Community mental health nurses in Wales: self-reported stressors and coping strategies

P. BURNARD[1] PhD MSc RMN RGN RNT DipN CertEd, D. EDWARDS[2] MPhil BSc(Hons), A. FOTHERGILL[3] PhD BSc(Hons) PGCE RMN RGN, B. HANNIGAN[3] MA BA(Hons) RMN RGN DPSN(CPN) & D. COYLE[3] MEd RMN RNLD CertEd(FE)

[1]Professor and Vice Dean, [2]Lead Researcher and [3]Lecturer, School of Nursing & Midwifery Studies, University of Wales College of Medicine, Heath Park, Cardiff, CF14 4XN, Wales, UK

Correspondence:
P. Burnard
School of Nursing and Midwifery Studies
University of Wales College of Medicine
Heath Park
Cardiff
CF14 4XN
Wales
UK

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Community mental health nurses in Wales: self-reported stressors and coping strategies

There is evidence to suggest that community mental health nurses experience stress and burnout related to their work. Previous research has been limited by a number of methodological problems. One of the problems is that studies have tended to have small or unrepresentative samples, and many researchers have only examined mental health nurses as a subset within their research, which limits the generalizability of the findings. The All-Wales Community Mental Health Nurse (CMHN) Stress Study was set up in order to address this issue. The total population of CMHNs in Wales was surveyed (N = 614) and 301 (49%) responded. The questionnaire booklet contained a number of validated instruments to measure stress, burnout, and coping, together with a demographic questionnaire. The demographic questionnaire included three open ended-questions. These questions were asked in order in determine the CMHNs' own views of the sources of stress in the workplace, and to investigate which methods they use to cope. This paper reports the findings from the content analysis of the three questions. The results from the other measures are reported in the companion paper (Edwards *et al*. 2000). The most frequently cited stressors included perceived workload, excessive paperwork and administration, and a broad spectrum of client-related issues. Coping strategies that CMHNs reported using included peer support, a range of personal strategies such as relaxation, and belief in self and supervision. It appears from the findings that a range of factors such as organizational pressures and factors related to working with patients are important in determining stress levels, and that informal rather than formal support networks are the preferred methods of coping.

Keywords: burnout, community mental health nurses, coping strategies, occupational stress

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Introduction

There is evidence that community mental health nurses experience stress and burnout related to their work (Parahoo 1991, Schafer 1992, Fagin *et al*. 1995, McLeod 1997, Snelgrove 1998, Drake & Brumblecombe 1999).

Previous researchers have identified mental health nurses and community mental health nurses (CMHNs) and speech therapists as the professional groups with the highest degree of stress within the helping professions (Rees & Smith 1991). There is considerable documentation of the sources of stress and burnout within the nursing

profession (see, for example, Guppy & Gutheridge 1991, Duquette *et al.* 1994). Sutherland & Cooper (1990) and Dunn & Ritter (1995) suggest that mental health nurses share many of the stressors that affect general nurses, but that they also face a number of additional stressors.

A recent review of the literature on stress and burnout amongst CMHNs identified a number of specific stressors. These included increases in workload and administration, time management, inappropriate referrals, safety issues, role conflict, role ambiguity, lack of supervision, not having enough time for personal study, NHS reforms, general working conditions, lack of funding, and resources (Edwards *et al.* 2000).

It has been suggested that research on stress in mental health nursing is limited by a number of methodological problems. One of the problems is that studies tend to have small or unrepresentative samples and many researchers have only examined mental health nurses as a subset within their research, which limits the generalizability of the findings (Carson *et al.* 1996). Dunn & Ritter (1995) have suggested that a number of studies have used their own research instruments, which have not been tested for validity and reliability, in order to measure stress and burnout. To address some of the criticisms, the current study was planned to survey the total population of CMHNs in Wales in the year 1998–9. The study has used a number of validated measures and is the largest of its kind conducted to date.

Methods

Six hundred and fourteen qualified CMHNs from ten NHS Trusts in Wales were surveyed. Three hundred and one questionnaires were returned, representing a 49% response rate.

