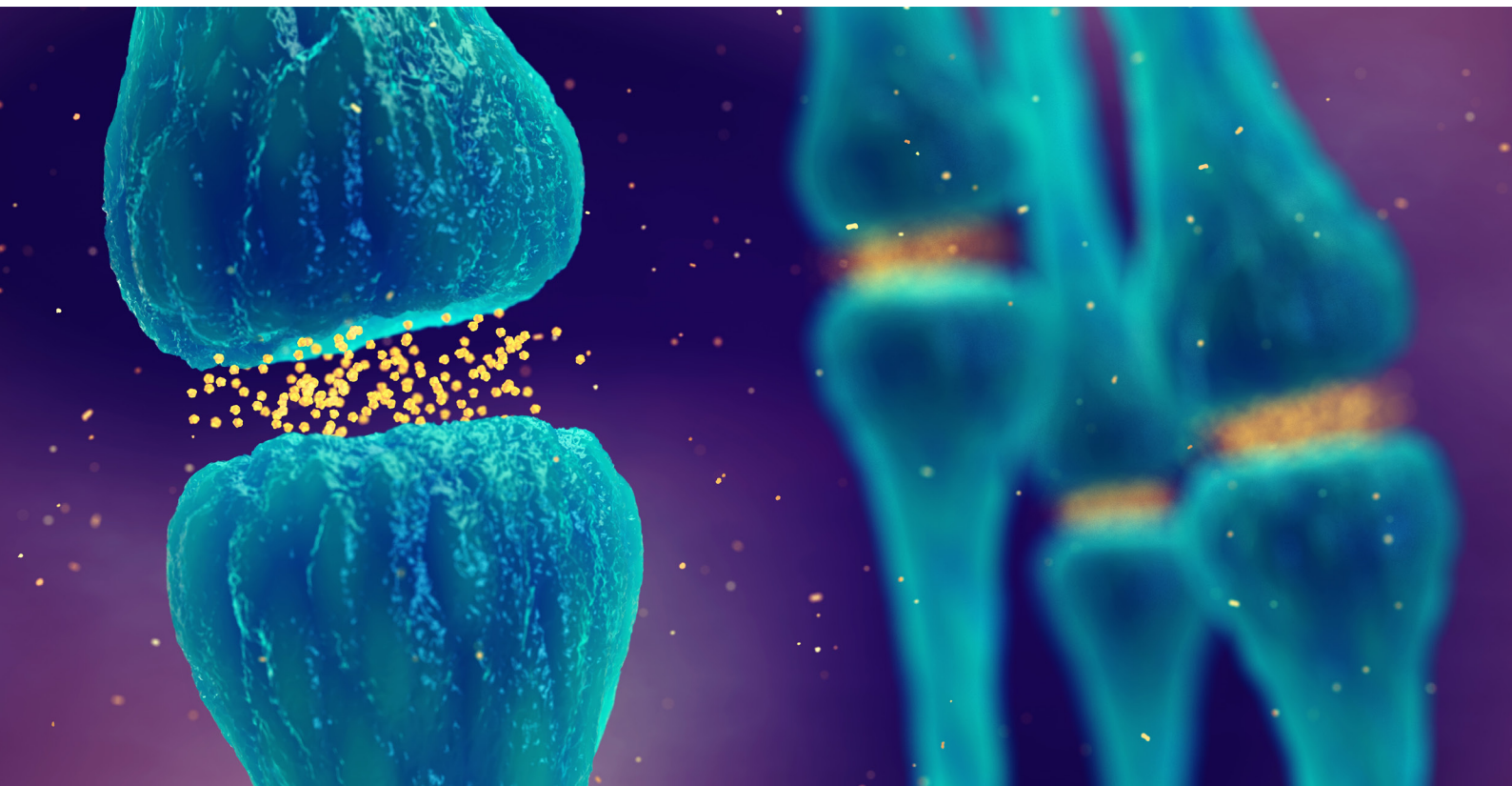




Bulletin Of The International Institute Of Organisational Psychological Medicine (IIOPM)



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A Bulletin devoted to promoting positive mental health, research and awareness in the field of Organisational Psychological Medicine

The Institute applies psychological medicine principles to the human elements in the work place and combines the specialties of Psychological Medicine, Administration and Management
The paradigm shift in Human Capital Management and Potential Enhancement

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The IOPM BULLETIN

Table of Contents

TITLE	AUTHORS	Page No:
Editorial	Professor Srikanth Nimmagadda	03
Board of Executive Directors		05
Moral Injury, Medical Workforce and Productivity	Professor Dr Russell Franco Dsouza	08
Presenteeism in Hospitals - Its Impact on Patient Care & Safety	Dr Deepak Singla Dr Bharathi Saxena Mr Amit Mahajan	11
Anxiety in Nurses Caring for People Afflicted with Cancer; Observations from a Speciality Hospital	Manjeshwar Shrinath Baliga Suresh Rao Mintu Mathew Prathima Rao Ovine Loyester D'souza Professor Russell D'Souza	17
Burnout and Coping in a Low and Medium Secure Hospital	Leanne K Dobson Mike J Berry	21
Compassion Satisfaction, Compassion Fatigue and Burnout: The Influence of Personality	Nicole Thordason John Atkinson	33
Corporate Mental Health – Why It Matters?	Pragya Lodha Dr Avinash De Sousa	41
Personality Types and Burnout in Forensic Psychiatric Staff	Miss Grace Day Miss Natalie Butcher Mr John Atkinson	45
The Trajectory of Child Sexual Abuse and Its Impact on Workplace Mental Health	Pragya Lodha Dr Avinash De Sousa	52
Developing and Embedding a Trauma Informed Clinical Model within a Forensic Service	Kerry Hinsby Anthony Owens Jane Ellis, Claire Layton	56
Does Emotional Intelligence Medicate the Relationship between Resilience and Burnout Amongst Prison Staff?	Charlotte Mayo Dr Jane Clarbourn Anthony Oliver John Atkinson	65
The Millennial Burnout – An Important Phenomenon	Pragya Lodha Dr Avinash De Sousa	73
Compassion Fatigue in Indian Psychotherapists	Dr Poovishnu Devi	77

Editorial

Professor Srikanth Nimmagadda
Professor of Psychological Medicine, IOPM
Director of the Academic Unit, IOPM
Cheswold Park Hospital, Doncaster, UK

I am extremely pleased to bring out the fourth edition of the bulletin of the International Institute of Organisational Psychological Medicine (IOPM). This bulletin is aimed to produce a globally contributed and globally relevant collection of articles, which comprehensively covers major themes comprising the field of organisational psychological medicine. The main objective of this bulletin is to advance our understanding and knowledge of many different approaches to human capital management in organisations. This edition incorporates expanded discussions and new research findings, and of selected human capital potential themes including positive psychological capacities, leadership, fatigue, physician burn out, embitterment, and compassion fatigue etc.

The main objective of the IOPM is to enhance the potential of human capital in the organisations and to achieve this by preventing, identifying, and managing workplace related psychological pathologies in the human capital. The branch of Organisational Psychological Medicine's scope of practice expands from the diagnosis and management of workplace-related psychological disorders to the added sphere of preventive psychological medicine, resilience and positive psychological medicine applied to the human capital within organisations. These include population health initiatives of developing programs that will enhance the outcomes of human capital of organisations. Thus, the discipline benefits the bottom line of both the individual and the organisation. It also broadens its horizons to encompass corporate social responsibility in this area and leadership along with the enhancement of human capital.

The psychological health of human capital in organisations can be impacted by the workplace and beyond. Poor psychological health results in poor outcomes in terms of the performance of both an organisation and its staff. Various studies on burn out and demoralisation of the human capital concluded that psychopathological sequelae resulted in the decreased efficiency and productivity of the workforce. Other studies have concluded that embitterment in the workplace resulted in psychopathological embitterment post-traumatic stress disorder. This sets into motion a vicious cycle, i.e., workplace-related psychiatric pathology impacts on outcomes and results in recruitment difficulties and poor retention of staff. This in turn negatively affects the need for good talent management for increased productivity in the organisations.

The connection between psychological health and job performance is widely known. Many organisations are now realising that success can only be achieved with a healthy workforce. The implementation of healthy living initiatives benefits both employees and employers in any organisation. A healthy workforce results in reduced downtime due to illness, improves morale, increases productivity and high employee retention in any Organisation. In turn the workforce, i.e. the human capital will get the benefits of increased job satisfaction and improve ability to handle stress. For example, Twitter, the social media giant encourages its employees at its San Francisco headquarters to stay healthy by offering onsite Yoga, Pilates and Cross Fit classes. One of the HR and Wellness programme managers at Twitter said

'attitude and energy we all bring to work is so important to our culture. But such energy can make us susceptible to fatigue and burnout. Twitter aims to avoid this by offering diverse fitness and wellness programmes to encourage renewal, so that as employees we can manage our energy better and get more done in a sustainable way', (Evans, Lisa. 'What three companies are doing to keep employees healthy.' Entrepreneur, March 15, 2013).

According to the Institute of Stress, employers lose 300 billion annually due to excessive worker stress. This is before the impact of health care costs which are nearly 50 per cent higher for workers reporting high levels of stress. Given these numbers, stress management/reduction programmes are getting more attention in the business communities. Research has highlighted that main stressors at work include a long-hours culture, lack of work life balance, lack of engagement, job insecurity, abusive and poor line management etc.

There is strong research evidence coming from various parts of the world that presenteeism is double the cost of absenteeism, with people turning up to work ill for fear of job loss, and ultimately burning themselves out and contributing little added value to their job and organisation. Companies are making various efforts to reduce stress in the workplace. Some of the programmes include the following: Assistance with time management; assistance with financial wellness; time off for exercise; and time off for meditation. Whilst the value of these programmes may remain questionable to some extent, the employers have recognised that stress arising from the workplace, impact the bottom line and are taking action as a result.

I shall highlight some of the work and initiatives undertaken by the Institute and the future in the next few paragraphs. The Institute has established active academic links with various renowned universities and organisations across the globe and continues to expand in various parts of the world. The Institute already has a memorandum of understanding (MoU) with a range of academic institutions and healthcare universities in USA, UK, India and Australia. Over the past year, the Institute has held human capital management conferences/seminars meetings in Doncaster (UK), Hyderabad (India) and Western Michigan University (USA). A stand-alone conference in October 2018 in Doncaster was a huge success with more than 170 delegates and speakers representing 5 continents. There were presentations on a range of topics, ranging from presenteeism, post embitterment syndrome, role of transcranial magnetic stimulation in burn out, emotional intelligent leadership, burnout and several research presentations. We had another IOPM international seminar in Hyderabad, India in 2018 and a recent IOPM conference in University of Western Michigan, Kalamazoo, USA in September 2019. The presentations were a resounding success and participants have realised the importance of some of the key issues that are relevant to improving the morale and the emotional and psychological health of employees in organisations. There was tremendous response and interest from various psychiatrists, senior managers, and doctors from other specialities. The scientific presentations essentially focused on human capital management based on a psychological approach and were hugely successful. The events enabled the participants to gain insight and understanding into key issues relating to the human capital management practices in organisations and learn ways to promote resilience and productivity of the workforce.

The IOPM board has designated Cheswold Park Hospital to hold the academic centre of the IOPM with an objective of various academic activities and programmes to be co-ordinated from this centre. Various research projects are underway in various parts of the world including research study on the efficacy of transcranial magnetic stimulation in improving burnout and stress, and other research studies in relation to coping, burnout, compassion fatigue etc in mainly staff groups in organisations.

The Institute signed an agreement with Oxford University Press and is working towards publishing the first textbook on Organisational Psychological Medicine. We are currently working with the contributing authors for relevant chapters and hoping that book will be published in the next 12-15 months. The textbook will provide an overview of this evolving discipline and will bring together the expanding research base covering the study of psychiatric and psychological pathology in the workplace and its prevention.

The Institute has honoured various senior psychiatrists and management professionals in health care organisations with a fellowship after they met the necessary requirements of rules and bye laws of the institute. The Institute has achieved a critical mass of Members and Fellows who are in positions of seniority in various fields of leadership, management and involved in enhancing significant capital productivity in respective organisations. With this human capital potential of the IOPM, the institute wishes to make more progress forward, for example, developing training packages that would assist organisations in terms of improving employee emotional wellbeing in various domains.

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Moral Injury, Medical Workforce and Productivity

Professor Dr Russell Franco Dsouza

Dean and Professor of Organisational Psychological Medicine, IOPM, Melbourne Australia

Introduction

Since Don Berwick and colleagues introduced the Triple Aim into the health care lexicon, this concept has spread to all corners of the health care system. The Triple Aim is an approach to optimising health system performance, proposing that health care institutions simultaneously pursue three dimensions of performance: improving the health of populations, enhancing the patient experience of care, and reducing the per capita cost of health care. 1 The primary Triple Aim goal is to improve the health of the population, with 2 secondary goals — improving patient experience and reducing costs— contributing to the achievement of the primary goal.

There are now statements such as, “We have adopted the Triple Aim as our framework, but the stressful work life of our clinicians and staff impacts on our ability to achieve the three aims.” These sentiments take to considering a fourth aim — improving the work life of health care clinicians and staff — that, like the patient experience and cost reduction aims, must be achieved in order to succeed in improving productivity in the population health. The Triple Aim is now to become the Quadruple Aim.

Medical workforce on the front lines of health care today are described as going to battle. It is an apt metaphor. Physicians, like combat soldiers, often face a profound and unrecognised threat to their wellbeing: moral injury.

Moral injury is frequently mischaracterised. In combat veterans it is diagnosed as post-traumatic stress; among physicians can be portrayed as burnout. But without understanding the critical difference between burnout and moral injury, the wounds will never heal, and physicians and patients alike will continue to suffer the consequences of personal and organisational lost productivity.

Burnout is a constellation of symptoms such as experiencing emotional exhaustion, depersonalisation, and feelings of low achievement and decreased effectiveness. Burnout is also a serious problem for doctors, nurses and other health care workers. Burnout also includes exhaustion, cynicism, and decreased productivity. More than half of physicians report at least one of these, but the concept of burnout resonates poorly with physician, nurses and health care workforce as it might suggest a failure of resourcefulness and resilience, traits that most physicians have finely honed during decades of intense training and demanding work. Even at the Mayo Clinic, which has been tracking, investigating, and addressing burnout for more than a decade, one-third of physicians report its symptoms.

There are considerations that burnout is itself a symptom of something larger: a broken health care system. The increasingly complex web of providers, highly conflicted allegiances — to patients, to self, and to employers — and its attendant moral injury may be driving the health care ecosystem to a tipping point and causing the collapse of human capital’s resilience.

The term “moral injury” was first used to describe soldiers’ responses to their actions in war.² It represents “perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations.”³ Journalist Diane Silver describes it as “a deep soul wound that pierces a person’s identity, sense of morality, and relationship to society.”

The moral injury of health care is not the offense of killing another human in the context of war. It is being unable to provide high-quality care and healing in the context of health care.

Most physicians enter medicine following a calling rather than a career path. They go into the field with a desire to help people. Many approach it with almost religious zeal, enduring lost sleep, lost years of young adulthood, huge opportunity costs, family strain, financial instability, disregard for personal health, and a multitude of other challenges. Each hurdle offers a lesson in endurance in the service of one's goal which, starting in the third year of medical school, is sharply focused on ensuring the best care for one's patients. Failing to consistently meet patients' needs has a profound impact on physician wellbeing — this is the crux of consequent moral injury. 4,5

In an increasingly business-oriented and profit-driven health care environment, physicians must consider a multitude of factors other than their patients' best interests when deciding on treatment. Financial considerations of hospitals, health care systems, insurers, patients, and sometimes of the physician himself or herself. This leads to conflicts of interest. Electronic health records, which distract from patient encounters and fragment care, but which are extraordinarily effective at tracking productivity and other health business metrics, overwhelm busy physicians with tasks unrelated to providing outstanding face-to-face interactions. The constant spectre of litigation drives physicians to over-test, over-read, and over-react to results, even at times actively harming patients to avoid lawsuits.

Patient satisfaction scores and provider rating and review sites can give patients more information about choosing a physician, a hospital, or a health care system. But these can also silence physicians from providing necessary but unwelcome advice to patients and can lead to over-treatment to keep some patients satisfied. Business practices may drive providers to refer patients within their own systems, even knowing that doing so will might delay care or at times that their equipment or staffing is sub-optimal for the encounter.

Navigating an ethical path amidst these intensely competing drivers is emotionally and morally exhausting. Continually being caught between the Hippocratic oath, a decade of training, and the realities of making an earning from people at their sickest and most vulnerable is an untenable and difficult demand. Routinely experiencing the suffering, anguish, and loss of being unable to deliver the care that patients need is deeply painful. These routine, incessant betrayals of patient care and trust are examples of “death by a thousand cuts.” Any one of them, delivered alone, might heal. But repeated on a regular basis, they coalesce into the moral injury of health care workforce.

Physicians are generally smart, tough, durable, resourceful people. If there was a way for them to find a way to make-shift themselves out of this situation by working harder, smarter, or differently, it is most likely that they would have done it already. Many physicians contemplate leaving health care altogether, but most do not for a variety of reasons: little cross-training for alternative careers, debt, and a commitment to their calling. Thus, they stay most times in this wounded, disengaged, and increasingly hopeless treadmill.

In order to ensure that compassionate, engaged, highly skilled physicians and health care work force are leading patient care, executives in the health care system must recognise and then acknowledge that this is not physician burnout. Physicians are rather the canaries in the health care mine, and they are killing themselves at alarming rates (twice that of active duty military members) signaling that something might be desperately wrong with the workplace.⁶

The simple solution of establishing wellness programs or hiring corporate wellness officers is unlikely to solve the problem. Nor will pushing the solution onto providers by switching them to team-based care; creating flexible schedules and float pools for provider emergencies; getting health work force to practice mindfulness, meditation, and relaxation techniques or participate in cognitive-behaviour therapy and resilience training is likely to bring relief in response to emotional distress crises. Such practices provide the same support that first responders provide in disaster zones, but the “disaster zones” where they work are the everyday operations in many of the country's major medical centres. None of these measures are geared to change the institutional patterns that inflict moral injuries.

Health care system leadership willing to acknowledge the human costs and moral injury of multiple competing allegiances will be a start to mitigating this moral distress and moral injury. This leadership must also have the courage to confront and minimise those competing demands. Physicians and health care workforce could be treated with respect, autonomy, and the authority to make rational, safe, evidence-based, and financially responsible decisions.

Health care leadership that recognises that caring for their medical and health care work force will result in thoughtful, compassionate care for patients, which ultimately is good business. Senior medical workforce whose knowledge and skills transcend the next business cycle might be treated with loyalty and not as a replaceable, depreciating asset to the health care service.

Patients must be empowered to ask what is best for their care and then demand that their insurer or hospital or health care system provide it. The digital mammogram, the experienced surgeon, the timely transfer, without the best interest of the business entity (insurer, hospital, health care system, or physician) always overriding what is best for the patient.

Finally, a truly free market of insurers and providers, is one without financial obligations being pushed to providers, which would allow for self-regulation and patient-driven care. These would enable creating a win-win where the wellness of patients correlates with the wellness of providers. In this way there can be mitigation of the ongoing moral injury to medical and health care work force associated with the business of health care.

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Presenteeism in Hospitals - Its Impact on Patient Care & Safety

Dr Deepak Singla, Medical Director; Maharaja Agrasen Hospital, Punjabi Bagh, New Delhi

Dr Bharathi Saxena, Joint Medical Superintendent, Maharaja Agrasen Hospital, Punjabi Bagh, New Delhi

Mr Amit Mahajan, PhD Research Scholar, Manav Rachna University, Faridabad (Corresponding Author)

Background

The healthcare industry always has concerns regarding absenteeism; and therefore, spent time, efforts and money to control absenteeism. Many researchers had focused their attention of the cost which the company is incurring because of absenteeism and also researched on the methods to control and reduce absenteeism. Recently, the companies had realised that there is another issue which require immediate attention i.e. Presenteeism¹. Presenteeism is coming to work when sick or suffering from any other condition which prevents the employee to work with full productivity².

In hospital scenario, if an employee is sick and still reporting to the duty; he is not only adversely impacting the productivity but also putting the patient at risk of acquiring infection from him/her. The patients in the hospital setting are vulnerable and are susceptible to acquire infection very easily. Many researchers have already proven that hospital acquired infections (HAQ) are among the most common complications of medical care among the patients admitted in the hospitals. HAQ is responsible for the increase in morbidity, mortality, and costs. The transmission of infectious diseases in health care facilities, where there is frequently a high concentration of individuals with immuno-suppression, severe chronic disease, or vulnerability due to age, is a major threat to patient safety³. Although infection prevention efforts have traditionally focused on preventing transmission of infection between patients, increased attention has been paid to another vector: sick health care workers⁴.

