	57%	56%	63%	df = 2, not significant
Married	65%	78%	56%	Chi-square = 16.9599, df = 2, p < 0.001
Age	34.68	38.56	35.12	Kruskal-Wallis, ANOVA, h = 18.39, df = 2, p < 0.0001
Years in nursing	10.22	14.62	10.38	Kruskal-Wallis, ANOVA, H = 34.59, df = 2, p < 0.0001
Time in present job	4.84	6.56	3.48	Kruskal-Wallis, ANOVA, H = 33.32, df = 2, p < 0.0001

Stress measures

General Health Questionnaire

The overall average was 3.77 (sd = 5.0). For study 1 = 3.41 (4.75), study 2 = 3.60 (4.65), study 3 = 4.54 (5.62). Differences between the three studies were not significant, Kruskal-Wallis, ANOVA, H = 4.7063, df = 2, p = 0.082. The overall Caseness rate was 31%, and for study 1 = 27%, study 2 = 32% and for study 3 = 38%. Differences between the three studies on this occasion were significant, Chi-Square = 6.45, df = 2, p < 0.05. Staff in study 3 clearly had the highest levels of psychological distress.

DCL Stress Scale

This was only administered to nursing staff in study 2 and 3, as it was not available at the time study 1 was conducted. Factor Scores and Total Scores are reported in Table 2. The two groups differed significantly on Factor 4 (Future Concerns). This is understandable in that the two hospitals involved in study 2 are both scheduled for closure, whereas those in study 3 are not.

Of the thirty items in the questionnaire, the most stressful items for nursing staff were:

1. Inadequate staffing cover in potentially dangerous situations.
2. Dealing with changes in the health service and hospital closures.

Table 2
DCL Stress Scale Scores

	Study 2	Study 3	Significance (Mann-Whitney)
Factor 1 (patient demands)	12.97 (7.24)	13.57 (5.89)	u = 12 212, z = 0.9759, n.s.
Factor 2 (organisational)	13.68 (6.58)	14.48 (5.76)	u = 11 755, z = 1.5198, n.s.
Factor 3 (staffing)	13.34 (6.17)	13.60 (5.47)	u = 12 712.5, z = 3803, n.s.
Factor 4 (future concerns)	7.92 (4.03)	6.02 (3.40)	u = 9554, z = 4.1470, p < 0.001
Factor 5 (job satisfaction)	4.74 (2.84)	4.78 (2.90)	u = 12 922.5, z = 0.1309, n.s.
Total Score	52.50 (22.90)	52.43 (19.47)	u = 12 764.5, z = 0.3179, n.s.

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Table 3
Smoking, drinking and sickness absence

	Study 1	Study 2	Study 3	Significance
Smoking more than 11/day	28%	35%	27%	Chi-square = 3.4269, df = 2, n.s.
Regular drinker	18%	17%	31%	Chi-square = 14.2625 $p < 0.001$
Days sickness in 12 months	8.57	7.66	9.31	Kruskal-Wallis, ANOVA, H = 25.7160, df = 2 $p < 0.0001$

3. Low morale and poor atmosphere within the organisation.
4. Not being notified of changes before they occur.
5. Knowing that individual patient care is being sacrificed because of lack of staff.
6. Lack of consultation from management about influential structural changes, e.g. internal rotation.

Smoking, drinking and absence data

Table 3 presents the information on smoking, drinking and absence. There were no significant differences in the numbers of staff in the three hospitals smoking more than 11 cigarettes per day. There was however a significant difference in drinking alcohol. The number of nurses who were regular drinkers was almost twice as high in study 3 as in the other two studies. Similarly, staff in study 3 had the highest sickness absence rate.