Detailed descriptions of the methodology and analysis of the items included in the questionnaire are reported elsewhere (Edwards *et al.* 2000). Briefly, the questionnaire booklet comprised a demographic questionnaire, the General Health Questionnaire GHQ-12 (Goldberg & Williams 1988), the Maslach Burnout Inventory (Maslach *et al.* 1996), the modified Rosenberg Self-Esteem Scale (Wycherley 1987), the CPN Stress Questionnaire (Revised) (Brown *et al.* 1995), and the PsychNurse Coping Questionnaire (McElfatrick *et al.* 2000).

This paper is concerned with the responses to the following three open-ended questions which were presented in the demographic questionnaire:

- What are the three things that cause you most stress?
- What would you say was the most stressful thing that has happened to you at work in the last month?
- What factors do you feel help you to cope with your job as a CMHN?

Analysis

The responses to these questions were collated and subjected to content analysis. This method of analysing the data was based on one outlined by Burnard (1991), and described as 'thematic content analysis'. First, all of the responses to each question were collated. Second, any repetition of themes was removed from each of the data sets, thus reducing the volume of the text. Third, responses were clustered together under thematic headings with the aim of each category heading being discrete. Fourth, the complete data sets were revisited and coded using the category system. The authors then diverged from Burnard's method in that the items under each category were counted. In the tables that follow, each table identifies the number of references to a particular category, and the categories are rank-ordered by numbers of responses, and their percentage rating is recorded.

Given the nature of this form of analysis, care must always be taken in reading such tables. The data are nominal and the category system is, at least to some degree, subjective (although objectivity was sought for the construction of the system through the involvement of two researchers).

However, the method does allow the researcher and the reader to identify the regularity with which responses were given and also identifies the range of responses. With this in mind, then, the analysis used in this study echoes the definition of content analysis offered by Clamp & Gough (1999):

> 'Content analysis: a procedure for analysing written or verbal communication in a systematic and objective fashion, typically with the goal of quantitatively measuring variables' (Clamp & Gough 1999, p. 228).

Results

Sources of most stress

First, respondents were asked to identify, generally, what caused them most stress in their jobs as community mental health nurses. A total of 691 stressors were identified. Table 1 identifies the responses to this question. Workload pressure and caseload pressure have been kept as separate categories; a CMHN could have a 'small' caseload but still feel pressured by the amount of work and time that this entails.

The category 'client-related issues' included, amongst others, a range of factors relating to the following:

- admitting people to hospital;
- aggressive clients clients identified as 'difficult';
- assessing patients;

Table 1
The most stressful aspects of the job as a CMHN

Source of stress	*n*	%
Workload/time related issues	101	14.6
Paperwork and administration	96	13.9
Client-related issues	79	11.4
Case overload	56	8.1
Poor resources	52	7.5
Lack of supervision/support	30	4.3
Role-based issues	24	3.5
Interpersonal issues	23	3.3
Working with other disciplines	20	2.9
Isolation and loneliness	20	2.9
Changes	19	2.8
Staffing issues	19	2.8
Transport problems	17	2.5
Accountability and responsibility	16	2.3
Problems with relatives/carers	16	2.3
Meetings	14	2.0
Attitudes and working styles of managers	13	1.9
Problems with referrals	12	1.7
Other	11	1.6
Working with other agencies	11	1.6
Expectations of others	11	1.6
Education and training issues	11	1.6
Being undervalued	7	1.2
Not able to provide quality care	4	0.5
Job insecurity	4	0.5
Worrying about other people's problems	3	0.4
Weather	2	0.3
Total	691	100.0

- non-compliance with medication;
- client self-harm;
- crisis intervention.

The category *other* included a range of issues; amongst others:

- dealing with housing and accommodation problems;
- discharging vulnerable people;
- ensuring up-to-date care places;
- intense visits about distressing life events;
- attending child care conferences;
- key worker to a patient with a supervision order.

The proportion of total respondents who cited more than one of the top three stressors was 13%.

Sources of stress over time

Second, respondents were asked to record the source of *most* stress over the month prior to completing the questionnaire. There were a total of 257 stressors identified. Table 2 identifies the responses to this question.

The category 'client-centred issues – general' was concerned with non-attendance, difficulties with referrals and non-compliance with medication. The category 'client-centred issues – behavioural' included items such as concerns about safety of clients, feelings of concern about the *nurses'* safety in certain home visits, coping with disturbances in the home, and dealing with suicidal behaviour.