Presenteeism: What is it?

In the early literature i.e. till 1970s, the term ‘Presenteeism’ was clearly meant either to be the literal antonym of absenteeism, or to connote excellent attendance. It remained until the 1980s for more contemporary definitions to emerge, and, in fact, until the current millennium for the most contemporary. Table 1 summarises nine definitions of presenteeism given or implied in the literature, with illustrative references. It can be seen that although all of the definitions pertain to being physically present at work, they differ to a greater or lesser extent from each other, occasioning potential confusion. Presenteeism is variously portrayed as good, somewhat obsessive, at odds with one’s health status, and often less than fully productive³.

Table 1. Definitions of Presenteeism

Smith (1970)	Attending work, as opposed to being absent
Canfield & Soash, (1955); Stolz (1993)	Exhibiting excellent attendance
Simpson (1998); Worrall et al.	Working elevated hours, thus putting in “face time,” even when

¹Marcos C. Baptista, Wayne N. Burton, Andressa Kutschenko Nahas, Wang Yuan-Pang, Maria Carmen Viana and Laura Helena Andrade, Absenteeism and Presenteeism Associated with Common Health Conditions in Brazilian Workers, *Journal of Occupational and Environmental Medicine*, DOI: 10.1097/JOM.0000000000001538, (1), (2019).

²Agata Wężyk and Karolina Czarnecka, Presenteeism Among Healthcare Sector Specialists, *Healthcare Policy and Reform*, DOI: 10.4018/978-1-5225-6915-2.ch060, (1300-1321), (2019).

³Mayon-White, R. T., et al. “An international survey of the prevalence of hospital-acquired infection.” *Journal of Hospital Infection* 11 (1988): 43-48.

⁴Julia E. Szymczak, *Health Care Worker Presenteeism: A Challenge for Patient Safety*, Patient Safety Network, (2017).

(2000)	unfit
Sheridan (2004)	Being reluctant to work part time rather than full time
Kivimäki et al. (2005)	Being unhealthy but exhibiting no sickness absenteeism
Aronsson et al. 2000; Dew et al. (2005)	Going to work despite feeling unhealthy
Evans, (2004); Johansson & Lundberg, (2004)	Going to work despite feeling unhealthy or experiencing other events that might normally compel absence (e.g., childcare problems)
Turpin et al., 2004	Reduced productivity at work due to health problems
Hummer, Sherman, & Quinn, (2002); Whitehouse, (2005)	Reduced productivity at work due to health problems or other events that distract one from full productivity (e.g. office politics)

(Source: Johns, *Presenteeism in the workplace: A review and research agenda*⁵)

A good way to describe presenteeism is being present at the workplace but not being productive due to an illness, lack of motivation, or work overload. Presenteeism can cause a large variety of work related issues. An example of this would be having an employee come into work with a bad cold or the flu. The major issue with employees that suffer from presenteeism for companies is it costs the same amount in wages and benefits for them, as it does for those working at full capacity. So, the cost is the same while the output of work is reduced. As such, any resulting productivity loss implies productivity in comparison to what one would exhibit without the medical condition (e.g., outside the hay fever season); compared to being absent, a presentee might be relatively (or even fully) productive. Similar to the act of presenteeism, diverse motives might also underpin unequal degrees of productivity loss exhibited by people with ostensibly identical medical conditions⁶.

Impact of Presenteeism on Employees

From an employee perspective, presenteeism is important in that it might exacerbate existing medical conditions, damage the quality of working life, and lead to impressions of ineffectiveness at work due to reduced productivity⁷. In addition, many organisational practices and policies that are designed to curtail absenteeism could in fact stimulate attendance while sick. On the other hand, under some circumstances, presenteeism might be viewed as an act of organisational citizenship and garner praise. Hence, focusing narrowly on productivity loss, as opposed to productivity gain compared to absenteeism, is unduly restrictive.

Impact of Presenteeism on Employees

From an organisational viewpoint, Hemp⁹ opines that the relative invisibility of presenteeism compared to absence makes its management an important source of competitive advantage, especially given an estimated \$150 billion cost in the US alone. The vehicle for this is said to be state-of-the-art pharmaceutical treatment that attenuates productivity loss when attending while ill: ‘Emerging evidence suggests that relatively small investments in screening, treatment, and education can reap substantial productivity gains’ (p. 50). Indeed, Burton, Morrison, and

⁵ Johns, G., Presenteeism in the workplace: A review and research agenda. *Journal of Organisational Behaviour*. DOI: 10.1002/job.630, (31, 519–542), (2010).

⁶ Johns, Gary. “Presenteeism in the workplace: A review and research agenda.” *Journal of Organisational Behavior* 31.4 (2010): 519-542.

⁷ Dew, Kevin, Vera Keefe, and Keitha Small. “‘Choosing’ to work when sick: workplace presenteeism.” *Social science & medicine* 60.10 (2005): 2273-2282.

⁸ Schultz, A. B., & Edington, D. W. Employee health and presenteeism: A systematic review. *Journal of Occupational Rehabilitation*, (17, 547–579), (2007).

⁹ Hemp, P. Presenteeism: At work—But out of it. *Harvard Business Review*, (82, 49–58), (2004).

Wertheimer¹⁰ review evidence that pharmaceuticals can stem productivity loss accompanying presenteeism. Most researched medical conditions are episodic or chronic problems such as depression, migraine, and allergies. However, the specter of contagion due to acute medical conditions is also a source of worry, and an outbreak of the deadly sudden acute respiratory syndrome (SARS) in Toronto in 2003 prompted much public concern about employees (including medical personnel) showing up at work while exhibiting typical symptoms¹¹.

Presenteeism and its Consequences in Hospital Setting

In particular, presenteeism has been linked to negative impact for staff members in previous literature. The literature has established factors like poor mental and physical health but there is little evidence regarding whether employees who attend work while unwell are more prone to making errors. Errors can have important consequences, particularly for those working in safety-critical occupations. Yet while stressors that cause workers’ health to suffer have been implicated more generally as key predictors of worker errors, the link between presenteeism and making errors is currently poorly understood. Moreover, there are many occupational groups for whom the consequences of presenteeism have yet to be identified. For example, while presenteeism is known to be most prevalent among health care professionals, little research has focused on direct healthcare staff like nurses, doctors and pharmacists. Not only this staff might experience negative consequences for their own health if they attend work while unwell, but there may also be grave implications for the patients; as an increase in employee errors could potentially lead to fatal consequences¹².

When direct health care workers, like nurses and doctors provide care while experiencing symptoms of infectious disease, they put their patients and colleagues at risk¹³. A symptomatic health care worker can transmit pathogens directly to others; contaminate shared, high-touch surfaces; and experience impaired judgment based on the severity of their illness. There are numerous reports of outbreaks within health care facilities for which sick health care workers have been identified as the primary source of disease from pathogens.

Previous Research

Despite how risky health care worker presenteeism is for patients, it commonly occurs. When health care workers from different occupational roles have been surveyed by Szymczak et al. (2015), 50%–90% of them report that they have worked or would work while experiencing significant symptoms of infection. In a survey study of 536 attending physicians and advanced practice clinicians at a large children's hospital, 83% reported working sick at least once in the past year, 9% reported having worked sick more than 5 times in the past year, 55% said that they would come to work with the acute onset of significant respiratory symptoms, and 30% reported they would work while experiencing diarrhea¹⁴. In a multihospital survey study conducted by Jena et al. (2010), of internal medicine, pediatric, general surgery, and obstetrics/gynecology residents, the authors found that 58% of residents reported working when sick at least once and 31% reported doing so more than once in the previous year¹⁵. Though it has been demonstrated that all

¹⁰ Burton, W. N., Morrison, A., & Wertheimer, A. I. Pharmaceuticals and worker productivity loss: A critical review of the literature. *Journal of Occupational and Environmental Medicine*, (45, 610–621), (2003).

¹¹ Owens, A. M. Disease is making a virtue of absenteeism. *National Post* (22 April 2003). pp. A1, A5, (2003).

¹² Vidyarthi, A. R., Auerbach, A. D., Wachter, R. M., & Katz, P. P. The impact of duty hours on resident self-reports of errors. *Journal of General Internal Medicine*, 22,205-209, (2007).

¹³ Huttunen R, Syrjänen J. Healthcare workers as vectors of infectious diseases. *European Journal of Clinical Microbiology & Infectious Diseases*. (33:1477-1488), (2014).

¹⁴ Szymczak JE, Smathers S, Hoegg C, Klieger S, Coffin SE, Sammons JS. Reasons why physicians and advanced practice clinicians work while sick: a mixed-methods analysis. *JAMA Pediatr*. 2015; 169:815-821.

¹⁵ Jena AB, Baldwin DC Jr, Daugherty SR, Meltzer DO, Arora VM. Presenteeism among resident physicians. *JAMA*. 2010; 304:1166-1168.

health care workers report coming to work while sick at times, physicians typically do so with a higher frequency than other occupational groups.

Chiu et al. (2016) used a national internet survey of 1,914 healthcare workers during the 2014–15 influenza season to calculate the frequency of working with self-reported ILI. Of 414 (21.6% overall) healthcare workers reporting ILI during the 2014–15 season, 183 (41.4%) reported working with ILI (median: 3 days). Pharmacists (67.2%) and physicians (63.2%) had the highest frequency of working with ILI. By setting, hospital-based workers had the highest frequency of working with ILI (49.3%). The most common reasons for working while ill included the following:

- still being able to perform job duties,
- not feeling bad enough to miss work,
- having a professional obligation to co-workers, and
- difficult to find coverage.

Research has shown that in occupations, such as doctors, nursing, pharmacist; poor performance at work can have serious consequences for patient safety.

Conclusion

Illness is an inevitable part of the human condition. Taking time off work due to illness (i.e., absenteeism) may be inconvenient to both workers and their employing organizations, due to issues including increased workload on return to work and difficulties and costs associated with finding replacements. For such reasons, a trend termed “presenteeism” is emerging in organisations, whereby people continue to attend work even when they are ill. Although at first glance presenteeism appears to address some of the issues associated with absenteeism, it may lead to other problems. Research suggests that attending work while unwell can reduce workers’ productivity, worsen the health of presentee workers, and lead to the spread of illness and may therefore have even greater costs than absenteeism.

The emerging trend toward staying at work when unwell may offset some of the more immediate costs associated with absenteeism, such as replacing staff. This trend could have devastating consequences for the well-being of healthcare workers and their patients. Reducing presenteeism and its associated concerns should therefore be on high priority for policy makers. Present scenario demands for monitoring the health of employees who are attending work and to establish whether there is any external pressure (e.g., from managers) or internal pressure (e.g., fear of losing one’s job) to attend work even when unwell. Any organisational practices that put undue pressure on employees to be present when unwell (e.g., policies whereby sick leave is prohibited unless a replacement can be found) should be strongly discouraged.

This concept analysis adds to the current literature on presenteeism by exploring both the concept within the healthcare workforce and in the larger business contexts. Future work is needed to explore the role of culture, measurement of different antecedents and consequences of presenteeism, and interventions to address presenteeism are needed in addition to work on the prevalence of presenteeism.

¹⁶ Chiu S, Black CL, Yue X, et al. Working with influenza-like illness: presenteeism among US health care personnel during the 2014–2015 influenza season. *Am J Infect Control*. 2017; 45:1254-1258.

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Anxiety in Nurses Caring for People Afflicted with Cancer: Observations from a Specialty Hospital

Manjeshwar Shrinath Baliga, Mangalore Institute of Oncology, India
Suresh Rao, Mangalore Institute of Oncology, India
Mintu Mathew, Mangalore Institute of Oncology, India
Prathima Rao, Mangalore Institute of Oncology, India
Ovine Loyster D'souza, Mangalore Institute of Oncology, India
Professor Russell D'Souza, Psychological Medicine, IOPM Australia

Abstract

Nurses working in hospital caring for people afflicted with cancer undergo a lot of anxiety. One of the principal objectives of the management is to mitigate anxiety and stress. In the present study we investigated the levels of anxiety in nurses and compared it by stratifying the accrued data on basis of age (below 25 and above 25 years) and number of years of experience (less than 1; 1.1 to 2 years and more than 2 years' service) using the General Anxiety Disorder-7 (GAD-7) questionnaire. The results indicated that the anxiety was 14.25 ± 2.63 for nurses who were below the age of 25, while it was 9.78 ± 2.20 for people above 25 years and was significant ($P < 0.0001$; $t = 5.17$). With regard to number of experience in nurses with working experience less than 1 year it was 14.11 ± 2.51 ; for nurses with 1.1 to 2 years' experience was 13.75 ± 3.15 and for more than 2 years' service in oncology hospital was 9.82 ± 2.25 ($P = 0.0004$; F value 10.06).

Key words: anxiety, nurses, oncology.

Introduction

Providing healthcare to patients admitted in a hospital is an important occupational stress and more so in hospitals that care for people afflicted with cancer (Karanikola et al., 2016). Of all the professionals involved in the care of people affected with cancer, the nurses are more in contact with the patients (Karanikola et al., 2016). In hospitals caring for people affected by cancer, the nurses work in ambulatory radiation, chemotherapy, surgical and palliative care sections and care for patients (Karanikola et al., 2016). Nurses working in oncology setup observe significant human suffering and have to deal with sorrow of the patient and their family members (Karanikola et al., 2016). Reports suggest that the prevalence of mental ill health among nurses is high (48.8%) and that many have minor psychiatric disorder like anxiety (Yang et al., 2004). Excessive anxiety has negative influence and prolonged exposure can cause significant maladjustment and health issues (Karanikola et al., 2016).

Of all the mental disorders, anxiety symptoms are the most common manifestations of mental health problems in both the general population and in health care professionals (Karanikola et al., 2016; Taghinejad et al., 2014). From a terminological perspective, anxiety is termed as "maladaptive feeling of intense and indeterminate fear, followed by physical and neuro-cognitive disturbances due to Autonomic Nervous System stimuli, including not only palpitations and sweating, but sleep disturbances, phobias or depressive symptoms, as well" (Karanikola et al., 2016; Taghinejad et al., 2014). At low levels, anxiety is beneficial because it alerts us to threats and helps evaluate and respond to them in appropriate ways (Sadock et al., 2010). However, inappropriate or disproportionate triggering of anxiety associated with anxiety disorders like panic, phobias and obsessive behaviors are harmful and unsuitable for nurses working in a hospital (Sadock et al., 2010). In this study we have attempted to understand anxiety in nurses caring for cancer patients.

Material and Methods

Study area and population

The study is a hospital based cross-sectional study conducted and was conducted in January 2019. The study was conducted at Mangalore Institute of Oncology. The inclusion criteria included nurses working in the hospital and were available at work during the data collection period. The exclusion criteria included doctors and other hospital staff. The study was approved by the institutional ethics committee and was carried out after obtaining the necessary permission from the hospital administration. are needed in addition to work on the prevalence of presenteeism.

Data collection instrument

The data was collected using an English version of structured self-administered questionnaire consisting of age, gender, years in oncological services. The investigators made a conscious attempt at having the questionnaire brief to avoid interference in nursing care. Anxiety was assessed using the GAD-7 developed by Spitzer and coworkers in 2006. The scale consists of 7 questions with options not at all (0), several days (1), more than half the days (2), and nearly every day (3). The cumulative scores obtained by adding each of the choices for the seven questions range from 0 to 21 and score 0-4 represents minimal anxiety, score 5-9: mild anxiety, score 10-14: moderate anxiety, and score greater than 15: severe anxiety (Kroenk et al., 2007; Plummer et al., 2016).

The most important aspect of GAD-7 is that the questions addressed are the ones described as the most prominent diagnostic features of the DSM-IV diagnostic criteria for generalized anxiety disorder (American Psychiatric Association, 2000). The other important aspect is that although designed as a screening tool for generalized anxiety, it is reported to be a useful tool for screening panic disorder, social anxiety disorder, and post-traumatic stress disorder (Kroenk et al., 2007). When screening for anxiety disorders, a score of 8 or greater represents a reasonable cut-point for identifying probable cases of generalized anxiety disorder; further diagnostic assessment is warranted to determine the presence and type of anxiety disorder. Using a cut-off of 8 the GAD-7 has a sensitivity of 92% and specificity of 76% for diagnosis generalized anxiety disorder (Spitzer et al 2006; Kroenk et al., 2007; Plummer et al., 2016).

Procedure:

The nurses were individually approached by the investigators and briefed about the study purpose. The willing volunteers were provided with an informed consent and the study questionnaire. The volunteers were requested to answer all the questions and not to write their names or leave any identification mark on the study questionnaire and requested to return the filled sheets enclosed in an envelope and drop it in to a collection box placed at the reception counter of the hospital.

Statistical analysis

Data was entered in Microsoft excel and analyzed on the online based Vassar Stats statistical program. Based on the scores of this test, the subjects are categorized as normal, mild, moderate, severe and extremely severe with respect to depression, anxiety and stress 35. All quantitative variables are illustrated through mean and standard deviation and the "t" test or Anova was applied. A p value of < 0.05 was considered significant.

Results:

A total of 34 nurses of the total 63 nurses filled the questionnaire and deposited them in the collection box. The data was stratified according to the age (below 25 and above 25 years) and number of experience (less than 1; 1.1 to 2 years and more than 2 years' service) and subjected to t test and Anova respectively. The anxiety was 14.25 ± 2.63 for nurses who were below the age of 25, while it was 9.78 ± 2.20 for people above 25 years and was significant ($P < 0.0001$; $t = 5.17$). With regard to number of experience in nurses with working experience less than 1 year it was 14.11 ± 2.51 ; for nurses with 1.1 to 2 years' experience was 13.75 ± 3.15 and for more than 2 years' service in oncology hospital was 9.82 ± 2.25 . Statistical analysis using Anova showed results to be significant ($P = 0.0004$; F value 10.06). Multiple comparison using the Tukey's Test showed that significant difference between the anxiety in nurses who had worked for less than 2 years verses the ones with more than two years' service ($P = 0.01$).

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Discussion:

Globally anxiety is one of the most prevalent mental health problems but is highly under-reported, under-diagnosed in healthcare sectors (Karanikola et al., 2012; Karanikola et al., 2016). Prolonged anxiety negatively impacts the nurse's coping skills, and this will consequentially cause decrease in an individual's resistance to manage adversities. Heightened anxiety coupled with depression and burnout can affect physical and emotional health and affect the working capacity of the nurse (Sadock et al., 2010). Decreased quality of nursing care is the worst consequence of burnout when nurses are emotionally spent and patients sense apathy and lack of compassion, while their needs are ignored. Ethically, inadequate nursing care is against the tenets of both Medical and Nursing ethics and violation of patients' rights (Kangasniemi et al., 2015). In addition to this, nurses' burnout consequentially results in substandard patient care and this will affect the hospital's goodwill and lead to economic loss (Ferreira et al., 2019).

In the current study it was observed that the anxiety was more in nurses who were less than 25 years of age (14.25 ± 2.63 vs 9.78 ± 2.20) and with less than 2 years of experience (14.11 ± 2.51 vs 13.75 ± 3.15 vs 9.82 ± 2.25) indicating that nurses who had just joined services in oncology hospital were having more anxiety than the nurses with more experience. Previous studies have shown that anxiety symptoms at the work environment can affect the employee's personal, social and professional life and that all these may consequentially lead to behavioral alterations in intra-professional and inter-professional relationships and also affect nursing care (Ferreira et al., 2019). In the case of nurses caring for people afflicted with cancer the difficult aspect is that they are repeatedly exposed to painful deaths and this increases anxiety and stress (Karanikola et al., 2016). In lieu of our observations and information available from other studies structured mentoring and relaxation skill training has been incorporated for the healthcare workers enhancing their coping skills and working efficacy.

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Burnout and Coping in a Low and Medium Secure Hospital

Leanne K Dobson, Trainee Forensic Psychologist, Mill Garth Hospital, Leeds
Mike J Berry, Visiting Professor, Birmingham City University

Abstract

The study explored burnout and coping processes of 109 clinical staff in a low and medium secure psychiatric hospital. Staff reported moderate levels of Emotional Exhaustion (EE) and Depersonalisation (Dp), and high levels of Personal Accomplishment (PA). No significant differences were found between burnout and gender, age, profession, level of security or ward/service however there was a significant positive correlation between employment duration and Emotional Exhaustion (EE). Confrontive Coping, Self-Controlling, Escape-Avoidance and Distancing coping processes significantly correlated with EE, Dp and/or PA. These coping processes alongside Positive Reappraisal also significantly predicted burnout, however Positive Reappraisal was the only significant predictor in reducing burnout. The study helped identify those more susceptible to burnout enabling prioritising of training needs for certain staff groups with regards to tackling burnout. As to burnout reduction and/or prevention, the hospital may benefit from interventions that specifically explore positive reappraisal techniques. The findings add to the paucity of research in forensic mental health settings however more research is recommended with larger samples in comparable settings to enable more certainty regarding the interpretation and generalisability of findings.