Coping Skills Results

Results on the Cooper Coping Skills Scale are presented in Table 4. Nurses differed in four out of the seven comparisons. Nurses in study 3 had the lowest coping skills scores on virtually all dimensions, showing a lower utilisation of coping strategies. The

Table 4
Cooper Coping Skills Scale

	Study 1	Study 2	Study 3	Kruskal-Wallis, ANOVA
Social support	17.73 (3.56)	17.80 (2.99)	17.21 (3.03)	H = 4.99, df = 2 n.s.
Task strategies	27.92 (4.89)	28.45 (4.37)	26.75 (4.08)	H = 13.35, df = 2 $p < 0.01$
Logic	12.80 (2.58)	12.45 (2.34)	11.97 (2.30)	H = 12.57, df = 2 $p < 0.01$
Home and work	17.69 (3.66)	16.94 (3.59)	17.35 (3.76)	H = 5.13, df = 2 n.s.
Time management	15.04 (2.67)	15.20 (2.52)	14.87 (2.67)	H = 1.68, df = 2 n.s.
Involvement	25.22 (3.89)	25.06 (3.72)	23.95 (3.59)	H = 15.22, df = 2 $p < 0.001$
Total	116.28 (15.44)	115.75 (13.85)	112.11 (13.59)	H = 11.88, df = 2 $p < 0.01$

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Table 5
Maslach Burnout Inventory Scores

	Study 1	Study 2	Study 3	Kruskal-Wallis, ANOVA
Emotional exhaustion	20.38 (11.99)	19.31 (11.40)	21.25 (10.35)	H = 3.06, df = 2, n.s.
Depersonalisation	7.40 (6.21)	5.46 (5.41)	7.93 (6.40)	H = 15.8165, df = 2 $p < 0.001$
Personal accomplishment	32.33 (8.84)	32.84 (7.81)	32.85 (7.57)	H = 0.2747, df = 2 n.s.

significance of this is that lower coping skills scores are associated with higher stress levels (Carson *et al.* 1996b).

Burnout results

Average scores on Maslach subscales

Maslach subscale scores for the three studies are given in Table 5. The groups differed significantly only on Depersonalisation. Study 3 had the highest Depersonalisation scores, and while their Emotional Exhaustion scores were also higher, the differences failed to reach significance. Personal Accomplishment scores were more evenly distributed.

Maslach categorical analysis

Percentage of mental health nurses scoring in the high burnout category on all three subscales was less skewed (see Table 6). This is most noticeable on Personal Accomplishment again.

On Depersonsalisation, some 22 per cent of staff in study 3 were in the high burnout category, in comparison with only 13% for study 2. Of the three subscales, mental health nurses had the highest proportion of high burnout scores on the Emotional Exhaustion subscale.

DISCUSSION

We presented our findings on stress in the three studies firstly in terms of the levels of psychological distress as measured by the GHQ, secondly in DCL Stress Scale scores and

Table 6
High burnout scores on the Maslach scale

	Study 1	Study 2	Study 3	Significance
Emotional exhaustion	31%	28%	32%	Chi-square = 0.8921, df = 2, n.s.
Depersonalisation	17%	13%	22%	Chi-square = 4.6149, df = 2, n.s.
Personal accomplishment	27%	26%	26%	Chi-square = 0.1392, df = 2, n.s.

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thirdly in terms of smoking, drinking and absence data. For the sample as a whole, the caseness figure of 31%, shows that three in ten ward nurses are experiencing significant psychological distress. The average GHQ score is quite low, and less than half of some clinical samples (Carson and Brewerton, 1991), or other staff groups that have been researched (Tobin and Carson, 1994). The caseness figure for study 3 (38%), is almost as high as that reported for community mental health nurses of 41% (Fagin *et al.* 1995). Study 3 nurses also had significantly higher alcohol consumption and more days off sick. Their source of stress scores on the DCL Stress Scale were comparable to Study 2 nurses. This perhaps suggests that the reason their stress outcomes were poorer may be due to ineffective stress moderating strategies. It is noteworthy in this respect that they had much lower scores on coping skills than nurses from the other two studies. Burnout Inventory scores also suggested that study 3 nurses were the most emotionally exhausted and the most depersonalised. Whilst the large number of nurses involved in the present studies gives its findings considerable credibility, it is also in a sense its main methodological weakness. While study 2 and 3 comprised nurses from two hospitals only, study 1 included nurses from seven separate hospitals. The sampling processes in the studies may have introduced another artefact into the study. Equally the differences in participant characteristics introduces a further possible source of bias into the findings. The study 2 population was probably closest in nature to that of the typical mental hospital nursing population, but even here the imminent closure of both hospitals may have increased stress levels. Again the fact that some of the measures used in the studies require further work on their psychometric properties, may be a further weakness. The studies did however use two of the most widely published scales in this field in the GHQ and the Maslach Scale.