Table 2
Sources of stress in past month

Source of stress	*n*	%
Client-centred issues – general	43	16.7
Client-centred issues – behavioural	26	10.1
Paperwork/administration	22	8.6
Concerns surrounding other agencies/disciplines	21	8.2
Changes in team/trust	21	8.2
Interpersonal problems – colleagues/managers	20	7.8
Covering illness/holiday	16	6.2
Volume of caseload	15	5.8
Issues concerning patients potential/actual suicide	15	5.8
Lack of resources	13	5.1
Time constraints	12	4.7
Other	9	3.5
Managerial responsibilities	9	3.5
Planning for holidays, returning from sick leave/maternity leave	8	3.1
Travel-related issues	7	2.7
Total	257	100.00

The category *other* included a range of issues; amongst others:

- presentation at a national conference;
- recent change of job;
- unsuccessful job interview;
- failure to get a new job;
- training assessments;
- working standby.

Coping strategies

Third, respondents were asked to identify the factors that helped them to cope with stress. Six hundred and sixty-three factors were identified and these are reported in Table 3.

Under the heading of 'personal approaches' there were a number of personal qualities and methods identified that individuals used to cope with stress. These included simply being able to relax, having confidence and belief in one's own abilities. Also included under this heading were a sense of humour as a means of dispelling stress, and having some sort of religious or spiritual conviction.

Discussion

The sources of stress can be divided into two broad categories: those which are related to the demands of working with patients, and those related to other aspects of the work. A picture seems to emerge of community mental

Table 3
Stress coping strategies

Coping strategy	*n*	%
Support (colleagues/managers/other disciplines/other agencies)	285	42.9
Personal approaches	74	11.2
Supervision	66	9.9
Interests and hobbies outside of work	48	7.2
Role as a CMHN	40	6.0
Happy home life	32	4.8
Good administration and organizational skills	25	3.8
Experience (age/maturity)	21	3.2
Education and training issues	19	2.9
Ability to switch off at the end of the day	18	2.7
Being able to take time out	7	1.1
Good knowledge of clients/area	6	0.9
Working part time	5	0.8
Good working environment	5	0.8
Caseload issues	4	0.6
Flexibility	3	0.5
Financial advancement	3	0.4
Looking for other jobs	2	0.3
Total	663	100.00

health nurses who perceive themselves to be overworked, struggling with considerable paperwork and administrative issues, having both too many clients and serious concerns about their client group.

The results from this study concur with the findings from the Claybury stress study (Carson *et al*. 1995). Here the authors found that caseload, paperwork/administration and management problems were the most stressful aspects of the job as a CMHN. Reid *et al*. (1999) have demonstrated such stressors to be common to all mental health staff, but that community staff appear to have extensive scope for autonomous work, and feel that they are expected to take on considerable responsibility.

One suggestion to help CMHNs with their work overload would be to reduce the size of their caseloads. In order to implement care in the community effectively, Wattereus *et al*. (1994) recommends that individual caseloads must be of a manageable size, i.e. 15–20 patients (Intagliata 1992). If this is exceeded, Wattereus (1994) stresses that there will be less time available for each patient, visits become less frequent and the nurses become reactive rather than proactive. However, research has shown that reducing the size of caseloads is not necessarily the answer to reducing stress in staff; Holloway *et al*. (1996) recommend that it might be helpful for staff to have more balanced caseloads, consisting of people experiencing a mixture of severe and less severe problems, and the facility to be able to share the responsibility for the more difficult and worrying clients. On the other hand, it may not be practical to vary the allocation of clients in that way, particularly in large rural areas.

When CMHNs were asked to state what had caused the most stress in the previous month, it was difficulties arising from relationships with clients that came out as the main source of stress. Coffey (1999) also identified managing difficult patients as the main cause of stress for forensic CMHNs.

Notable, in this section, was the reference to client aggression. Whittington & Wykes (1992) report a series of studies of violence amongst inpatients in a mental hospital. They found that apparently minor episodes of violence could trigger periods of absence from work. They also noted that *social support* was a strong moderator of the adverse affects of violence. We report that respondents in the present study often relied on such social support as a means of moderating stress. In another study, Rix (1987) explored the relationship between staff sickness and client violence in a regional secure unit. He found that violence was associated with feelings of vulnerability and frustration in nurses who also went off sick. Levels of absenteeism in Rix's (1987) study were moderated by complex organizational and dispositional factors amongst the nurses. Again, we report similar, although slightly different, findings. It should also be noted that the findings reported by Whittington & Wykes (1992) and Rix (1987) were from studies carried out in inpatient settings.