Introduction

Burnout has been defined in various ways but most research favours a multifaceted definition such as that developed by Maslach and colleagues (1993; 1996) which encompasses three dimensions: Emotional Exhaustion (EE; feeling emotionally exhausted by one's work), Depersonalisation (Dp; a negative, impersonal or detached attitude toward recipients of one's care, etc.) and reduced Personal Accomplishment (PA; feelings of competence and successful achievement in one's work). UK prevalence rates for high EE have ranged from 21-48 per cent for general mental health workers and reported to be 54 per cent for forensic mental health workers (Oddie & Ousley, 2007). Westwood et al. (2017) identified 69 per cent of UK psychological therapists suffering from burnout, while internationally burnout rates have ranged from 21-67 per cent (Morse et al., 2012).

The exploration of burnout in mental healthcare has lagged behind research in other areas of healthcare (Johnson et al., 2018) but is now increasingly being viewed as a concern. High levels of burnout are particular concerning due to its negative impact on patient care including reduced empathy (Fagin et al., 1995), reduced patient interaction (Ewers et al., 2002) and failure to recognise patient distress (Aiken et al., 2002). Psychological and physical health problems amongst staff have also been identified (Acker, 2010; Peterson et al., 2008). It is therefore unsurprising that burnout correlates with negative organisational measures such as increased staff sickness, absenteeism, turnover, and turnover intention (Morse et al., 2012; Sherring & Knight 2009; Yanchus et al., 2016). High turnover has resulted in poorer implementation of evidence-based practices (Woltmann et al., 2008), a decrease in patient safety (Johnson et al., 2017) and more patient suicides (Kapur et al., 2016). These issues appear to be exacerbated by difficulties in filling vacancies; approximately 10 per cent of all posts in specialist mental health services in England remain unfilled forcing mental health providers to cancel patient activities and close wards (Gilburt, 2018). Multiple vacancies with similar outcomes are also reflected in forensic mental health services (Care Quality Commission, 2017).

Situational factors (e.g. job, occupational and organisational characteristics) and individual factors (e.g. demographic and personality characteristics) are considered to contribute to burnout. For example, role conflict and ambiguity (situational factors) consistently show a moderate to high correlation with burnout, and age (compared to other demographic variables) has been most consistently related to burnout (younger employees report higher burnout, Marchand et al., 2015). Overall, burnout's relationship to individual factors is not considered as great in size as those for situational factors (Maslach et al., 2001) suggesting burnout to be more of a social phenomenon than individual. This, however, has not prevented research exploring individual factors, including personality (e.g. Wang et al., 2015) and coping (e.g. Shin et al., 2014).

Coping plays a crucial role in burnout and has been explored across various non-forensic settings, professions and cultures, e.g. teaching (Carson et al., 2012; González-Morales et al., 2010), social work and nursing in Israel (Ben-Zur & Michael, 2007), Portugal (Garrosa et al., 2010) and South Africa (van der Colff & Rothmann, 2009) and drug service workers across Europe (Reissner et al., 2010). Lazarus and Folkman (1984) categorise coping as problem-focused (actively planning or engaging in a specific behaviour to overcome or change the stressful event) or emotion-focused (attempts to regulate the emotions evoked by the stressful event). The former appears to be more effective (associated with lower levels of burnout) than emotion-focused coping (Shin et al., 2014). However this correlation is not entirely straight forward as problem-focused coping is not effective if the situation is uncontrollable or chronic (Cameron et al., 2015), and emotion-focused coping can be effective if it involves positive acceptance, positive reappraisal and development/practice of spiritual beliefs (Tugade & Fredrickson, 2007; van der Colff & Rothmann, 2009). Additionally, emotion-focused coping can be detrimental if involving strategies such as distancing, avoidance or denial regarding the situation (Haberthür et al., 2009; Isaksson Ro et al., 2010).

Various person-directed interventions have been implemented to improve burnout, including cognitive coping strategies and problem solving (Günüşen & Ustün, 2010), stress management (Rowe 1999, 2006), mindfulness (e.g. Asuero, 2014) and psychosocial interventions (e.g. Redhead et al., 2011). The majority of these have been shown to maintain effectiveness for up to one year for Emotional Exhaustion and Depersonalisation, and six months for Personal Accomplishment (Lee et al., 2016).

Burnout is largely related to the care-giving nature of a job (Maslach et al., 2001) which may help explain why it occurs frequently among the teaching, customer service and nursing professions (Pines, 1993). Maslach et al. (1996) explain how interactions in these professions are frequently centred on the client's problems and thus charged with strong feelings such as anger and fear; because solutions are not always easily obtained, the situation becomes more frustrating. For people who work continuously under such circumstances, chronic stress can be emotionally draining and lead to burnout. Nursing is a stressful and emotionally demanding profession (Shin et al., 2014) and the likeliest occupation to develop burnout due to exposure to specific stressors including pain, death and interpersonal conflicts (Garrosa et al., 2010). Similarly, forensic mental health services are regarded as highly stressful environments (Elliot & Daley, 2013) due to increased exposure to occupational stressors such as verbal and physical aggression (Mason, 2002). It is thus assumed that nurses and other professionals working in forensic mental health services will report high burnout. However research results are varied, e.g. high rates of burnout in nurses and care workers in secure settings (Dickinson & Wright, 2008), high emotional exhaustion in forensic community mental health nurses (Coffey, 1999), high depersonalisation in staff working with intellectual disabilities in secure services (Langdon et al., 2008), moderate levels of burnout in forensic healthcare professionals in medium secure units (Elliot & Daley, 2013), and more forensic nurses reporting low levels of burnout than high levels of burnout in a medium secure service (Happell et al., 2003).

Aims

Considering the wide-ranging levels of burnout and the paucity of research within forensic mental health settings that explores the relationship between burnout and coping or compares burnout across various demographic variables, further exploration was considered necessary to add to the forensic mental health literature. This would potentially offer important practical implications in the prevention or reduction of burnout within such settings and in the negative impact of burnout on patients, employees and employers. This study therefore aimed to investigate (a) burnout prevalence in forensic healthcare professionals working in a low and medium secure psychiatric hospital, (b) significant differences or correlations between burnout and gender, age, employment duration, profession, level of security and ward/service, (c) correlations between burnout and coping processes, and (d) if coping processes significantly predict burnout.

Research Questions

In line with the above aims were four research questions:

- R1. What levels of burnout occur in professionals working in a low and medium secure hospital?
- R2. Does burnout differ significantly across gender, age, employment duration, profession, level of security or ward/service?
- R3. Are there any significant correlations between reported burnout and coping processes?
- R4. Can coping processes help towards predicting levels of burnout of professionals in a low and medium secure hospital?

Method

Design

The study comprised of:

- An independent measures design with six independent variables (gender, age, employment duration, profession, level of security and ward/service) and three related dependent variables (the three dimensions of burnout: Emotional Exhaustion, Depersonalisation, and Personal Accomplishment).
- A correlational design exploring the strength and direction of relationships between the three burnout dimensions and various coping processes.
- A correlational predictive design in which the predictor variables were various coping processes and the outcome variables were the three dimensions of burnout.

Participants

The voluntary sample comprised of 109 clinical staff members (46 males, 62 females, one did not disclose gender) working in a low and medium secure psychiatric hospital in South Yorkshire. The participants represented various departments (psychiatry, psychology, nursing, social work, occupational therapy and support work) whose ages ranged from under 25 years to 55+ years categories. The participants worked across low and medium secure services, had been employed by the hospital between 1-126 months ($M=46.73$, $SD=41.09$ months), and worked across the following services: Mental Illness, Personality Disorder, Autism Spectrum Disorder and Learning Disability. A 33 per cent response rate was achieved.

Materials

Demographic Data Sheet.

This consisted of six questions regarding gender, age, employment duration, profession, level of security (low or medium) and ward/service, (e.g. personality disorder, mental illness) on which the participant worked.

Maslach Burnout Inventory-Human Services Survey (MBI-HSS).

The MBI-HSS (Maslach & Jackson, 1981) is a 22-item self-report questionnaire assessing burnout of people working in the human services and health care occupations. It consists of three subscales: Emotional Exhaustion (EE; measuring feelings of being emotionally exhausted by one's work), Depersonalisation (Dp; measuring one's negative, impersonal and/or detached attitude towards a patient), and Personal Accomplishment (PA; measuring feelings of competence and successful achievement in one's work). Respondents answer questions on a seven-point Likert scale, ranging from 'never' to 'everyday'. High scores on the EE and DP subscales and low scores on the PA subscale are characteristic of burnout. The subscales demonstrate acceptable internal consistency ('acceptable' equates to a score of $r=.70$ or higher) measured by Chronbach's alpha; these are as follows: $r=.90$ (EE), $r=.79$ (Dp), $r=.71$ (PA). Test-retest reliability coefficients for the subscales are; $r=.82$ (EE), $r=.60$ (Dp), $r=.80$ (PA) (Maslach et al., 1996). Method

Ways of Coping Questionnaire (WAYS).

The WAYS (Folkman & Lazarus, 1985) is a 66-item self-report questionnaire assessing human coping in a specific environment. It consists of eight subscales: Confrontive Coping (aggressive efforts to alter the situation), Distancing (cognitive efforts to detach oneself and to minimize the significance of the situation), Self-Controlling (efforts to regulate one's feelings and actions), Seeking Social Support (efforts to seek informational, tangible and emotional support), Accepting Responsibility (acknowledging one's role in the problem and trying to put things right), Escape-Avoidance (wishful thinking and efforts to escape or avoid the problem), Planful Problem Solving (problem-focused efforts to alter the situation, alongside an analytic approach to solving the problem) and Positive Reappraisal (efforts to create positive meaning by focusing on personal growth. It also has a religious dimension). Respondents answer questions on a four-point Likert scale ranging from 'not used' to 'used a great deal'. Because WAYS measures coping processes, which by definition are variable, traditional test-retest estimates of reliability are considered inappropriate. Folkman and Lazarus (1985) report the majority of subscales to demonstrate acceptable internal consistency ($r=.70$ and above) with three narrowly below; Distancing ($r=.61$), Accepting Responsibility ($r=.66$) and Planful Problem-Solving ($r=.68$).

Procedure

Authorised access to the hospital's off-ward areas was granted which created opportunity to approach clinical staff members at convenient times, (e.g. lunchtimes, breaks and before/after shifts). With further authorisation some staff members were approached before/after training sessions in the hospital. Each potential participant was provided with both verbal and written (via the Participant Information Leaflet) information about the study. The voluntary and anonymous nature of the research was emphasised. They were informed that it would take approximately 20 minutes to complete, advised to consider the information at their leisure and offered the opportunity to ask questions at any time. The study telephone number and email contact details of the researchers were provided to allow further opportunity for staff to ask questions at any time they wished. Participants signed a consent form prior to taking part in the study. Once informed consent had been gained, the participants were handed an envelope containing a second copy of the Participant Information Leaflet, a demographic data sheet, the MBI-HSS and WAYS. Participants were reminded to complete these at a time that was convenient and in private; some participants chose to complete the questionnaires at that moment whereas others completed the questionnaires at a later point. On completion of the questionnaires, the participants placed the data sheet and two questionnaires in the provided envelope and posted it into a secure metal box labelled 'Research' (in the hospital reception), which only the researchers had a key to access its contents. The anonymous questionnaires and demographic data sheets were subsequently scored,

and the data was transferred onto a computer, encrypted and securely stored within a unique electronic folder provided by the Royal College of Surgeons of Ireland (RCSI). Paper copies were destroyed.

The data was analysed using SPSS Statistics 23.0 incorporating: Independent t-tests to compare gender with burnout, One-Way Multivariate Analysis of Variance (MANOVA) to analyse the categorical demographic variables consisting of more than 2 groups (e.g. profession) with burnout, Pearson Product-Moment Correlation to explore correlations (e.g. between burnout and coping processes), and Multiple Regression Analysis to investigate whether coping processes could significantly predict burnout. The full procedure received ethical approval from the RCSI prior to data collection.

Results

The sample comprised of 109 clinical staff members (33 per cent response rate). In each demographic category the highest frequency of responses were: females, staff aged 25-34 years, support workers, staff working in medium secure and on the Mental Illness service. Participants had been employed by the hospital between 1-126 months ($M=46.73$, $SD=41.09$ months).

Prevalence of burnout in forensic healthcare professionals

The numerical cut off points for each category of burnout (low, moderate or high) are shown in Table 1 and the mean MBI scores for this study are shown in Table 2. On average, the self-reported levels of EE and Dp fell within the moderate burnout category ($M=16.56$, $SD=10.60$; $M=5.28$, $SD=5.41$ for EE and Dp respectively), and the self-reported levels of PA fell within the low burnout category ($M=36.58$, $SD=7.18$).

Table 1.*Categorisation of MBI scores*

MBI Subscales	Low Burnout	Moderate Burnout	High Burnout
Emotional Exhaustion (EE)	≤ 13	14 – 20	≥ 21
Depersonalisation (Dp)	≤ 4	5 – 7	≥ 8
Personal Accomplishment (PA)	≥ 34	33 - 29	≤ 28

Note. Normative Sample scores are taken from MBI validation sample (730 mental health workers: psychologists, psychotherapists, counsellors, mental hospital staff and psychiatrists)

Table 2.*Mean MBI subscale scores*

Sample	<i>N</i>	EE		Dp		PA	
		M	SD	M	SD	M	SD
Low and medium secure hospital	109	16.56	10.60	5.28	5.41	36.58	7.81

Analysis of each MBI subcategory showed nearly one third of staff reported high EE and one quarter reported high Dp. Table 3 provides a breakdown of the three MBI subcategories.

Table 3.*Frequencies of MBI subcategories*

MBI subcategory	n	% of sample
<i>EE</i>		
Low	47	43
Moderate	29	27
High	33	30
<i>Dp</i>		
Low	58	53
Moderate	24	22
High	27	25
PA		
Low	15	14
Moderate	20	18
High	74	68

To explore burnout prevalence in more detail, further analysis of each demographic categorical variable highlighted where the results deviated from the overall moderate burnout scores (of EE and Dp) and overall low burnout scores of PA. The most noticeable differences are summarised below. For further details please refer to the full research report.

- Age: Staff members aged 35+ years reported lower levels of Dp falling within the low burnout category, the lowest being in the 55+ years age group (M=3.50, SD=3.58).
- Profession: Social Work reported higher levels of Dp falling within the high burnout category (M=10.50, SD=2.38). Psychiatry and Occupational Therapy reported the lowest levels of Dp falling within the low burnout category (M=3, SD=4.08; M=3.11, SD=2.85 for Psychiatry and Occupational Therapy respectively). Psychiatry also reported levels of PA falling in the moderate burnout category (M=32, SD=10.39).
- Ward/Service: Participants working on the Mental Illness and Personality Disorder service reported higher levels of EE and Dp falling in the high burnout category (M=22.36, SD=14.90; M=9.36, SD=7.41 for EE and Dp respectively).

Differences in burnout across the demographic data

An independent samples t-test compared differences between gender and the three MBI subscales. No significant differences were found $t(106)=-1.31, p=.19, d=.25$; $t(106)=-.37, p=.71, d=.07$; $t(106)=-.07, p=.94, d=.01$ for EE, Dp and PA respectively.

Separate one-way Multivariate Analysis of Variances (MANOVAs) were conducted to explore main differences between the three MBI burnout subscales and age, profession, level of security and ward/service. Prior to conducting the MANOVAs, a Pearson's correlation was performed between the dependent variables (EE, Dp, PA) to test the MANOVA assumption that the dependent variables were correlated. A meaningful pattern of correlations was observed (for full details please refer to the full research report) suggesting the appropriateness of a MANOVA. Additionally, based on Huberty and Petoskey's (2000) guideline regarding significance levels (i.e. $p<.005$), the Box's M values were interpreted as non-significant, i.e. age (Box's M=34.04, $p=.14$), profession (Box's M=59.06, $p=.05$), level of security (Box's M=27.48, $p=.01$) and ward/service (Box's M=47.03, $p=.06$). Thus, the covariance between the groups was assumed to be equal for the purposes of the MANOVAs. In an analysis of Wilks' Lambda values, no statistically significant MANOVA effects were found between the three MBI subscales and age $F(12,270)=0.93, p=.53$, Wilks' $\Lambda=.90, \eta^2=.04$; profession $F(15,257)=1.02, p=.43$, Wilks' $\Lambda=.85, \eta^2=.05$; level of security $F(6,204)=0.96, p=.45$, Wilks' $\Lambda=.95, \eta^2=.03$; or ward/service $F(15,260)=1.54, p=.09$, Wilks' $\Lambda=.79, \eta^2=.08$.

A Pearson's product-moment correlation explored the relationship between employment duration and the three MBI subscales. Employment duration significantly positively correlated with EE, $r=.32, n=107, p=.001$, but not with Dp, $r=.02, n=107, p=.84$, or PA, $r=-.06, n=107, p=.58$.

Correlations between burnout and coping processes

A Pearson's product-moment correlation explored the relationship between the MBI burnout subscales and the WAYS coping processes. The significant correlations are identified below.

- EE significantly positively correlated with: Confrontive Coping, $r=.31, n=106, p=.001$; Self-Controlling, $r=.29, n=105, p=.003$; Escape-Avoidance, $r=.38, n=105, p<.001$; and Distancing, $r=.35, n=106, p<.001$).
- Dp significantly positively correlated with: Confrontive Coping, $r=.28, n=106, p=.004$; Escape-Avoidance, $r=.34, n=105, p<.001$; and Distancing, $r=.20, n=106, p=.04$.
- PA significantly negatively correlated with: Self-Controlling, $r=-.25, n=105, p=.01$; Escape-Avoidance, $r=-.26, n=105, p=.006$; and Distancing, $r=-.24, n=106, p=.02$.

Predictive ability of coping processes on burnout

Multiple regression analysis was used to test if the WAYS coping processes significantly predicted EE, Dp and PA:

EE: Four coping processes explained 27 per cent of the variance, $F(4,100)=9.28$, $p<.001$, $R^2=.27$, $f^2=.37$. It was found that: Escape-Avoidance, $\beta=.24$, $t(100)=2.34$, $p=.02$; Positive Reappraisal, $\beta=-.31$, $t(100)=-3.24$, $p=.002$; Distancing, $\beta=.25$, $t(100)=2.49$, $p=.02$; and Confrontive Coping, $\beta=.21$, $t(100)=2.10$, $p=.04$ significantly predicted EE.

Dp: Three coping processes explained 19 per cent of the variance, $F(3,101)=8.07$, $p<.001$, $R^2=.19$, $f^2=.24$. It was found that: Escape-Avoidance, $\beta=.30$, $t(101)=2.99$, $p=.003$; Positive Reappraisal, $\beta=-.26$, $t(101)=-2.68$, $p=.009$; and Confrontive Coping, $\beta=.23$, $t(101)=2.21$, $p=.03$ significantly predicted Dp.

PA: Three coping processes explained 16 per cent of the variance, $F(3,101)=6.56$, $p<.001$, $R^2=.16$, $f^2=.19$. It was found that: Escape-Avoidance, $\beta=-.23$, $t(101)=-2.13$, $p=.04$; Positive Reappraisal, $\beta=.29$, $t(101)=3.01$, $p=.003$; and Self-Controlling, $\beta=-.24$, $t(101)=-2.19$, $p=.03$ significantly predicted PA.

Discussion

Regarding the first research question, overall, staff reported moderate levels of emotional exhaustion (EE) and depersonalisation (Dp), and high levels of personal accomplishment (PA), the latter equating to low burnout due to its inverse relationship. Thirty per cent of staff reported high EE, 25 per cent reported high Dp and 14 per cent reported low PA. Conversely, 43 per cent of staff reported low EE, 53 per cent reported low Dp and 68 per cent reported high PA. As to the second research question, no significant differences were found between burnout and gender, age, profession, level of security or ward/service.