Methodological weaknesses notwithstanding, large scale empirical studies such as our own, can help us develop our understanding of the stress process. Some authors (Duquette *et al.* 1994), suggest that there are three main moderators of burnout, social support, hardiness and coping skills. We need to examine how effective some of these moderating variables are at actually reducing the effects of stress on staff. Once we have this knowledge, it should then guide our stress management interventions. It seems highly likely that such interventions will need to be broadly based, and not be focussed on a single strategy such as social support (Ritter *et al.* 1995; Beehr, 1959). Further research in this field needs to expand our knowledge of the stress process. Researchers need to study larger more homogenous groups of staff in depth, e.g. Jones *et al.* (1987). This will reduce variance due to the effects of the hospital *per se*, which clearly make it difficult for us to be able to explain what might be happening in our study 1, with seven separate hospitals involved. Secondly, researchers need to utilise more longitudinal designs, rather than the cross sectional designs largely employed to date. We do not have accurate information on the natural history of burnout, though some authors suggest that it has a chronic course and is stable over time (Maslach & Schaufeli, 1993). Thirdly, especially with better longitudinal data, there is a need to apply more powerful statistical techniques to the data to test out predictions from stress models. Techniques such as structural equation modelling (Martin, 1987), would seem to have an important role to play here. Finally we outline a tentative model of the stress process, which is an evolution of a previous model that guided our earlier work (Fagin & Bartlett, 1995).

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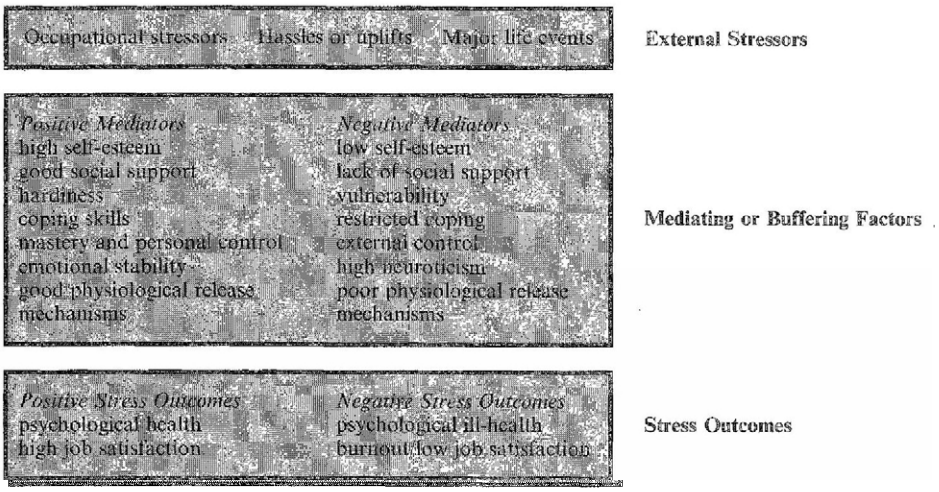

Figure 1. A revised model of the stress process.

The model proposes that there are three main sources of external stress. Firstly, occupational stressors such as those assessed by the DCL Stress Scale. Secondly, major life events (Holmes & Rahe, 1967). Thirdly, minor or microstressors, sometimes referred to as hassles and uplifts (Kanner *et al.* 1981). These stressors will only lead to negative stress outcomes if the individual has insufficient resources to manage them. The critical factor in the model is what mediating or buffering factors individuals can call on to help them. We suggest that there are a number of such factors. We include self-esteem (Turner & Roszell, 1994), social support (Brugha, 1995), hardiness (Kobassa & Puccetti, 1983), coping skills (Carver *et al.* 1989), mastery and personal control (Pearlin *et al.* 1981), emotional stability (Eysenck & Eysenck, 1975), and good physiological release mechanisms such as the ability to relax, exercise, retain a sense of humour and the ability to let off steam generally. It is our contention that individuals who have such personal resources available, will experience better stress outcomes than those without them. Increased personal resources may depend on inherent personality characteristics or on direct experiences. We now need to begin to empirically test our predictions from this model.

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