Models of the stress process inform us those individual characteristics of personality, demographic factors and the use of various coping strategies (Cooper & Baglioni 1988, Cooper *et al*. 1988) moderate the experience of stress. The coping strategies that CMHNs reported using included peer support, personal approaches (which included activities such as relaxation and belief in one's own abilities), good communication skills and receiving clinical supervision. Peer support included support from colleagues, managers, other disciplines and other agencies (42% of all strategies cited). Respondents were often complimentary about the support they received from their managers and colleagues but, also, having a 'satisfactory and supportive life outside of the job' was often identified as a strategy for coping with stress.

Being *supervised* was sometimes quoted a source of de-stressing. Other coping mechanisms included having interests away from work and a 'happy home life'; having good administrative and organizational skills, having had experience of life through age and maturity and education and further training.

Nurses tended to favour informal approaches to coping with occupational stressors; only a small number of CMHNs favoured clinical supervision. This finding is sup-

ported by findings from previous research (Trygstad 1986, Sullivan 1993, Carson *et al*. 1995, Kipping & Hickey 1998, Coffey 1999). The most favoured coping strategy found in all of these studies were support from colleagues, managers or other professionals. This support from colleagues refers to the day-to-day contact with other members of the team and the ability to have impromptu meetings to discuss difficult clients. Coffey (1999) suggests that it is often easier to access the support of colleagues in the office than by using more formal routes such as clinical supervision. Several studies have suggested an association between support from colleagues and increased levels of satisfaction (Pines & Maslach 1977) and reduced 'levels of burnout' (Corrigan *et al*. 1995).

One of the perceived benefits of clinical supervision is the reduction of stress levels (Bishop 1998).

Clinical supervision might be an effective support system in helping nurses process the many challenges they encounter in clinical practice. The benefits of clinical supervision have been described through out the literature. Butterworth *et al*. (1998) identified that clinical supervision could lead to increased feelings of support and personal wellbeing and higher staff morale and satisfaction, leading to a decrease in staff sickness/absence. Clinical supervision has also be identified with increased confidence and decreased incidence of emotional strain and burnout (Hallberg & Norberg 1993). Berg *et al*. (1994) found that the introduction of clinical supervision, which focused on the work itself, led to improvements in creativity and reduction in burnout among nurses.

The reasons why clinical supervision was not favoured in the present study therefore need further investigation, and a series of interviews are planned to investigate this topic in greater depth. Bishop (1998) suggests that there are many problems in setting up clinical supervision, including increasing workloads and time shortages. The most common reason for difficulties in getting clinical supervision up and running in her study was shortage of time. This was mainly attributed to staff shortages and increased activities in contracts.

Limitations of the study

Although this study involved a total population of CMHNs in Wales, the return rate was only 49%. However, Oppenheim (1992) claims this to be a reasonable response to a postal questionnaire.

The authors appreciate that content analysis of textual data is a subjective process and, in the end, the researcher has to stand by his or her development of categories and collation of items within that category system. In this case, the category system was developed and checked by two of the researchers.

Conclusions and recommendations

The effects on individuals of stress and inadequate methods of coping may be problems of mental or physical health and a reduction in job satisfaction. For the organization, the effects of stress may be many, including high absenteeism, poor job performance and reduced efficiency and effectiveness, low staff morale and high staff turnover (Rees & Cooper 1990).

It appears from the findings that a range of factors such as organizational pressures and factors related to working with patients are important in determining stress levels, and that informal rather than formal support networks are the preferred methods of coping.

The apparent preference for *informal* rather than *formal* support networks is an issue that warrants further investigation. While informal supervision has been identified as being generally important in mental health nursing (Butterworth *et al*. 1998), it has not been so readily identified as a coping device in the community mental health nursing literature. Thus, it may be useful to explore the ways in which CMHNs make best use of these informal networks.

The current research team has planned an in-depth *qualitative* study of a sample of the total population described in this paper. It is hoped that such a study will allow a more in-depth view of how CMHNs in Wales organize their work and manage their stress.

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