There was a significant positive correlation between employment duration and EE, but not with Dp or PA. With the third research question, Confrontive Coping, Self-Controlling, Escape-Avoidance and Distancing significantly positively correlated with EE and/or Dp, and three of these coping processes (Self-Controlling, Escape-Avoidance and Distancing) significantly negatively correlated with PA. In terms of predicting burnout (the fourth research question), Escape-Avoidance, Self-Controlling, Distancing and Confrontive Coping were all significant predictors of EE, Dp and/or low PA. Positive Reappraisal was the only significant predictor in reducing burnout.

The overall moderate levels of burnout (EE and Dp) supported the findings of Elliot and Daley's (2013) study of forensic healthcare professionals in medium secure units. When the frequencies of each burnout category (low, moderate, high) were explored, the current study also supported the findings of Happell et al. (2003) as more staff reported low levels of burnout than high. However, the percentage of staff reporting high EE in the current study (30 per cent) fell short of the 54 per cent of forensic mental health workers identified by Oddie and Ousley (2007). The reason for this is unclear but may be explained by the sample; the earlier study used nurses ($n=115$) and occupational therapists ($n=9$). The early work of Cacciabarne et al. (1986) suggested nurses experience the highest degree of burnout due to having more direct contact with patients. Thus, it is possible the higher proportion of staff with more direct contact with patients (i.e. nurses) in the study by Oddie and Ousley (2007) in comparison to the proportion used in our study (Table 1) may have contributed to the different findings. Furthermore, positive changes in organisational practices over the past decade may have contributed. In an increasing effort to understand, reduce and/or prevent burnout, research has identified various organisational issues leading to recommendations and subsequent changes in practice, e.g. greater support systems such as provision of regular clinical supervision and formal analysis of critical incidents (Dickinson & Wright, 2008). Over time, these may have contributed to a gradual reduction in high burnout.

Albeit non-significant, the direction of the means in relation to age and Dp supported previous findings (e.g. Marchand et al., 2015) in which younger employees report higher burnout. Additionally, whilst there is a lack of available research to compare the results across different ward/services it was noted (although non-significant), participants reporting the highest average EE and Dp scores were those working on a ward treating both mental illness and personality disorder. A possible explanation for this could be increased role conflict or ambiguity, both of which are related to high levels of burnout (e.g. Kilroy et al., 2016; Tunc & Kutanis, 2009). Staff may be required to adhere to different procedures and/or treatment approaches in accordance with the differing diagnoses resulting in confusion regarding the tasks and activities they are required to perform.

Regarding coping processes, our study supported previous research within non-forensic settings, i.e. the detrimental impact on burnout of certain emotion-focused coping including distancing, avoidance and denial regarding the situation (Haberthür et al., 2009; Isaksson Ro et al., 2010) and the effectiveness of positive reappraisal and development/practice of spiritual beliefs (Tugade & Fredrickson, 2007; van der Colff & Rothmann, 2009). In contrast to previous research (e.g. Shin et al., 2014) problem-focused coping did not appear effective in reducing burnout (it did not predict lower burnout). In fact, our study identified Confrontive Coping (aggressive efforts to alter a situation) to significantly predict EE and Dp. This finding (the negative impact of a problem-focused strategy) may be explained by work related problems being chronic or uncontrollable (Cameron et al., 2015) where a person has much less control over work related stressors than in other domains of his or her life and therefore such attempts at solving problems are futile. Wallace et al. (2010) suggest this can result in progressive disengagement and may therefore help explain the hospital's overall moderate levels of Dp (a negative, impersonal and detached attitude).

With regards to the variance explained by coping processes, the percentages were small (ranging from 16-27 per cent) but unsurprising when considering the research that suggests individual factors play a smaller role in burnout than situational factors (Maslach et al., 2001).

Limitations

The study's results have limitations, the first of which was the 33 per cent response rate. This resulted in a smaller than anticipated sample and impacted on the power of the study (the majority of effect sizes were small/small-moderate) increasing the possibility of Type II error. Our results should therefore be interpreted with caution as a larger sample size would be required in order to establish more certainty regarding the study's findings.

It is likely the low response rate was partly due to our study relying on voluntary participation. Whilst being mindful of the ethical implications regarding influencing participants' decisions to take part, a solution to achieve a large more representative sample might be to use proportionate rewards/incentives (BPS, 2014). The occurrence of voluntary response bias is another possibility due to relying on a self-selecting sample (which tends to over-represent individuals who have strong opinions). Again, using a proportionate reward may reduce the likelihood of this bias. Conversely however, voluntary samples have the potential to provide more meaningful results; the participants have volunteered themselves and may therefore be more willing to put the time and effort into providing thoughtful and meaningful responses. Another consideration is the likelihood of a number of staff being unavailable to participate (due to annual leave, sick leave, etc.) which automatically lowered the response rate. Future studies should consider the benefits of extending the data collection duration in order to include such staff members or consider alternative data collection methods that enable researchers to access these staff members, e.g. postal or online surveys.

Whilst the anonymous nature of our study was made explicit it is possible, due to the nature of the research and it being undertaken in the participants' place of work, that social desirability bias affected the results. To minimise this, future research may benefit from considering alternative data collection methods, e.g. postal or online surveys. Additionally, whilst adhering to the manual's guidance on respondent privacy and confidentiality, due to minimising deception the participants were not blind to the study; this may also have impacted on scores due to the reactive effect of personal beliefs and expectations surrounding burnout (Maslach et al., 1996). To minimise this, future studies should think about incorporating this element of deception, whilst considering the ethical implications and subsequent management of such, e.g. via full debrief procedures.

Recommendations and Implications

Our study's results raise organisational awareness of those more vulnerable/susceptible to burnout (i.e. those employed longer by the organisation). As such it provides the organisation with an evidence based and cost effective approach for prioritising training needs with regards to tackling burnout for certain individuals.

The study highlights the significance of positive reappraisal in predicting lower burnout scores within the hospital. It is therefore recommended the hospital give consideration towards bespoke interventions that specifically target this type of coping (e.g. cognitive restructuring strategies and mindfulness techniques) thus strengthening staff's internal resources. The effectiveness of this intervention could be measured via a randomised control trial.

The results have the potential to enhance the organisation's interview process, not as a screening method but instead a supportive measure; the WAYS coping questionnaire would help identify individuals who may use detrimental coping processes such as escape-avoidance and distancing in work-related stressful situations. This would allow the organisation to confidentially support these individuals by prioritising their needs for burnout reduction and/or prevention interventions, and subsequently minimise the negative impact on patients and employers.

Our study has contributed to the literature by comparing results with existing research, exploring burnout in a wider range of professionals and other demographic variables, and exploring the effects of coping. These results perhaps provide a snapshot of the larger picture within forensic mental health settings. To enable more understanding and certainty regarding whether these results are representative of UK forensic mental health settings, further large-scale research is recommended.

Conclusions

The study successfully met its aims by exploring the prevalence of burnout and its relationship with coping processes with staff working in forensic mental health. Staff generally reported moderate levels of burnout (EE & Dp) in which EE increased with length of time employed. The coping processes that significantly correlated with burnout and were found to significantly predict burnout were predominantly avoidant emotion-focused strategies. The problem-focused strategies employed by staff were considered to predict burnout within this study due to work related problems being chronic or uncontrollable and thus such efforts being unsuccessful and subsequently exacerbating burnout. Positive Reappraisal was the only strategy to predict lower burnout within this setting.

Whilst taking the limitations into consideration, our results suggest the hospital may benefit from focusing on burnout interventions that specifically explore positive reappraisal techniques, however more research is recommended with larger samples in comparable settings to enable more certainty regarding the interpretation and generalisability of findings.

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Compassion Satisfaction, Compassion Fatigue and Burnout: The Influence of Personality

Nicole Thordarson, Student, MSc Applied in Forensic Psychology, University of York
John Atkinson, Forensic Psychologist, Cheswold Park Hospital, Doncaster

Introduction

Occupational Burnout

In recent years professionals working within mental health services in the UK have experienced immense pressures due to funding cuts, spiraling workloads and a lack of occupational support. This has often resulted in staff experiencing mental health difficulties themselves. In a recent UNISON survey around half of respondents indicated that they were considering leaving their jobs and the health-care profession as a whole (UNISON National, 2019). Such statistics suggest that the aforementioned problems faced within mental health services may increase in future, potentially jeopardising the health of staff working in the sector and, in turn, impacting on the quality of the care provided to patients. To combat this, research should explore the principal elements which influence the development of occupational 'burnout' and determine how this can be ameliorated in such chaotic and demanding environments.

The World Health Organisation defines occupational burnout as a syndrome consisting of a group of symptoms that are linked to long-term, unresolved, work-related stress (World Health Organisation, 2018). The majority of research into burnout has focused upon exploring the organisational factors that influence burnout rates. Studies have consistently found that insufficient staffing and unmanageable workloads contribute to the development of burnout due to resentment amongst workers, depleted staff morale, and extreme negative views towards the healthcare industry from employees (Callaghan, 2003; Totman, Hundt, Wearn, Paul and Johnson, 2011). Other researchers have suggested that it is the patient group being cared for that determines likelihood of burnout development, i.e. through nursing trauma victims, staff experience increased stress and therefore an increased level of burnout symptoms (Deville, Wright & Varker, 2009, Heritage et al., 2018). As neither of these contributing factors are likely to change, a more effective way of managing and preventing burnout within the healthcare industry should be identified. This has led researchers to explore the personal attributes that could influence individuals working in the sector to be more (or less) affected by the organisational and patient-focused stressors (Bakker et al., 2006). Through both identifying characteristics that act as either protective against or which predict burnout, staff could be provided with a personalised approach to reducing their own susceptibility to burnout symptoms. This could have implications in developing the resilience of this workforce.

The only previous study to have explored the relationship between personal qualities and susceptibility to burnout collected data within a population of volunteer counsellors (Bakker et al., 2006). Burnout rates were found to be considerably low, possibly due to the part-time nature of the role and the lack of stressors present. To gain a more valid representation of the influence of personality characteristics on a person's susceptibility to burnout, research should explore a population where the organisational stressors are high, the patient-group are demanding and the professionals vary in terms of their qualities, motivations to work and abilities to cope in stressful situations. The present study was therefore carried out in a forensic environment, where research has previously found that all of the above factors are present (Happell, Pinikahana, & Martin, 2003; Dickinson, & Wright, 2008).

Forensic Mental Health Sector

Working within the forensic sector is recognised as both physically and emotionally demanding for mental health professionals. Regardless of job role or organisation worked for, staff employed by these services are faced with violence, challenging behaviours and complex patient cases. Whittington and Richter (2006) found that repeated exposure to violence and aggression in the workplace was a contributor to occupational stress and burnout in health services.

Further stressors that have been found to influence burnout include exposure to self-harm behaviours and verbal threats (Dickinson & Wright, 2008), both of which are increasingly common in forensic mental health environments. These studies highlight the physical dangers that come with working alongside forensic patients, and the psychological harm that can be caused following this.

Stamm's model of Compassion Satisfaction and Compassion Fatigue (2009)

Stamm (2009) suggested that it is the combination of organisational factors, the patient group and the personal attributes of the individual staff that influence the development of either “compassion fatigue” or “compassion satisfaction”. Stamm's model proposed that compassion satisfaction acts as a protective factor to burnout whilst compassion fatigue acts as a risk factor. The two concepts are presented in the literature as the positive and negative aspects of helping respectively.

Compassion satisfaction relates to the pleasure and fulfilment derived from working in helping, care-giving systems. Individuals who have compassion satisfaction are likely to embrace the difficult aspects of caring for others through knowing they are doing good for society and contributing positively to the work setting. Research has shown that regardless of the traumatic events faced at work and the prolonged stress endured, individuals who score highly in compassion satisfaction are able to sustain their caring capabilities and thrive in the workplace (Gillespie, 2013).

Conversely, compassion fatigue is a cumulative response to distress and discomfort caused by close, continuous contact with patients. Common symptoms include feelings of self-contempt, difficulty sleeping, irritability and depersonalisation. The triggers and manifestations of compassion fatigue resemble those of burnout. However, compassion fatigue is a direct outcome of exposure to distress and is linked to empathetic care, whilst burnout occurs even in professionals who do not work in helping professions (Flarity, Nash, Jones & Steinbruner, 2016).

By exploring the personality factors that cause an individual to develop compassion satisfaction and protect themselves from burnout, researchers should gain insight into the attributes of a person that allow them to cope in an environment where stress is high, and burnout is expected. Furthermore, by identifying personality factors that, when combined with environmental stressors will naturally make staff more susceptible to burnout (via compassion fatigue), employers may be able to identify professionals who require further support. Additionally, it is possible that the combination of these findings may allow future researchers to develop training programmes aimed at allowing healthcare providers to strengthen the characteristics that are more likely to see them thrive in a demanding working environment.

Burnout and the Big Five Personality Factors

Personality has previously been defined as “the combination of certain qualities that an individual holds which determines their distinctive character and affects the way they will respond to certain situations” (Allport, 1932). The majority of early research surrounding personality focused upon exploring low level personality characteristics such as such as hardiness, and self-esteem as predictors of burnout (Schaufeli and Enzmann, 1998). Psychologists currently prefer the application of integral models of personality in research, as these allow personality to be considered as a whole concept, rather than as many separate elements. The most widely researched model of this nature is The Big Five Factors of Personality (Goldberg, 1990), which organises personality under five broad dimensions: extraversion, agreeableness, conscientiousness, openness and neuroticism.

Neuroticism

Neuroticism is defined as a tendency to experience negative and distressing emotions. Neuroticism is characterised by traits such as social anxiety, low self-esteem and fearfulness. In the literature, this factor is more related to burnout than any other (Bakker et al., 2006), possibly because neuroticism is associated with strong emotional reactions to stressful situations, which can eventually lead to physical illness (Van Heck, 1997). Allport, (1930) suggested that neurotic individuals may present as unstable and self-centered, which could cause them to struggle in an environment where teamwork is key. More neurotic individuals are likely to experience secondary trauma when working in forensic units, as distressing incidents could result in them fixating upon their negative emotions, leading to rumination and symptoms of stress.

Conscientiousness

Conscientiousness is concerned with self-discipline, drive and competency. Researchers have linked conscientiousness with successful problem-solving abilities and the drive to complete tasks on time (Watson and Hubbard, 1996). Individuals who score highly on this trait are characterised as being extremely persistent in striving for achievement. Subsequently, they may approach challenges in the workplace objectively, avoiding the effects of burnout or compassion fatigue. Conscientiousness has previously been positively associated with compassion satisfaction in Oncology nurses, and negatively associated with burnout in primary school teachers (Yu, Jiang and Shen, 2016; Kokkinos, 2007). Research has found that individuals who score highly in this trait will describe themselves as very thoughtful and persevering (Cattell, 1945). Perseverance is arguably a key factor needed to work within a difficult environment, such as a forensic hospital, and which guards against the development of extreme negative views towards associated with burnout.

Agreeableness

Agreeableness refers to an individual's caring and trusting nature. Higher levels of agreeableness are associated with people who are sympathetic towards others and always willing to help. The few studies that have investigated the link between agreeableness and burnout suggest that higher scores in agreeableness encompass the "stereotypical view of an ideal nurse" (Bakker et al., 2006). Piedmont (2003) supports this argument, finding that agreeableness negatively correlates with emotional exhaustion and positively correlates with personal accomplishment. These findings suggest that agreeable individuals are less susceptible to burnout as they can successfully endure stressors in the workplace and seek the personal accomplishment that comes with this. In a follow-up study to Piedmont's (2003) research, scoring highly on agreeableness was also found to reduce an individual's tendency to report negative views towards patients. In the forensic setting, professionals who score highly in agreeableness will likely thrive, as they are more likely to consider the trauma that a patient has experienced (Măirean & Turliuc, 2013), which should reduce their tendency to feel resentment and negative emotions when dealing with stressful situations.

Openness

Openness indicates how open minded a person is. The trait is often associated with creativity and mindfulness. Research has suggested that individuals scoring highly in openness will likely approach challenges with an open mind and attempt to learn something valuable from all experiences (Ferguson & Patterson, 1998). Openness to experience has previously been linked to the use of humour in response to stress (McCrae & Costa, 1986), which previous research has found occurs frequently in mental health services (Simon, 1988). However generally, studies in relation to this factor are lacking across all domains, and some researchers even suggest it should not be included in the five-factor model of personality at all (Ferguson & Patterson, 1998).

Predictions for the present study

- Extraversion will be positively associated with compassion satisfaction and negatively associated with compassion fatigue and burnout
- Agreeableness will be positively associated with compassion satisfaction and negatively associated with compassion fatigue and burnout
- Conscientiousness will be positively associated with compassion satisfaction and negatively associated with compassion fatigue and burnout
- Neuroticism will be positively associated with compassion fatigue and burnout whilst being negatively associated with compassion satisfaction

No prior predictions are made in relation to openness as a predictor of compassion satisfaction, compassion fatigue or burnout

Method

Participants

In total, 99 forensic mental health professionals participated in the study. 46 of these were recruited from a secure forensic mental health hospital in Yorkshire which provides medium and low secure care for men diagnosed with mental illness, personality disorders and various intellectual disabilities. The additional 53 participants were recruited through social media outlet 'Facebook' after response rates within services were found to be considerably low. Of the 93 respondents that completed all aspects of the survey and were included in the final analysis (M=33 years old, Range= 20-56 years old), 19 (20.4%) identified as male and 74 (79.6%) identified as female, 39 (41.9%) were qualified members of staff and 54 (58.1%) were non-qualified. Participants indicated that they spent on average 80% of their role engaging in direct face-to-face contact with patients.

Design /Materials

The study adopted a non-experimental predictive survey design, featuring three outcome variables (Compassion Satisfaction, Compassion Fatigue and Burnout), and five predictor variables (Extraversion, Agreeableness, Conscientiousness, Openness and Neuroticism). The Big Five Inventory (BFI; John, Naumann and Soto, 2008; John, Donahue and Kentle 1991) was used to measure The Big Five factors of Personality; Extraversion, Agreeableness, Conscientiousness, Openness and Neuroticism. The Professional Quality of Life Subscale (ProQOL; Stamm, 2005) was used to measure compassion satisfaction, compassion fatigue and burnout using a 30-item scale.

Statistical Analysis

Data was collected using the online software tool Qualtrics. This data was then converted onto the Statistical Package for Social Sciences (SPSS) software for analysis and three multiple regression analyses were conducted with the Big Five Factors of Personality included as predictor variables and the burnout concepts included as dependent variables.

Results

Personality Factors as Predictors of Compassion Satisfaction

Using the enter method it was found that level of extraversion, agreeableness, conscientiousness, openness and neuroticism explained a significant amount of the variance in compassion satisfaction score ($F(5, 85) = 7.3, p < .001, R^2 = .3, R^2 \text{ Adjusted} = .26$). The analysis found that extraversion level significantly predicted higher scores for compassion satisfaction ($\text{Beta} = .24, t(91) = 2.5, p < .05$), as did agreeableness level ($\text{Beta} = .21, t(91) = 2.1, p < .05$) and openness level ($\text{Beta} = .23, t(91) = 2.5, p < .05$). Conversely, level of conscientiousness did not significantly predict higher scores for compassion satisfaction ($\text{Beta} = .1, t(91) = 1.1, ns$), and neither did neuroticism ($\text{Beta} = -.1, t(91) = -1.2, ns$).

Personality Factors as Predictors of Compassion Fatigue

Using the enter method it was found that level of extraversion, agreeableness, conscientiousness, neuroticism and openness explained a significant amount of the variance in compassion fatigue scores ($F(5, 87) = 2.6, p < .05, R^2 = .13, R^2 \text{ Adjusted} = .08$). The analysis found that neuroticism was a significant predictor of compassion fatigue ($\text{Beta} = .33, t(92) = 2.9, p < .05$). Conversely, openness ($\text{Beta} = -.08, t(92) = -.8, p = ns$), conscientiousness ($\text{Beta} = -.05, t(92) = -.47, p = ns$), agreeableness ($\text{Beta} = -.1, t(92) = .98, p = ns$), and extraversion ($\text{Beta} = -.09, t(92) = -.87, p = ns$) did not significantly predict compassion fatigue.

Personality Factors as Predictors of Burnout

Using the enter method it was found that level of extraversion, agreeableness, conscientiousness, openness and neuroticism explained a significant amount of the variance in burnout ($F(5, 87) = 6.08, p < .001, R^2 = .26, R^2 \text{ Adjusted} = .22$). The analysis found that level of neuroticism was a significant predictor of burnout ($\text{Beta} = .43, t(92) = 4.1, p < .001$). Conversely, level of extraversion ($\text{Beta} = .04, t(92) = .42, p = ns$), level of agreeableness ($\text{Beta} = -.06, t(92) = -1.5, p = ns$), level of conscientiousness ($\text{Beta} = -.15, t(92) = -.6, p = ns$) and level of openness ($\text{Beta} = 0, t(92) = .002, p = ns$) were not significant predictors of burnout.

Discussion

The present study found significant models for all three of the burnout factors considered. Individuals who scored highly in extraversion and agreeableness were found to hold significantly higher levels of compassion satisfaction compared to those who elicited lower scores in these personality factors. These findings strengthen the conclusions made by previous researchers, who have suggested that individuals with a pro-social and positive outlook on life generally are less susceptible to stress enhancing stimuli in the healthcare environment (Bakker et al., 2006). By replicating these findings in a forensic environment where the level of stressors are enhanced, the present study suggests that these personality factors can act as a protective factor to burnout symptoms on a greater level than previously established.

Interestingly, this is one of the first studies to find openness as a significant predictor to any burnout related factor. Previous researchers have suggested that individuals who score highly on openness have significantly higher levels of plasticity, which allows them to mould and shape themselves where needed to meet any criteria (Yu et al., 2016). By adapting to meet the needs of the organisation, professionals who score highly in openness may see the drawbacks of the forensic environment (low staffing levels, low staff morale, negative views towards the job) and mould themselves as representing the hardworking, energetic and positive individuals needed to endure work stressors and make efficient contributions to the team. As there is generally a lack of empirical research available to support this argument, future research should aim to further explore openness in relation to burnout, in order to establish how this personality facet reacts to workplace stressors and whether it can assist mental health professionals to cope more efficiently within these environments.

Within both the compassion fatigue and burnout models, Neuroticism was found to be the only significant predictor included in the analysis. Here, a positive relationship was found, as predicted in the current study and concluded in previous research (Van Heck, 1997; Francis, Loudon & Rutledge, 2004). These findings suggest that individuals who naturally hold higher levels of neuroticism are predisposed to develop burnout/compassion fatigue symptoms when beginning work within the healthcare industry, regardless of the organisational stressors that are present within the environment. Many approaches could be taken to reduce the risk of these individuals from developing burnout. As an example, employers may look to provide potential employees with personality questionnaires prior to their assignment to a post, which will allow the identification of professionals who are deemed highly neurotic at an early stage. These individuals could then be given extra support from the commencement of their role. This support could feature research-based awareness training regarding the aspects of their personality type that could cause them to become distressed when working within the healthcare environment (e.g. fearfulness, anxiety). Alternatively, as a stronger relationship between the neurotic personality facet and compassion fatigue/burnout was found in forensic roles compared to less stressful job roles (as seen in Bakker et al., 2006), those higher in neuroticism could be strategically placed onto wards/with patient groups who elicit less traumatic and distressing behaviours, thus reducing the risk of burnout symptoms.

Previous research in the burnout domain has struggled to differentiate between compassion fatigue and burnout because the variables explored in relation to these concepts often affect both factors in the same way (Hooper et al., 2010). As seen above, the present study has in some ways followed this trend, as higher scores in neuroticism were found to significantly predict higher levels of compassion fatigue and burnout in forensic mental professionals. However, the present study found that the Five Factor Personality model accounted for 8% of the variance in compassion fatigue and 22% of the variance in burnout. Burnout is presented in Stamm's (2009) model as being more concerned with the organisational factors relating to stress rather than the factors associated with patient group (as seen in compassion fatigue). These findings imply that personality has a greater effect on an individual's response to environmental stressors, compared to their response to prolonged contact with trauma patients and the distressing and draining nature of the role itself. This could be because individuals working within these settings are more accepting of patient-related stressors (Gates, Fitzwater & Meyer, 1999), as these are expected within helping professions, whereas organisational stressors such as lack of supervision and low staffing levels are viewed as unfair and unacceptable (Hayes et al., 1995).

Limitations

Some limitations must be considered in relation to the above findings. These all derive from the drawbacks of survey style research within services. Frohlich, (2002) found that in recent years, dwindling response rates within research have become a cause for concern. Researchers cite survey style designs as the least likely to receive response, due to the multiple measures presented, length of time required and lack of perceived benefit for the participant (Sax, Gilmartin & Bryant, 2003). Researchers have also discussed the likelihood that survey style research exploring personality could cause further concern in relation to bias, as it is likely that individuals who complete all parts of a survey will hold certain 'desirable' personality factors i.e. agreeableness (kind, compassionate and driven). Conversely those who become bored and leave the survey without completion will likely hold collectively less desirable personality factors i.e. neuroticism (anxious, fearful). Due to this, there is an increased chance that the participants included in the study itself and the final analysis will not vary as widely as hoped in terms of personality structure.

Additionally, as the current study received considerably low response rates within the first two weeks of data collection, the decision was made to continue data collection through means of social media. Here, a link to the survey was posted in multiple networking forums and support groups aimed at assisting UK mental health professionals of a forensic background. By doing this, the present study could have been subject to further bias as it is likely that the portion of participants collected through social media were gathered from a population of professionals actively struggling in their role and aiming to seek assistance for this.

When considering the above limitations, it is made clear that the methodologies used to explore burnout and the well-being of workers within healthcare environments are not as efficient as once thought. By distributing survey style research to workers within these settings, an automatic reduction in motivation to participate is brought about due to the length of time required of individuals and the tediousness of the task at hand. Future research may aim to explore the factors that effect a professional's motivations to participate in research at work. Furthermore, future research aimed at exploring burnout and personality could adopt a mixed-method design that allows the assessment of personality prior to an interview regarding burnout and wellbeing where likelihood of willing engagement is increased.

Recommendations for Future Research

The present research was successful in highlighting various personality factors that may naturally put some forensic mental health professionals at risk of burnout whilst providing others with an innate protection. The next steps in this line of study should aim to address the limitations discussed above and provide more comparability for research in this domain. By strengthening these findings, and validating the conclusions made, future researchers may be in a better position to develop evidence-based interventions aimed at highlighting individuals at risk of burnout and supporting them according to their needs. In achieving this, the resilience of this workforce could be strengthened, allowing increased wellbeing in the forensic mental health sector and in turn, enhanced patient care.

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Corporate Mental Health – Why It Matters

Pragya Lodha, Clinical Psychologist, Private Practice, Mumbai.

Dr Avinash De Sousa, Consultant Psychiatrist and Founder Trustee, Desousa Foundation, Mumbai

The World Health Organisation defines positive mental health as “a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community”. Positive mental health can be promoted and maintained by various ways. It requires a health living, supportive environment, good health, sound working environment and several other little things that are a part of our daily lives.

Similarly, positive mental health is also affected by several factors which belong to our daily living as well. Workplace is one of the crucial factors among many.

According to the National Alliance on Mental Illness, “work is at the very core of contemporary life for most people, providing financial security, personal identity, and an opportunity to make a meaningful contribution to community life”.

The workplace of an individual has a significant impact on his or her mental wellbeing, and there is a growing awareness about this fact. In his book “Work, Unemployment, and Mental Health”, Peter Warr has stated that gainful employment provides five categories of psychological experience that promote mental wellbeing:

1. Promotion
2. Time structure (an absence of time structure can be a significant psychological burden)
3. Social contact
4. Collective effort and purpose (employment offers a social context outside the family)
5. Social identity (employment is an essential element in defining oneself)
6. Regular activity (organising one’s daily life)

Even as we keep the above points in mind, it is important to note that mental health problems are among the most important contributors to the burden of disease and disability worldwide.

It is estimated that five of the ten leading causes of disability around the world are due to mental health issues. Unfortunately, the impact of mental health disorders on employee productivity has long been underestimated, even though the workplace is where one spends most of their professional life. We live in a world where appraisals, feedback, competition, meeting deadlines and constant improvements are only some of the enormous pile of stressors that we encounter at the workplace. The working space, context of work, and interpersonal relationships are also unavoidable factors that impact the mental health of employees.

In today’s global economy, mental health is an essential driver for successful business, and there are many reasons why employers should make the promotion of mental health in the workplace a priority. In the share of the cost of occupational and work-related diseases, mental illnesses have a share of 7% on a global level. Therefore, mental health is a pressing issue in its own right.

An oft-discussed topic is that of work-life balance. It emphasises the need for individuals to create a healthy balance between work (career and ambition) and lifestyle (health, pleasure, leisure and family).

Globalisation and the advances in workplace technology have resulted in rapid changes in the nature of work across different fields. This affects the content, organisation and intensity (quality and quantity) of the work of an employee, which increasingly requires more skills and competency regarding innovation, communication and social intelligence. While these changes are rewarding for employees, they can also mean that employees experience more pressure and stress. The increase in workload demands upon their cognitive, social and psychological skills which have a direct impact on their mental wellbeing.

Therefore, mental health is crucial: both for the formation of these skills and their efficient use in the workplace.

Mental health problems can affect anyone, of any age, culture, socio-economic status and background. However, with adequate support, most people can and do recover. By making changes to the workplace environment, and offering support to employees, the duration and severity of mental health issues can be reduced, and recovery can be accelerated. The wellbeing of employees ensures constant performance, less absenteeism, productivity and success for the employee and the Organisation, and in the larger picture, for an economy.

Unfortunately, it is not an issue that is addressed by the Mental Health Care Act 2017 and nor are there any policies that account for the same. Nevertheless, workplace mental health is an important aspect of a working individual's life and overall wellbeing. With time larger number of companies are getting open to the idea of accommodating to address mental health within the working place. Although it is difficult to quantify the impact of work on personal, social and psychological well-being, it is agreed workplaces can offer several measures to promote psychological well-being and positive mental health, such as:

1. Flexibility in working hours and giving employees the option to work from home, as and when possible
2. Introducing and encouraging breaks from work that are conducive to social interactions
3. Making employer and employee relationships more open and friendly
4. Advancing career development and career mapping for freshers and old employees to keep steady growth
5. Offering inhouse counselling for employees — addressing both personal and Organisational problems
6. Involving employees in the process of decision-making
7. Recognising and rewarding the contribution of employees

With the increasing prevalence of mental disorders, workplace mental health is an essential need in the time of increasing stress.

Additionally, the stigma around mental health can be reduced by employer support to employees that can start a discussion around mental health. Organisations have slowly taken up the responsibility to support individuals with mental disorders at the workplace. There have also been questions where the question of a 'mental health leave' (parallel to sick leave) has come in the picture. Though it does not form a uniform policy privilege, the debate around it has begun. The culture of talking about mental health is slowly taking place and the momentum that needs to be maintained. We all play a critical role in the advocacy of mental health, including the workplace.

The Need for Mental Health in Corporate Wellness Programs

Incentives often include lowering healthcare premiums, reducing co-pays, and increasing costs for smokers. Often missing from corporate wellness programs, however, is a focus on mental health and emotional wellness. While mental health is not as easily measured as blood pressure or cholesterol, it deserves equal attention especially when considering the costs associated with poor mental and emotional health.

Productivity loss, absenteeism, job abandonment, and higher turnover are often directly linked to poor mental health. For example, research shows that people with symptoms of depression have a fivefold or greater increase in time lost from work compared to those without symptoms of depression.

Employers can begin to focus on mental health by ensuring that employees have access to mental health benefits including an employee assistance program (EAP). EAPs are useful in that they can provide referrals to mental health professionals and other services while maintaining strict standards of confidentiality.

Employers with mental health benefits are at a significant advantage over those who do not supply such benefits in that they are likely to have lower incidents of job burnout, onsite violence, and workplace injury. Employers should complete an assessment of their organisational culture before implementing any mental health programs. They need to acknowledge when there are cultural drivers that are influencing people's resiliency and their ability to be emotionally well at work.

At the onset, companies need to be certain that their culture and work practices can support the mental health and emotional needs of its employees. They must communicate that they care about each employee as a person and that they are committed to providing the best working environment possible. Employers can suggest that their employees complete a health risk assessment (HRA) which often includes questions pertaining to mental health.

Wellness leaders can launch awareness and education campaigns of these illnesses using the latest social media and other tools to help people find helpful resources. When employees experience symptoms such as the desire to isolate, withdrawal from normal activities, physical aches and pains, irritability, and low tolerance of others, having a resource to turn to for help can likely defuse a potentially serious situation.

By providing educational opportunities and enhancing awareness of mental illnesses through discussion, organisations are de-stigmatising those very illnesses which keep employees silent in their pain. Wellness programs may offer peer-to-peer support groups for mental health conditions. One recent study suggested that for lasting behaviour change, people are best served to not only set attainable goals but to participate in small groups.

When people come together with similar experiences, they are less likely to feel so alone. In small groups, people are more likely to openly discuss topics such as how to cope with the pressures of work, how to improve job performance, or how to deal with a demanding boss. Peer support groups are not to be therapy sessions, but they can be therapeutic for participants.

There are risks associated with corporate wellness programs giving equal attention to mental health. First, employees may not attend educational sessions or other such gatherings for fear of being "outed". Unfortunately, shame is often associated with mental illness in the workplace. Employees may be fearful that others will not perceive them to be competent, capable, or a solid performer.

The best way to mitigate the risk of low participation is regularly and visibly offer sessions which signals that the company is interested and open to the topic. Another way to mitigate risk is to ask organisational leaders to talk about mental health issues in public forums. Second, employees could find the discussions about mental health to be too intrusive. Mental health is an intensely personal topic for some people.

It can be even more private than some physical health topics. To mitigate the sensitivity risk, wellness leaders can set rules of engagement at events. For example, rules around not judging others, not interrupting when someone is speaking, and no cross-talk may help establish a feeling of "emotional safety" for the sensitive employee.

Third, there is a risk that once attention is paid to mental health, an organisation will incur costs associated with the use of mental health services and pharmaceutical usage of psychotropic drugs increase. Employers need to be mindful that when people seek treatment, they are less likely to have more costly hospital stays and are less likely to experience other chronic conditions that could drive increased costs in the long term.

Corporate wellness programs will continue to evolve. Our hope is that more attention will be paid to employee mental health and that the stigma associated with it will dissipate. By addressing mental health issues and emotional wellness, employers are addressing the total health of an employee when combined with programs for clinical measure achievement. That makes everyone stronger, more productive, and happier.

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Personality Types And Burnout In Forensic Psychiatric Staff

Miss Grace Day, Trainee Forensic Psychologist, Cheswold Park Hospital

Miss Natalie Butcher, Teesside University

Mr John Atkinson, Forensic Psychologist, Cheswold Park Hospital

Introduction

Burnout can be summarised as a stress related phenomenon, defined as an emotional reaction to job stressors that primarily affects those who work in interpersonal jobs or helping professions (Cordes & Dougherty, 1993; Ganster & Schaubroeck, 1991; Perlman & Hartman, 1982). Due to the interpersonal nature of their job, the nursing profession has been of interest in the research literature. Accordingly, the target group within the current study is forensic psychiatric staff, of which the majority were nursing staff. In terms of research into the general workforce, Jackson and Schuler (1983) showed that burnout can lead to symptoms such as social withdrawal, strained relationships and reduced performance, all of which affect organisations. Furthermore, Jackson et al (1983) suggested burnout adversely impacts on staff members' family lives and physical health. Ultimately, understanding the elements contributing to burnout in forensic services could help reduce symptoms, increase positive interactions between staff and patient, and reduce staff turnover.

Research has begun to explore the aetiology of burnout in order to be able to protect against this phenomenon. Many factors have been considered including lack of positive feedback, reduced social and community support, reduced autonomy, role ambiguity, high expectations and workload (Maslach, & Jackson, 1984; Leiter and Maslach, 1999). In a study of 1363 nurses, Greenglass, Burke and Fiksenbaum (2001) found that, as workload increased, emotional exhaustion also increased, and that this led to cynicism and reduced professional efficacy (Leiter, Frank & Matheson, 2009). The effect that workload has on individuals may be moderated by the perceived amount of control they have at work. This was demonstrated by Schmitz, Neumann and Oppermann (2000) who found locus of control to be an important factor in the nursing population, where a greater sense of control assisted management of stress. A sense of community has consistently been found to be protective against burnout. Ronen and Mikulincer (2009) emphasised that team cohesion was essential for attachments to others at work and was related to a decrease in burnout (McCarthy, Pretty & Catano, 1990). Not all those who work in stressful and challenging environments become burnt out. This has led to the exploration of the potential attenuating effects of individual characteristics on stress and burnout. Indeed, Cordes et al (1993) suggest that personal characteristics such as gender, career progress and personal expectations may be associated with burnout. Research studies in this area to date appear very limited however and therefore, exploration into the link between individual differences and burnout needs to be extended and developed.

The research literature around personality has evolved to the point where the most prominent and commonly used model suggests five personality types; extraversion, agreeableness, conscientiousness, neuroticism and culture/openness (Tupes & Christal, 1992). A relationship between personality factors and burnout has been found, (Bakker, Van Der Zee, Lewig & Dollard, 2006; Ghorpade, Lackritz & Singh, 2007; Piedmont, 1993), with results specifically exposing a discernible connection between experiences of burnout and high neuroticism traits (Azeem, 2013; Kim, Shin & Swanger, 2009; Lent & Schwartz, 2012). These results are potentially explained by the fact that people who are highly neurotic, often do not engage in effective coping styles (Watson & Hubbard, 1996). The ability to cope in difficult situations and overcome stress, are characteristics of resilience (Rutter, 1999). Therefore, it is suggested that higher resilience not only reduces burnout (Taku, 2014), but is also important for wellbeing, increasing feelings of optimism and influencing perseverance (Eley, Cloninger, Walters, Laurence, Synnott & Wilkinson, 2013).

Dickinson and Wright (2008) revealed that burnout is prevalent in forensic settings such as psychiatric hospitals and prisons. In exploring why prevalence rates are high in this specific field, most research has focused on the environmental factors. It is known that spending large proportions of time in contact with aggressive and suicidal individuals increases the risk of experiencing burnout; particularly if there is a perception of reduced support (Garland, 2004; Melchior, Bours, Schmitz, & Wittich, 1997; Pines & Maslach, 1978; Savicki & Cooley, 1987).

However, other factors may also be important. In their study of clinical staff in a medium secure Oddie and Ousley (2007) found that social issues, such as challenges among staff and limited resources, were significantly related to burnout. Again this study emphasised that sense of community and support from colleagues is important. This was corroborated by Dickinson et al (2008) in their review of forensic mental health nurses' experience of burnout, where it was found that interpersonal conflicts, increased workload and lack of decision making predicted higher levels of burnout. Furthermore, Jenkins et al (2004) considered workload further, and found that within an acute inpatient setting, qualified and non-qualified staff appeared to have different sources of stress. The qualified staff members had increased burnout when workload was high and non-qualified staff experienced more burnout due to challenging patients and threat of physical aggression. Importantly, they suggested that constructive support groups could be useful for all staffing levels. Collectively, research supports the claim that burnout is related to environmental factors. However, it appears to overlook individual differences in staff working within forensic services.

Research has only recently begun to explore how personality factors could relate to burnout in the prison service. Lovell and Brown (2017) found that high scores in neuroticism and a high external locus of control from those working in the prison service, led to increased risk of experiencing burnout. Emphasising this relationship, Maylor (2018) showed that in correctional personnel, neuroticism was the only trait to link to all subcategories of burnout, specifically 'emotional exhaustion' and 'depersonalisation'. Nevertheless, there exists a gap in research and knowledge regarding the influence of personality factors, specifically within the forensic psychiatric services.

In general nursing, research has explored the effect of treatment pathway on the extent to which staff experienced burnout. Skirrow and Hatton (2007) completed a literature review, finding that those who worked with adults with learning disabilities experienced less burnout when compared to those working with patients with different diagnoses. In theorising this relationship, staff perceptions may be important, and research has shown differing attitudes towards different diagnoses. In a study of staff attitudes, Markham and Trower (2003) found that negative attitudes were more prevalent for borderline personality disorder than for schizophrenia. When considering how attitudes relate to burnout, Bowers et al. (2006) found that holding positive attitudes towards patients with personality disorder led to lower levels of burnout, along with improved job performance. Together these findings suggest a link between a patients' diagnosis and staff attitudes. However, more research is required to determine how burnout fits within this relationship.

As the research into burnout has developed, further attention is centred on discovering the multifaceted aetiologies of the phenomenon. The current study aimed to investigate this further, with a specific focus on how personality is related to burnout in forensic psychiatric staff. In line with the research, (Bakker, Van Der Zee, Lewig & Dollard, 2006; Ghorpade, Lackritz & Singh, 2007; Piedmont, 1993), it was hypothesised that personality traits would be related to burnout. Specifically, it was predicted that high scores on neuroticism would correlate with increased levels of burnout (Lovell & Brown, 2017). Based on previous findings (Bowers et al., 2006; Markham & Trower, 2003; Skirrow & Hatton, 2007), the current research also predicted that those working with learning disabilities would experience less burnout than those working on other treatment pathways, such as personality disorder and mental health wards. A consideration of the relationship between dispositional traits and burnout aimed to support employers in selecting, placing and training their employees in order to protect from burnout.

Current Research

Participants were staff recruited from a forensic psychiatric hospital in the north of England which has both medium and low secure wards. 100 staff members volunteered for the study, and in total, 82 participants completed the study (82% return rate). Participants were from a range of disciplines and had differing educational backgrounds. They were also selected due to working on a range of four treatment pathways. These pathways were 1. Personality disorder, 2. learning disability and autistic spectrum disorder, 3. Mental illness and 4. a mixture of all treatment pathways.

The research questionnaires were provided in the following order. Firstly, participants completed a questionnaire to gather brief demographic data, including role, time in role and treatment pathway worked on. Secondly, *The Connor Davidson Resilience Scale (CD-RISC scale 25)*: Connor & Davidson, 2003) was completed. This is a 25 item, self-report questionnaire which provides a score ranging from 0-100; higher scores indicate higher resilience. Thirdly, *the Maslach Burnout Inventory – General Survey* (MBI-GS: Maslach et al, 1986; Schaufeli, Leiter, Maslach & Jackson, 1996) was provided.

This is a 16 item self-report questionnaire, using a 7-point Likert scale. Within the questionnaire, each question relates to one of the three factors of burnout; professional efficacy, exhaustion, and cynicism. The MBI-GS was developed from the general MBI and has been demonstrated good validity in measuring burnout, showing consistency with other burnout measures (Maslach, et al, 1986). Lastly, The Big Five Inventory (John & Srivastava, 1999) was administered. This is a 44-item self-report questionnaire, using a 5-point Likert scale. Scores are derived for each personality factor: Agreeableness, Conscientiousness, Extraversion, Neuroticism, and Openness.

Results

The study utilised a series of multiple regressions to explore whether personality factors predicted level of burnout. The first multiple regression assessed whether personality traits significantly predicted professional efficacy. The results indicated that the three predictors explained 14.8% of the variance of burnout ($F(3, 76) = 4.393, P < 0.01$). On exploration, it was found that resilience was the only personality factor that significantly predicted professional efficacy ($b = .03, P < 0.01$). The second multiple regression was utilised to assess whether the personality traits significantly predicted exhaustion. The results indicated that the three predictors explained 14.3% of the variance of burnout ($F(3, 76) = 4.235, P < 0.01$). On exploration, it was found that neuroticism was the only personality factor that significantly predicted exhaustion ($b = .078, P = 0.001$). The third multiple regression explored if the personality traits significantly predicted cynicism. The results showed no significant relationships ($F(3, 76) = .595, P > 0.05$).

To explore whether each of the four treatment pathways investigated moderated the relationship found between personality and burnout, two moderation analyses were completed. The first moderation explored whether the relationship between resilience and professional efficacy, was moderated by type of treatment pathway. The moderating variable of treatment pathway explained 12.75% of the variance within the model ($F(3, 77) = 3.7494, P = 0.01$). However, when exploring this further, it appeared that resilience was the only significant predictor ($b = .0542, P = 0.05$) of professional efficacy, as the interaction was not significant ($b = -.0071, P > 0.05$). Therefore, there was no significant moderation. The second moderation explored whether the relationship between neuroticism and exhaustion was moderated by treatment pathway. The moderating variable of treatment pathway explained 13.55% of the variance within the model ($F(3, 77) = 4.0228, P < 0.05$). However, when exploring this further, neither neuroticism nor the interaction showed to be significant. Therefore, there was no significant moderation.

Discussion

It was hypothesised that personality would predict burnout, and that higher scores on neuroticism would predict higher levels of experienced burnout. The analysis found that employees working in a forensic psychiatric hospital experienced significantly higher levels of exhaustion when they scored higher on the neuroticism scale. Being able to use effective coping skills, appears to be important within this relationship (Watson et al, 1996). Narumoto et al, (2008) proposed that there was a relationship between high neuroticism scores and using emotion-orientated coping skills, which is associated with higher burnout. Taris et al (2005) suggested that depersonalisation (detaching oneself from feelings and thoughts) appears to be a maladaptive method to cope with continued job stressors. This again suggests that an individual's style of coping is linked to experience of burnout. This has large implications for supporting individuals with neuroticism as it may be that intervention such as training effective coping skills could go some way into reducing burnout for staff in forensic services.

In the current study, those that scored high on resilience also scored high on professional efficacy and experienced less burnout. Epstein and Krasner (2013) suggested that increasing the resilience of staff can decrease burnout, which in turn, improves staff attrition and ultimately improves the quality of care employees provide to patients. In concordance with this, the current study reported significant results in that the personality of the participants was significantly linked to their level of experienced burnout.

The current analysis did not find any significant moderation interaction, suggesting that the treatment pathway did not influence the amount of burnout experienced. This is inconsistent with previous research which suggested that those working with patients with learning disability were experiencing less burnout (Mutkins et al, 2011; Skirrow et al 2007). This is also inconsistent with research regarding burnout experienced by staff working with personality disorder, which showed increased negative attitudes towards patients with personality disorder (Markham et al, 2003). In terms of explaining these results, it is feasible that the staff who took part in the current study often work on different wards; volunteering for bank (ad-hoc) shifts and moving wards to cover staff shortages. This resulted in a limited number of participants who only worked on a specific treatment pathway. Similarly, patients on a specific ward, for example, a personality disorder ward, may have comorbid diagnoses. This would in turn affect the results, and not clearly differentiate how staff working with one diagnosis experience burnout.

Causation is challenging when exploring burnout, and this could not be controlled for in the current study. There is uncertainty as to whether personality traits led to being more prone to burnout, or whether the higher level of burnout increased the personality traits. Future research should therefore consider longitudinal studies, providing new employees with the burnout scale and personality questionnaire to gain a base level of data and re-administer the scales at periods of time throughout their employment. At a clinical level, this would also allow the hospital to intervene at times where staff might score high on burnout scales and need increased support. Future studies should also focus on making the research more accessible to all staff members, including those that are experiencing burnout. A qualitative approach may allow for this, as it may provide the participant with a sense of support through the research whilst providing a more in depth understanding of burnout.

The investigation into the experience of burnout in staff working at a forensic psychiatric service could have large implications for not only the organisation itself, but the rehabilitation of patients. It allows for research to consider how to support staff in these challenging environments; for example, appropriately placing staff on relevant wards based on their personality and resilience level as well as providing interventions and support to staff in need. This should allow organisations to intervene earlier, thereby increasing effectiveness and enthusiasm at work, supporting the welfare of staff and in turn, increasing the positive provision of care to patients.

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The Trajectory of Child Sexual Abuse and Its Impact on Workplace Mental Health

Pragya Lodha, Clinical Psychologist, Private Practice, Mumbai.

Dr Avinash De Sousa, Consultant Psychiatrist and Founder Trustee, Desousa Foundation, Mumbai

Introduction

Child sexual abuse (CSA) is an important public health problem and is known to affect the brain and neurobiological development. This article posits CSA as a risk factor for the future developmental of workplace mental health problems and tries to propose a model that looks at the handling of such issues at the workplace.

CSA is significantly associated with a wide range of psychiatric disorders in adulthood that range from depression, posttraumatic stress disorder, panic disorder, and substance abuse to schizophrenia and antisocial personality disorder. Numerous studies also show that adults who report suffering maltreatment/abuse as children have more physical and psychological problems both medically explained and unexplained.

It has been estimated that out of patients visiting a psychiatric out-patient clinic, at any given time, 20-40% carry with them a history and burden of CSA. The pathway of genesis of a psychiatric disorder in response to CSA is complex and determined by a number of intertwining factors like genetics, epigenetics, neurobiological changes, neurochemical and synaptic changes as well effects of the neuroendocrine axes due to cumulative stress. These changes have their effects at the workplace and occupational mental health as well. We shall delineate some effects of CSA at the workplace and also look at various presentations that may be noticed.

It is well known that victims of CSA are 3 times more likely to suffer from depression, 6 times more likely to suffer from posttraumatic stress disorder, 13 times more likely to abuse alcohol, 26 times more likely to abuse other drugs and 4 times more likely to contemplate suicide when compared to the normal population. CSA also is different from trauma like a natural disaster or road accident which are one time hit traumas while CSA occurs for years and months at end. The perpetrator is often known to the victim and there is element of guilt of not having done when things could have been controlled. This leads to feelings of shame and helplessness which affect the person all the more and can cause deep seated psychological long-term effects.

Some of psychological symptoms demonstrated by survivors of CSA are nightmares, sleep disturbances, panic attacks, phobic behaviors, hypervigilance, exaggerated startle responses, eating disorders, irritability, anger, depression, anxiety, relationship difficulties and social withdrawal. There is a lot of self-blame that leads to shame and guilt which also is accompanied by emotional numbing and detachment.

Many survivors of CSA may present with psychological symptoms that in turn affect workplace productivity and work performance, some of which are:

1. Relatively poor interactions and lack of social interactions with co-workers along with lack of interest in worker get-togethers and parties.
2. Greater resistance to make cordial relations with the workers that may also identify as the same gender as that of the perpetrator.
3. There may also be memory triggers of their experience of CSA and may become averse to someone in the workplace who may remind them of the perpetrator.
4. There is often poor attendance and high absenteeism rates due to various psychological problems faced and this may overburden co-workers with extra work and a hatred towards the survivor at office may develop.
5. The survivors of CSA often have boundary issues in relationships and may either be too withdrawn or get too familiar and this may lead to boundary violations and even multiple emotional attachments that are either too strong or short lived and this takes its toll on the victim.

6. There may be anxiety when fraught with difficult and time-crunch situations at work and there may a tendency to escape from those situations and leave it to others to handle. Important meetings and presentations may be missed over handed over to other because of not wanting to handle the tension.
7. There may also be an obsession with work, and this may lead to overworking, workaholic like attitudes and putting higher pressure on juniors.
8. Aggression may be manifested in the form of abusive language, rude behavior with colleagues and aggressive behavior like getting into fights and arguments over trivial issues.
9. There may be extreme relationships with authorities – either the worker may be too aggressive, and this may land him in trouble or may be too submissive and may be overburdened with work.
10. Memory problems are common and there may be a failure to remember the assigned work and there may be problems in multi-tasking.
11. Survivors of CSA due to their boundary issues may be more prone to sexual overtures and sexual harassment at work.
12. They may also not like to be corrected and may demonstrate an extreme sensitivity and emotionality to criticism.
13. They may overwork and they may be more prone to burnout due to various psychological and personality factors.
14. In general, they are more affected as compared to their colleagues and co-workers because of the heightened sensitivity and response to environment.

Thus, CSA causes indirectly loss of workdays, human resource issues at the workplace, loss of productivity, faulty judgements, poor decision making, medical and health costs.

What can be done at a human resource level

- Maintaining employment and the economic security and independent access to health care it provides may be critical to a victim's ability to meet his/her basic needs and to recover
- Listen to the employee's limitations related to job performance
- Identify what specific tasks may be challenging
- Identify specifically how you can assist
- Provide training for co-workers and subordinates
- Believe an employee who confides in you
- Maintain confidentiality
- Seek professional help for the employee if needed

What can be done at Co-worker/Subordinate level

- Believe when a survivor confides in you
- Be non-judgmental
- Educate the self on CSA
- Ask how you can assist
- Be open to communication about accommodations
- Maintain confidentiality

What can be done at an organisational level

- Providing time off for medical care, counseling, and court proceedings
- Flexible work arrangements
- Maintain privacy
- Provide sensitivity trainings for all employees

Things to remember when managing employees who are survivors of CSA

1. Believe them. Fear of not being believed or having their experience minimized or normalized is a huge problem in reducing rape culture.
2. Clearly state to them that this is not their fault! Tell them that this is horrible and unacceptable, and they are not to blame.
3. Listen with respect and compassion and patience. They are overwhelmed or may be unable to express themselves easily while they find their words and reconstruct what happened.
4. Listening to this may be uncomfortable for you to hear or difficult to identify with. It helps to frame it to yourself with how good your relationship must be that they trust you. This reframe will help you be a better listener to let them express themselves.
5. Ask them how you can help.
6. If they want to go somewhere such as a clinic, you can offer to accompany them and wait in the waiting room with them for the first visit.
7. Get informed. Get guidance. Processing another's difficulties is hard on us. If this is a close relationship or is triggering emotions in yourself, it is helpful for you to access support for yourself.
8. Ask them who else they want to talk to about this. Help them explore the resources.
9. Authentically tell the person how courageous they are to come forward and to deal with this. Remind them that they have been resilient with other difficulties and to trust in themselves and the tools they have.
10. Check in regularly by asking them if they are OK.

Things that one must never do

1. People sometimes ask why the survivor took so long to come forward. There are many factors that will stop a person from coming forward. Some include not feeling emotionally safe, strong negative emotions they are experiencing and fear of reprisals. Even though the law has a statute of limitations, our emotional healing happens at different times outside of those parameters depending on the circumstances and triggers.
2. Victim blaming. Asking questions like: "What were you doing when this happened?" "Why didn't you tell someone and just kept quiet?" "Why were you there in the first place?" The problem is not the victim: it is the perpetrator that committed the abuse.
3. Do not impose what we would do. We can tell them we are there for them and that we will support them, but not what to do.
4. Don't treat them differently or like they are fragile. Let them guide you as to where they are now. Some days will be bad. Other days will be normal. There is an ebb and flow to healing.
5. Do not insist they tell you everything. They are not on trial here and some people never fully disclose.
6. Do not share your own personal experience while they are telling you theirs. You can do so at another time. It can be appropriate to say something like "I believe you because something similar happened to me. How can I help you right now?" Just keep the focus on them.

Some general things to remember

1. Anyone (man, woman, young, old) can be a victim of CSA. They should all be believed and supported.
2. CSA is a punishable offence, considered by the Indian law. It is a lot about power and control and never about a person's sexual desirability.
3. There is nothing intuitive around these situations. Let's face it, whether we are the victim of CSA, or we are the person being told about an event, most of us don't really know how to react. But we all can learn to be more empathetic, it's good to be aware about a phenomenon like CSA that is commonly prevalent and educate ourselves how to be more supportive in our approach.
4. Survivors have many feelings that have nothing to do with culpability on their part. They second guess themselves and feel guilty that maybe they did something to allow this to happen or didn't do enough to stop it. Repeat that they are not to blame. Say it with compassion and conviction.
5. When they know their perpetrator, they may feel betrayed or confused about whether they should continue the relationship. Victims of abuse don't always realise that they have been abused. They don't have a benchmark for what happened, and they cannot be blamed for it. About 90%-95% of perpetrators are people known to the victim.
6. Mostly, they feel powerless. Being non-judgmental and accepting of what they are saying will give them a safe place to heal and find their resilience and courage.
7. Different people have different reactions and coping towards CSA. Some people are scarred for years and never speak to anyone until a trigger comes along where more empowering circumstances are present. Respect their space but also be encouraging that they have someone to talk to. Others feel free to talk about it, listen to them with compassion and lead on for help that may benefit them.
8. Should you feel incapable of handling this, do reach out to mental health professionals.

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Developing and Embedding a Trauma Informed Clinical Model within a Forensic Service

Kerry Hinsby, Consultant Clinical and Forensic Psychologist
Anthony Owens, Organisational Development Consultant
Jane Ellis, Assistant Psychologist
Claire Layton, Nurse Matron

Abstract

This article describes the process of creating, embedding and sustaining a clinical model underpinned by the principles of Trauma Informed Care (TIC) within a forensic service. The emphasis is on the systemic change approaches and the process of engagement as the essence of the model as opposed to a product. Consideration is given to the need to interpret the principles of TIC in a culturally sensitive way to ensure a fit with the competing demands inherent within a forensic setting.

Introduction

The widespread popularity of the NHS can overlook the volatility, uncertainty, complexity, anxiety and ethical tension at every level from policy makers to public. Taken for granted founding principles of treatment according to need, free at the point of delivery and available to all reflected a post-World War II society's belief in the power of its medical capability to make health a human right. The principles were never straight forward (Seedhouse 1994). An overreliance on treatment and cure arguably fuels the tensions facing today's NHS along with a lack of reflection on the principles that have become expectations. The NHS Five Year Forward View (2014) and The NHS Long Term Plan (2019) acknowledges the service's accomplishments and reflect on what could have been designed differently to look forward with an emphasis on prevention ahead of treatment, supporting quality of life for illness where treatment/ cure is not available and emphasising public collaboration in managing health.

In mental health there has been a shifting emphasis in models from clinical recovery to personal recovery (Mann et al, 2014) and social models of distress rather than individualised symptomatology such as the Power Threat Meaning Framework (Johnstone and Boyle, 2018) and TIC (Muskett, 2014, Sweeney, 2018).

Clinical Recovery	Personal Recovery
Pathology	Health
Illness	Strengths
Symptoms	Wellness
Exclusion	Inclusion

However, there are very real tension of applying these models within the structures and confines of forensic services. Mann et al (2014) highlights the dilemma in balancing recovery and public protection. They describe "secure recovery" where person centred care sits alongside the need to challenge risks to self and others where social exclusion is in itself a barrier to recovery.

Definitions of models and care and clinical models are often blurred and poorly defined or differentiated. Our paper suggests Clinical Models act as an active and collaborative syntheses of ethics, theory, responsibility and practice to respond to client needs in a work and cultural context Friedmann (1989). Whereas models of care offer operational processes aimed to ensure people get the right care, at the right time, by the right team and in the right place. We suggest this is more associated with design and resourcing a service than clinical principles. A clinical model helps people bring the operational processes to life in the face of complex dilemmas.

The process of clinical model development is therefore as important as the model itself if we are to question what might otherwise be taken for granted (Agency for Clinical Innovation, 2013).

Our paper is set within a forensic service where significant conflict had developed impacting on wellbeing, clinical governance and the viability of the service. The process of clinical model development has been fundamental to the subsequent turnaround and optimism with which the service now views its potential.

From Personal to Clinical Models

We don't describe the world we see; we see the world we describe (Descarte, Jaworski).

People actively construct mental models to make sense of their world which invariably has a social or cultural context. Ongoing comparison between current data, past experience, values, beliefs and our ability to act and respond to others, shape our internal models as lenses through which we see the world. Descriptions of perceived reality are often reflections of the models we hold. As indicated this process of construction and re-construction cannot be undertaken by individuals but occurs between people via the medium of language and behaviour (Burr, 95).

Gladkowski (1980) posited that practitioners working with people experiencing mental health problems necessarily construct a conceptual framework that bestows meaning and direction to their work. He proposed that due to systemic constraints the framework often remains internal and un verbalised. Gladkowski (1980) emphasised the importance of externalising practitioners' frames of reference, and reviewing the mental models used for clinical working and decision-making through discussion within teams. Through this sharing of conceptual frameworks, a collective clinical model can be constructed, which staff members can use to inform their practice. In this way, a clinical model can be seen to bridge the gap between theory and practice, since it combines the theoretical knowledge of staff with the cultural context and requirements of the workplace and the client group.

West (2012) and others, describe the importance of shared goals, clear roles, supportive behaviour and the collective ability to reflect on these as fundamental to team-working and team results. Rogers (2015) posits that any system of individuals will naturally self organise around a common direction whether for good or ill. Sensemaking processes naturally align over time and members of groups come to construe or process information in similar ways. This is part of culture and formation, patterning the layers of interaction between people including social and professional dynamics. This brings strength and vulnerability. However, this surface alignment, if not deliberately attended to, can hide conflicting internal models, primary tasks and values.

We suggest clinical model development in multidisciplinary teams requires, healthy tension between diverse perspectives that contribute to the quality of care. See figure 1. However, when difference is poorly understood and articulated or seen as problematic and conflicting, quality can be eroded and catastrophic failures can ensue as highlighted in the Mid Staffordshire Public Inquiry (Francis, 2013).

Conflict & Creative Tension in Clinical Model Development

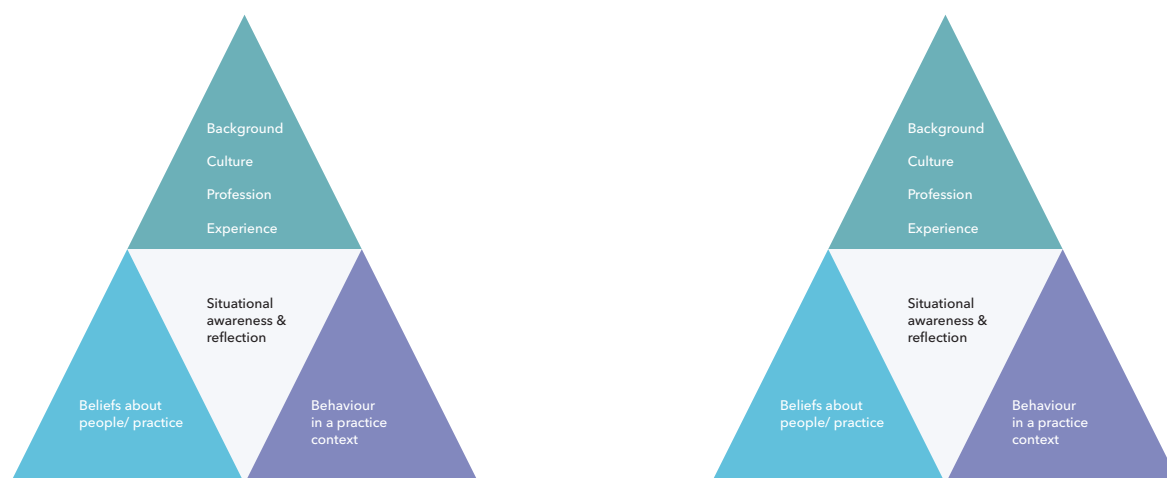


Figure 1; Conflict versus Creative Tension in Clinical Model Development.

Research suggests that using a collective clinical model that underpins clinical practice is essential to ensure consistent delivery of care (Gladkowski, 1980) Writing on model development Lennard (2010) suggests a model provides a shared reference point to guide decision making and acts as a baseline tool for continual learning and service development.

In recognition of the importance of a shared clinical model all forensic services must meet the quality standard as outlined by the Royal College of Psychiatrist’s Peer Review Quality Network. It states, forensic Services must operate within a clinical model that “describes the purpose of the service and details the clinical approach in relation to key therapeutic outcomes” (QNFMH; Holder and Souza, 2016 p.18). Despite this clarity on the characteristics of a clinical model the process for its development is poorly defined.

Given the organisational, professional and policy contexts outlined, the service was keen to develop and embed a clinical model as part of its own recovery and aspiration. Learning from past attempts and evidence of successful implementation (e.g. MacArthur et al, 2017) the service adopted a systemic change approach whose focus we contrast with a systematic or product approach. See figure 2.

Systematic / Product Approach	Systemic Approach
Parts	Whole
Objects	Relationships
Measuring	Mapping
Contents	Patterns
Quantitative	Qualitative
Context free	Contextual
Linear thinking	Emergent Thinking
Building Blocks	Organising principles

Figure 2; Systemic versus Product approach to change.

The process of model development formed part of a wider commitment by the whole forensic service embarking on a process of organisational change (Affina Team Journey).

Within his model of organisations as “living systems” Rogers offers a set of six maxims that help frame systemic organisational change. We elaborate these with an additional maxim below. Whilst the maxims are presented categorically, they run fluidly throughout the different sections with each maxim offering saliency rather than exclusivity at each stage. Although the process is set out linearly for clarity, in reality the process was more cyclical.

Maxim 1: You Can’t Get Anywhere From Not Here

Previous attempts to implement a clinical model involved researching and proposing a model to the service which resulted in resistance. Good intention overlooked Gladowski’s proposition that people actively create and use a clinical model. Offering or imposing a model would inevitably conflict with pre-existing and trusted models. The service had been starting in the wrong place by assuming there was no model. Counter to Gladowski’s view that shared models arise from a conscious process, systems theory would suggest unverballed models become shared models by the patterns of thinking and action that emerge from interactions between those involved in the care process. Our starting point shifted from imposing a clinical model to a proposition that there is always a model (helpful or unhelpful) within systems and curiosity to surface this was the first step of the process.

Maxim 2: People Own What They Help Create

Literature on clinical model development identifies problems in implementation and sustainability from models designed by a few for the many (Harvey, Fisher and Green, 2011, Stevens and Sinn (2005). This is also contrary to our description of a clinical model as an active sense making process.

To develop ownership an invitation was offered to the whole service for diverse staff to contribute to a process of clinical model development as representatives of the whole service. Contribution involved participation in a series of design-focused workshops. Each workshop was preceded by guided reading and reflection. Post workshop commitments involved sharing, testing and refining workshop learning in everyday interactions with colleagues in the wider service.

Maxim 3: Start Anywhere, Follow Everywhere

A broad process was outlined (figure 3), with an end point of creating a clinical model agreed. However, the process followed was not linear or prescriptive, but responsive to the ideas of the group and embodying the principles of co-creation as part of the journey. This allowed movement beyond the traditional boundaries of working.

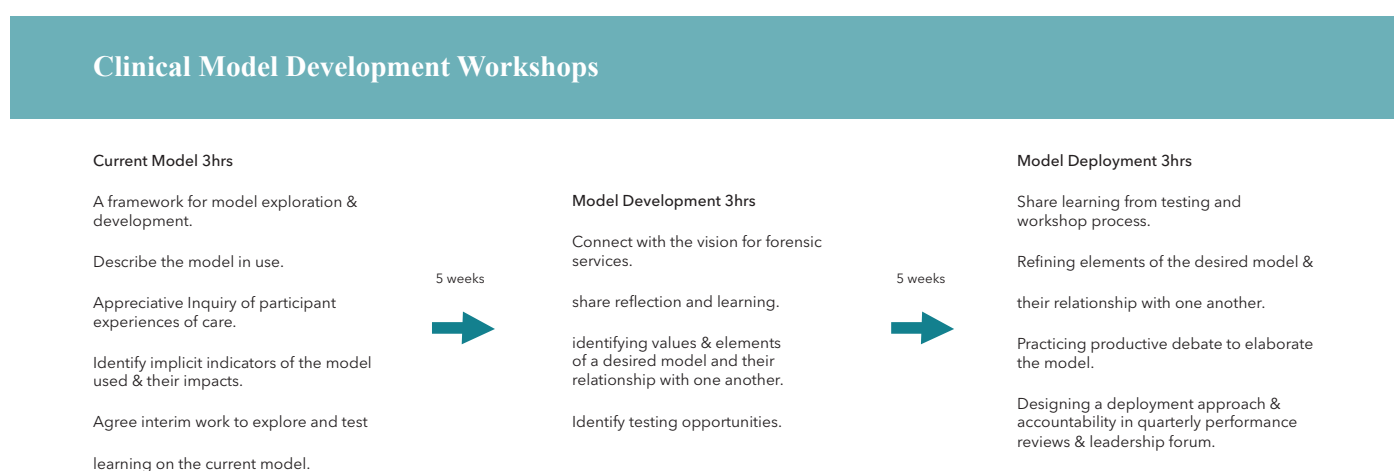


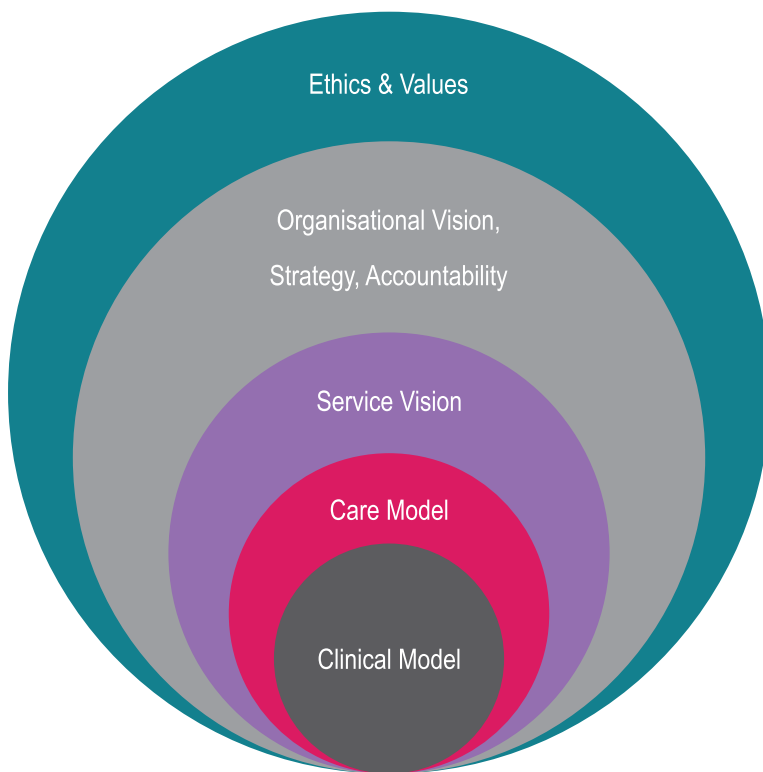
Figure 3; Clinical Model Development Workshops

Surfacing the current clinical model

The process of surfacing an operating model and basic assumptions brought about widespread recognition that the service was dominated by the infrastructures and tasks it was required to practice within; namely the Mental Health Act and ministerial oversight of the Ministry of Justice and wider criminal justice system. Whilst necessary, these were experienced as limiting. There was little room for other ways of viewing patients. All staff felt compromised with this practice, feeling constrained and restricted and at times, in dissonance with their professional values. Whilst acknowledging these were fundamental structures, there was a collective desire to consider the richness, diversity and complexity of the service users; and the skills and professional knowledge of the staff as part of the model development.

Model Development

The second step involved *identifying elements of the desired clinical model* including its elements and position within the wider systems. Here theories of Appreciative Inquiry (Magruder Watkins and Mohr, 2001) were important to align our clinical practice (behaviours) with our ethics and values (see figure 3).



The principles of Trauma Informed Care (TIC) (e.g. Sweeney, Clement, Filson and Kennedy, 2016) were introduced as a way to help articulate

- » Recognition
- » Resist Re-traumatisation
- » Cultural, historical & gender contexts
- » Trustworthy & transparent
- » Collaboration & Mutuality
- » Empowerment, choice & control
- » Safety
- » Survivor partnerships
- » Pathways to trauma specific care

Figure 4. Aligning the clinical model with values and ethics.

important but underappreciated values. Trauma informed approaches have been developing internationally for over thirty years. They draw on the growing evidence base that there is a strong link between childhood trauma and adult mental distress (Bentall et al., 2014) and emphasise the importance of connecting current presentations with the context of people's lives.

In addition to the values of the model, the functionality of the model was surfaced. The aim from the outset was not to deliver on a specific therapeutic clinical model but create a clinical model that was:

Structured enough to provide consistency but flexible enough for professional and individual differences and ward variations.

- *Owned by the service and different professional and staff groups.*
- *Evidence based and meaningful.*
- *Administratively efficient, with no extra work requirements.*
- *Consistent with the service vision*
- *Empowering for staff*
- *Operating within existing structures (e.g. Mental Health Act).*

Throughout this stage an approach described as "Framing" was established (Owens, Anthony Clinical Model Concept Development Meeting (Sept 2016). This involved helping participants and stakeholders to reflect on specific experiences and describe factors that intentionally or unintentionally "framed" the experience. Our proposition being that without a frame to hold complexity, chaos ensues. This process helped wider stakeholders to surface current and desired models in the wider system and surfaced tensions, ambivalence and aspiration of multiple stakeholders and multiple perspectives inherent within a forensic setting (as described by Adlam et al, 2012).

Making the often opposing values and tasks explicit and central to the model allowed them to be considered openly, named and discussed rather than held individually and operating in a poorly articulated manner. For example, within the model the principles of trauma informed care are framed by the drivers of establishing safety with creating shared meanings which may pull the system and individuals in opposing directions (see figure 4).

Model development & deployment then entered an iterative stage where interaction between workshop participants and the wider service raised awareness, engagement and consideration of the clinical models in use and desired elaborations of these.

Maxim 4: Those Who do the Work, do the Change

Diverse staff who represented the service in workshops left with raised awareness, curiosity and confidence to take learning and its application to their colleagues. They were proactively sharing their models with colleagues and inquiring of the models held by colleagues.

Formally sharing the work with the wider leadership team involved a day long condensed process of the steps and exercises the core team had experienced. The aim was, to test the viability, effectiveness and meaningfulness of the process and emerging model and generate next steps as a whole service. However, by also replicating the process with a larger group of individuals the intent was for increased numbers to be involved in the work and have ownership of the changes.



Figure 5. The clinical model as an emblem.

It was at this stage the clinical model and Affina Team Journey converged most noticeably. Despite some trepidation as to how the clinical model concept would be received within the wider team of the forensic service enough systems change had occurred for new ideas to be welcomed and embraced. Those involved in the process had also grown in confidence, clarity and commitment. The day was experienced as new connections between groups and individuals forming and new patterns of relating and talking beginning to arise. There was a sense that something novel was possible and the foundations for thinking differently were ready. The old patterns in the service were collapsing and the system felt ready for something new.

As illustrated in figure 5 the clinical model has at its heart the strap line “Nurturing Safer Futures”. This denotes the need not only to consider the future of our patients but as a forensic service to also keep the public and staff safe. The trauma informed care principles broadens our service delivery lens to recognise that most of our service users have experienced multiple traumas and challenges in their lives and these experiences shape their choices, behaviours, thoughts, feelings and relationships as adults. The wider framing extends consideration to the often-competing ambitions and complexity of the service and highlights the need for a culturally informed translation of the trauma principles.

Maxim 5: Connect the System to More of Itself

With the model established and agreement to implement reached, the principles of the model and systems change were re-visited and a fundamentally different approach to embedding change was adopted. There was deliberately no launch date, no mass training, or no change of paper work. Instead the focus has been on connecting and ensuring the model runs through the heart of everything the service does. The emphasis has been on experiential learning through existing structures and reflective spaces rather than classroom based didactic learning.

To date, some of the elements of the system that have been connected include ensuring the clinical risk process and training has a strength based focused (SAPROF, Vogel et al, 2012) and has a section on formulation linking violent behaviour and adverse child experiences. The service consistently adopts a trauma informed approach to case formulation sessions and policies are reviewed through a trauma lens to minimise the risks of retraumatisation. Our reflective practice draws attention to the impact on staff of working closely with individuals who have experienced trauma and the risks of vicarious traumatisation and the importance of self-care (Proctor et al, 2017). All staff receive supervision and supervision training. The service has adopted the 7-eye model (Hawkins and Shohet, 2012) as it explicitly encourages systemic awareness and reflection on a range of relationships at different points in the system. We have adapted it to include trauma informed prompts under each level of reflection with a single sheet summary to carry classroom learning into supervision sessions.

Maxim 6: Real Change Happens in Real Work

Alongside connecting the model to existing structures there was awareness that new structures and ways of relating needed to be created. At this point the focus of work shifted from the leadership community to frontline staff and service users, with an emphasis on co-creating different ways of working and how to embed our principles into everyday care delivery.

To this end, three further work streams are currently underway. Firstly, via the recovery college staff and service users are developing a leaflet to help explain the model and the expectations of care to new staff and service users. Secondly, representatives from each ward of staff and service users are creating a ward pledge in the form of a “principles in practice” poster. Finally, the wards and Forensic outreach teams are coming together to design and implement a trauma pathway underpinned by Livesley’s (2005) work on treating trauma to ensure there is consistency across the service.

It is anticipated further work will evolve from these work streams. For example, there is already discussion of co-delivered and co-created trauma training via the recovery college and for safety huddles to have a trauma focus.

Maxim 6: The Process you use to Get to the Future is the Future you Get

The final maxim, which Rogers added in 2017, can be considered as containing all its predecessors. It privileges the importance of the process over the product or content. Evaluations of attempts to embed new clinical models also recognise that change is a process and it takes time (MacArthur et al, 2017).

The journey of developing and embedding a clinical model has served many more functions than the actual clinical model itself. The model work evolved alongside a service development journey that allowed for new relationships, new structures, new conversations and new possibilities to emerge. Together, these strands have created the environment that not only maximises the sustainability of the model but also the sustainability of new and novel ways of existing as a team.

In keeping with the principles of the journey, there is no endpoint in mind. It is recognised our services and client group are complex and the literature supporting our understanding is constantly changing. Evaluation is key to ensure we assess and respond to the impact of implementation. To this end we are in our second cycle of administering a co-created patient experience questionnaire – capturing evaluation along dimensions of service delivery that are important to service users and from a staff wellbeing perspective we have administered the ProQOL (Hudnall Stamm, 2009). In terms of capturing clinical change, the intent is to administer a trauma specific measure.

Conclusion

Effecting change that is enduring can be seen as the result of a robust development and implementation process focusing on the relationships and connections within the system. Sustaining change is an active process. Appropriate supervision (Stevens and Sin, 2005), strong and consistent leadership (Powell et al, 2009) and ongoing monitoring and evaluation (Haslam, 2006) have all been identified within the literature as key to sustaining change. These are all ways in which, the living system focuses on a shared and deliberately selected model rather than a reactive model underpinned by individual understandings. To deliver trauma informed care requires active and ongoing attention to its principles and the service will continue to respond and evolve where the evidence base, connections and values lead us.

This paper has distinguished the concept of a clinical model from service and care models by suggesting a clinical model as an ongoing and active process that holds ethics, theory, responsibility and practices in creative tension to navigate dilemmas and respond to client needs in a work and cultural context. We suggest the process of clinical model development is of greater importance than the model as a product. Our process suggests a practical and important approach that is an important system capability and able to support meaningful, sustainable and clinically relevant change.

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Does emotional intelligence mediate the relationship between resilience and burnout amongst prison staff?

Charlotte Mayo, Student, MSc Applied in Forensic Psychology, University of York
Dr Jane Clarbour, Senior Lecturer, University of York
Anthony Oliver, Her Majesty's Prison and Probation Service
John Atkinson, Forensic Psychologist, Cheswold Park Hospital, Doncaster

Abstract

Consistently, research suggests that staff in forensic occupations are highly susceptible to the experience of burnout. Recent studies have examined how certain aspects of personality may reduce this susceptibility, and resilience and emotional intelligence (EI) have been identified as possible protective factors. However, research is particularly limited amongst prison staff within Her Majesty's Prison and Probation Service (HMPPS) and the plausibility of a relationship between the three variables (burnout, EI and resilience) remains unexplored. The present study used a mediation model to examine whether EI mediates the relationship between resilience and burnout amongst prison staff. Participants ($N = 68$) were recruited opportunistically from a Category B prison in the North of England. They completed the 10-item Connor Davidson Resilience Scale (Campbell-Sills & Stein, 2007), the Maslach Burnout Inventory (Maslach & Jackson, 1981), and the Schutte Self-Report Emotional Intelligence Test (Schutte et al., 1998). Results revealed a significant indirect effect of Resilience on Personal Accomplishment (Burnout) through Management of Emotion (EI) and a significant indirect effect of Resilience on Personal Accomplishment (Burnout) through Utilisation of Emotion (EI). These findings are discussed in relation to the existing literature, practical implications explored, and methodological limitations acknowledged.

Introduction

Burnout in Forensic Occupations

Burnout has been defined as a psychological disorder that occurs as a result of excessive and prolonged exposure to occupational stressors (Maslach & Leiter, 2016). More specifically, burnout is defined by the following three dimensions: depersonalisation, is characterised by a development of impersonal feeling toward clients, emotional exhaustion, is a depletion of one's own emotional resources, and personal accomplishment, is characterised by feelings of achievement and competency within one's role, although burnout is accompanied by the absence of personal accomplishment (Maslach & Jackson, 1981).

There has been a recent emergence of literature examining the presence of burnout amongst forensic staff. However, studies examining the presence of burnout amongst prison staff within HMPPS are limited. The most recent, conducted by Bell et al. (2019), explored experiences of burnout amongst prison officers and mental health nurses. Results revealed that 6% of participants exhibited high levels of burnout, 50% exhibited moderate levels of burnout, and 44% exhibited low levels of burnout. Additionally, increased burnout was significantly associated with increased frequency of exposure to traumatic events ($p < .001$). This indicates that burnout is prevalent among staff within HMPPS and is exacerbated by exposure to traumatic events, which recent statistics highlight is increasing (MoJ, 2019; HMPPS, 2019). However, this study was limited in that participants were only recruited from mental health focused services within the establishment (e.g. the Care and Separation Unit) which resulted in a small sample ($N = 36$). The rationale for excluding potential participants from elsewhere in the establishment was unclear and perplexing as traumatic events that characterise forensic occupations are not unique to staff within mental health services (HMPPS, 2019). Nonetheless, this finding is one of few to highlight the prevalence of burnout amongst staff within HMPPS.

Further research has examined the impact of burnout from an operational perspective amongst staff in critical occupations, revealing that burnout is associated with increased staff turnover and sickness, decreased colleague and client interaction, and overall job performance (Jackson, Schwab & Schuler, 1986; Parker & Kulik, 1995; Wright & Cropanzano, 1998; Maslach, Schaufeli & Leiter, 2001). This suggests that burnout has an adverse effect on staff in a personal capacity, which in turn impacts on staff in a professional capacity. Whilst recent statistics suggest that burnout has significant consequences for HMPPS in relation to its business priorities, this research is also limited.

Consequences of Burnout for HMPPS

Recent statistics suggest that burnout has a detrimental impact on HMPPS from an operational perspective, particularly with regards to staff retention and sickness absence.

Staff retention: The recruitment and retention of sufficient numbers of staff is of utmost importance to HMPPS in order to fulfil its capacity operationally. However, attrition rates have risen over the past six years. In 2018 alone, 62% of prison officers resigned, signifying an increase from 53% in 2017. During exit interview, leavers cited the stress of the environment on their physical and psychological wellbeing as their most common reason for resignation. Further reasons included low salary, excessive workload, inconvenient shift patterns, and discrimination from colleagues. Concerningly, it is estimated that HMPPS will need to recruit 2,700 prison officers and 500 operational support grades in this financial year alone in order to replace these leavers and maintain minimum staffing levels. However, recruitment of staff proves challenging, where it can take a year to receive sufficient applications to replace those who have resigned (HMPPS, 2019).

Staff sickness absence: During the year March 2018 to March 2019, staff sickness absence in HMPPS increased from 9.1 to 9.3 average working days lost. This was relatively at its highest in the Youth Custody Service (12.5 days lost). On examination the most common reason for staff sickness absence was due to a result of mental, behavioural, and stress-related disorders which accounted for 34.2% of average working days lost across HMPPS (MoJ, 2019).

Evidently, HMPPS is undergoing difficulties with staff retention and sickness absence, resulting in negative consequences from an operational perspective. Whilst burnout is not specified as the direct cause of this crisis, the evidence indicates that stress is a significant driving force. This is of particular importance when considering that excessive and prolonged stress is a catalyst for burnout (Maslach & Leiter, 2016). It appears that HMPPS staff are exposed to increasingly frequent traumatic events, which trigger stress, and may lead to burnout. Consequently, research has examined whether burnout susceptibility amongst forensic staff can be reduced. Specifically, the role of personality factors including resilience and emotional intelligence (EI) have been identified as possible protective factors.

Resilience and Burnout

Resilience has been defined as a personal quality that enables individuals to adapt and thrive in the face of adversity (Connor & Davidson, 2003). Resilience represents the ability to “bounce back” from difficult experiences, which includes exposure to significant sources of occupational stress (American Psychological Association, 2019). For some time, there has been debate around whether resilience should be classified as a binary concept, a static personality quality, or a dynamic personality quality. Furthermore, within recent years the literature has reached a consensus that resilience exists on a continuum, whereby it presents itself in different capacities throughout the lifespan, possessing the ability to be strengthened or weakened (Southwick, Bonanno, Masten, Panter-Brick & Yehuda, 2014). It is also widely acknowledged within the literature that resilience is a necessary quality to enable an individual to overcome the various challenges that occur throughout their lifetime (Windle, Bennet & Noyes, 2011).

In recent years, there has been an increased emphasis on the importance of resilience amongst staff in critical occupations as a way of “bouncing back” from the traumatic events that characterise such occupations. It is argued that without resilience, professionals are likely to respond to traumatic events with stress, which further depletes resilience, leads to further stress, and creates a vicious cycle which can result in burnout (Green & Humphrey, 2012). It can therefore be speculated that resilience protects against burnout among staff in forensic occupations. A study by Klinoff et al (2018) lends support to this speculation. Klinoff et al’s research into correctional officers in Florida, USA, revealed that resilience and burnout were significantly negatively associated. Whilst this finding suggests that resilience lessens burnout amongst correctional officers, results found resilience in this instance was a mediator between personal strengths (e.g. hope, optimism, and social support) and burnout. This suggests that resilience alone is not enough to lessen burnout and should instead be incorporated as part of a more complex model. This suggests that there may be other variables which contribute to reducing burnout susceptibility. As such, research has examined the contributory role of additional personality qualities in reducing burnout amongst staff in critical occupations, such as the role of EI.

Resilience and EI

The existing literature consistently identifies resilience and EI as protective factors for burnout amongst staff in forensic occupations. Interestingly however, the research studies to date have simply examined how EI and resilience relate to burnout independently, i.e. the possible reciprocal relationships between EI, resilience and burnout have not been explored. This is particularly surprising as consistently, research has demonstrated that resilience and EI are significantly positively correlated (Armstrong, Galligan & Critchley, 2011; Magnano, Craparo & Paolillo, 2016). This suggests that as resilience increases EI increases. Furthermore, the research examining these relationships independently highlights that there may be additional variables that contribute to lessening burnout (Klinoff et al., 2018; de Looff et al., 2019). This implies that the capacity for EI to reduce burnout may be dependent on resilience.

Aims and Hypotheses

The present study aims to examine whether EI mediates the relationship between resilience and burnout among staff within HMPPS. In doing so, the present study intends to broaden the existing research exploring the role of personality in lessening burnout amongst forensic staff and offer insight into the possible practical implications of this for HMPPS. In line with this aim, the present study predicts that EI will significantly mediate the relationship between resilience and burnout amongst prison staff within HMPPS.

Method

Participants

G*Power was used to determine the required sample size ($N = 68$) for the mediation analysis (Faul, Erdfelder, Buchner & Lang, 2009). The final sample size satisfied this power analysis. Participants ($N = 68$) were recruited opportunistically via an email sent to prison staff at a Category B Prison in the North of England.

Measures

10-item Connor Davidson Resilience Scale (CD-RISC 10; Campbell-Sills & Stein, 2007)

The CD-RISC 10 is a 10-item measure of resilience. Participants are required to indicate how true or false each item is to them using a 5-point Likert scale. Higher scores correspond to greater resilience.

Maslach Burnout Inventory (MBI; Maslach & Jackson, 1981)

The MBI is a 22-item measure of burnout which incorporates three subscales: 1. *Depersonalisation* is comprised of 5 items. Higher scores on this subscale correspond to greater burnout; 2. *Emotional exhaustion* is comprised of 9 items. Higher scores on this subscale correspond to greater burnout; 3. *Personal accomplishment* is comprised of 8 items. Lower scores on this subscale correspond to greater burnout. Participants are required to indicate how often they experience each item using a 7-point Likert scale.

Schutte Self-Report Emotional Intelligence Test (SSEIT; Schutte et al., 1998)

The SSEIT is a 33-item measure of EI incorporating four subscales: 1. *Perception of Emotion*, is comprised of 10 items; 2. *Management of Emotion*, is comprised of 9 items; 3. *Utilisation of Emotion*, is comprised of 6 items; 4. *Management of Emotion with Others*, is comprised of 9 items. Participants are required to indicate the extent to which they agree or disagree with each item. Higher scores on all subscales correspond to greater EI.

Procedure

All components of the research were uploaded to Qualtrics, a software for collecting and analysing data. Participants completed the CD-RISC 10, MBI, and SSEIT in a counterbalanced order to minimise the possibility of order effects.

Statistical Analysis

Preliminary Correlation Analyses

Several preliminary correlation analyses were conducted between the CD-RISC 10, MBI subscales, and SSEIT subscales, which were used to form the mediation models.

Mediation Analyses

Mediation refers to a situation in which a relationship between a predictor variable (x) and outcome variable (y) can be explained by their relationship to a mediator variable (m), as shown in Figure 1. The simple relationship between x and y is denoted path c. However, for the conditions of mediation to be satisfied, x must predict m (denoted path a) and m must predict y (denoted path b). For successful mediation, the relationship between x and y must significantly change with the addition of m (denoted path c'). In the present study, three mediation models were performed.

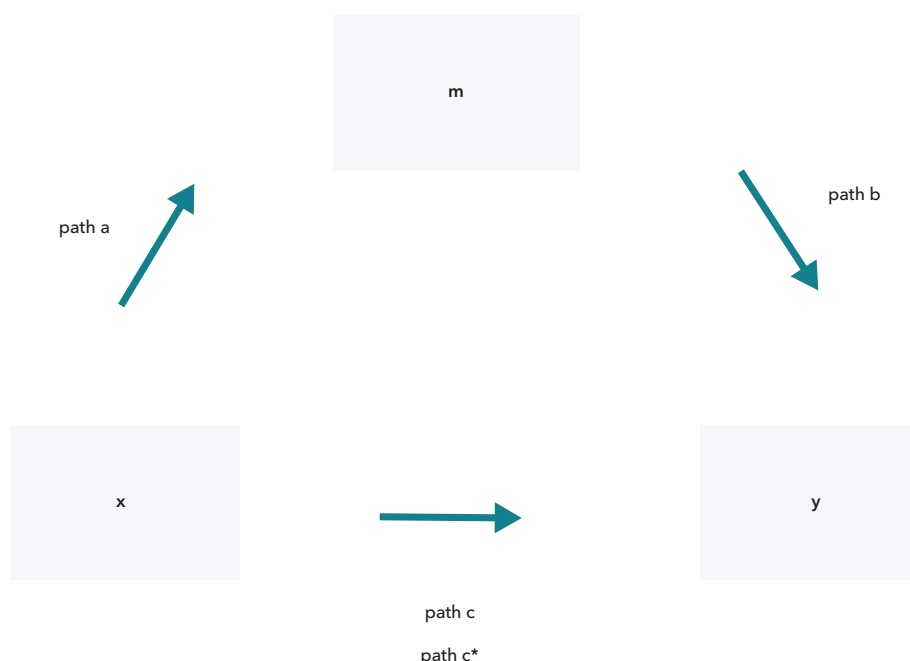


Figure 1. A visual representation of a mediation model.

Results

Model 1

Model 1 examined whether Management of Emotion (EI) mediated the relationship between Resilience and Emotional Exhaustion (Burnout). Several regression analyses were conducted in order to examine the three separate paths of the proposed mediation model. Firstly, Resilience and Personal Accomplishment (Burnout) were significantly negatively associated ($p = .001$). Secondly, Resilience and Management of Emotion (EI) were significantly positive associated ($p = .001$). Thirdly, Management of Emotion (EI) and Personal Accomplishment (Burnout) were non-significantly negatively associated ($p = .067$). As a result, the conditions for mediation were not met resulting in no subsequent analysis.

Model 2

Model 2 examined whether Management of Emotion (EI) mediated the relationship between Resilience and Personal Accomplishment (Burnout). Several regression analyses were conducted in order to examine the three separate paths of the proposed mediation model. Firstly, Resilience and Personal Accomplishment (Burnout) were significantly negatively associated ($p = .007$). Secondly, Resilience and Management of Emotion (EI) were significantly positively associated ($p = .001$). Thirdly, Management of Emotion (EI) and Personal Accomplishment (Burnout) were significantly negatively associated ($p = .001$). Consequently, a mediation analysis was performed using bootstrapped bias corrected confidence intervals (MacKinnon, Lockwood & Williams, 2004).

The 95% confidence interval was obtained with 5000 bootstrap resamples (Preacher & Hayes, 2008). Results of the mediation analysis confirmed a significant indirect effect of Resilience on Personal Accomplishment (Burnout) through Management of Emotion (EI), as shown in Figure 2.

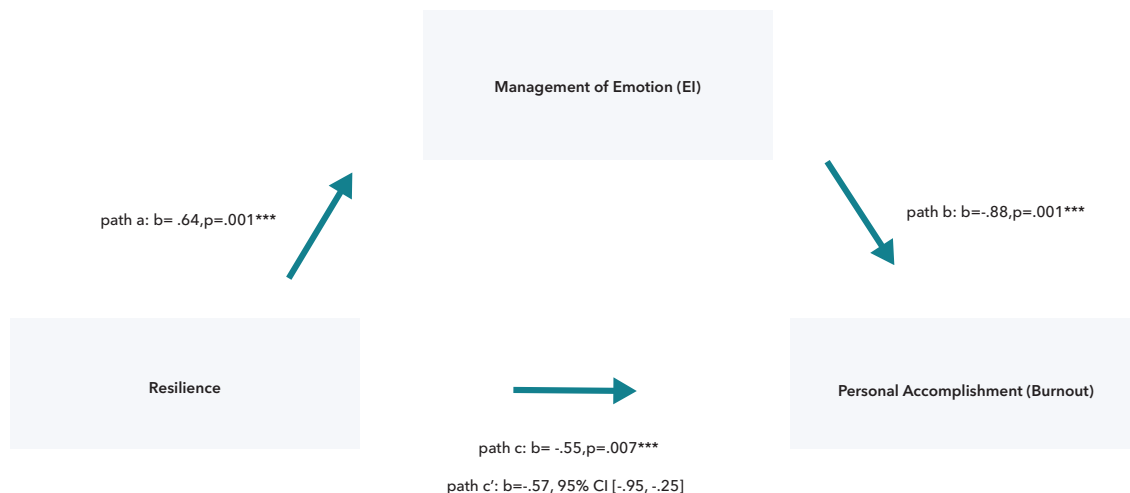


Figure 2. The indirect effect of Resilience on Personal Accomplishment (Burnout) through Management of Emotion (EI). Note. ** $p < .01$, *** $p < .001$.

Model 3

Model 3 examined whether Utilisation of Emotion (EI) mediated the relationship between Resilience and Personal Accomplishment (Burnout). Several regression analyses were conducted in order to examine the three separate paths of the proposed mediation model. Firstly, Resilience and Personal Accomplishment (Burnout) were significantly negatively associated ($p = .007$). Secondly, Resilience and Utilisation of Emotion (EI) were significantly positively associated ($p = .026$). Thirdly, Utilisation of Emotion (EI) and Personal Accomplishment (Burnout) were significantly negatively associated ($p = .004$). Consequently, a mediation analysis was performed using bootstrapped bias corrected confidence intervals (MacKinnon, Lockwood & Williams, 2004). The 95% confidence interval was obtained with 5000 bootstrap resamples (Preacher & Hayes, 2008). Results of the mediation analysis confirmed a significant indirect effect of Resilience on Personal Accomplishment (Burnout) through Utilisation of Emotion (EI), as shown in Figure 3.

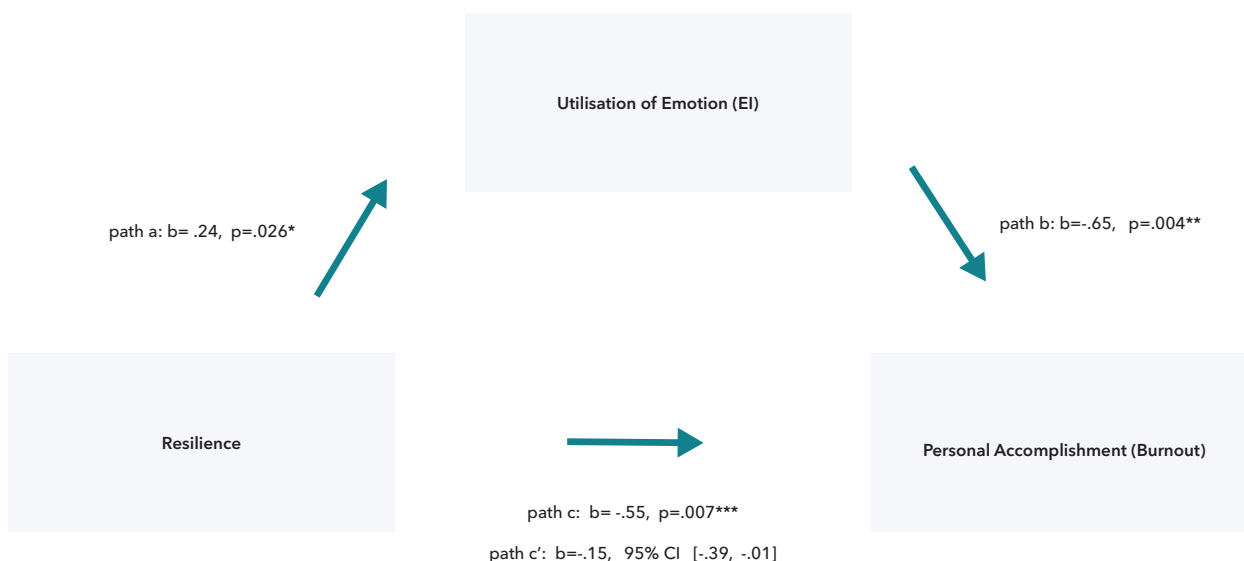


Figure 3. The indirect effect of Resilience on Personal Accomplishment (Burnout) through Utilisation of Emotion (EI). Note. * $p < .05$, ** $p < .01$.

Discussion

The present study aimed to examine whether EI mediates the relationship between resilience and burnout amongst prison staff within HMPPS.

To summarise the main findings, Mediation Model 2 revealed a significant indirect effect of Resilience on Personal Accomplishment (Burnout) through Management of Emotion (EI) and Mediation Model 3 revealed a significant indirect effect of Resilience on Personal Accomplishment (Burnout) through Utilisation of Emotion (EI). Firstly, these findings will be discussed with reference to the existing literature. Secondly, these findings will be explored in relation to their practical implications for HMPPS. Finally, the methodological limitations of the present study will be acknowledged.

Results revealed a significant indirect effect of Resilience on Personal Accomplishment (Burnout) through Management of Emotion (EI) and Utilisation of Emotion (EI). These findings yield support for the hypothesis – that EI would mediate the relationship between resilience and burnout amongst prison staff within HMPPS. Firstly, these findings strongly suggest that resilience reduces symptoms of burnout. Specifically, participants who exhibited more resilience experienced less burnout in relation to personal accomplishment, suggesting that resilience reduces burnout by eliciting feelings of achievement and competency. With reference to the existing literature, this finding is consistent with previous research identifying resilience as a protective factor for burnout amongst forensic staff (Klinoff et al., 2018). Secondly, these findings suggest that the relationship between resilience and burnout is facilitated by EI. Specifically, participants who exhibited more resilience also exhibited more EI, and in turn experienced less burnout in relation to personal accomplishment. In this way, the strength of the relationship between increased resilience and reduced burnout can be explained by their independent associations with EI, specifically the subscales relating to the management and utilisation of emotion. This finding is consistent with previous research demonstrating that resilience and EI are positively associated (Armstrong, Galligan & Critchley, 2011; Schneider, Lyons & Khazon, 2013; Magnano, Craparo & Paolillo, 2016) and EI and burnout are negatively associated (Năstasă and Fărcaș 2015; de Looft et al., 2019). However, the specific finding highlighting the mediational role of EI in the relationship between resilience and burnout is ultimately novel, as the present study is the first to examine this amongst forensic staff. In this way, the novel contribution of these findings to the literature is a strength of this research. The present study is also one of the first to contribute to the body of literature adopting a positive psychology approach to studying burnout amongst forensic staff, through its focus on resilience and EI. Most previous research within this area is dominated by a concentration on classifying staff as “at risk” of burnout due to static personality traits (Lovell & Brown, 2017), meaning that the present study offers a shift in focus from staff weaknesses to strengths.

In light of the above, future research should examine more complex mediation models that include additional variables in order to contribute further understanding of the role of positive personality qualities in reducing burnout susceptibility amongst forensic staff. Whilst the present findings highlight the mediational role of EI in the relationship between resilience and burnout, there may be additional variables that contribute to this relationship.

Undoubtedly, the present findings have practical implications for HMPPS. According to recent statistics, burnout amongst prison staff has extremely detrimental consequences for HMPPS from an operational perspective, particularly with regards to staff retention and sickness absence (HMPPS, 2019; MoJ, 2019). Therefore, methods of reducing burnout susceptibility amongst prison staff are of paramount importance. Currently, HMPPS offers several support services to staff, many of which centre on staff psychological wellbeing. Some examples include PAM Assist (a confidential support service), The Care Team (a staff-led support service within an establishment), and Trauma Risk Management (a staff-led support service to aid recovery from occupational trauma). However, services such as these are solely focused on supporting staff after they have been exposed to traumatic events, meaning that they adopt a restorative as opposed to a preventative approach to managing staff burnout. Additionally, these services are reliant on staff independently seeking them. As a result, certain staff who are in need of support may fail to access it. This is of particular concern when considering the evidence to suggest that forensic staff are particularly reluctant to seek or utilise psychological support services (Wester, Arndt, Sedivy & Arndt, 2010; Steinkopf, Hakala & Van Hasselt, 2015), namely due to the stigma that surrounds mental health (Mind, 2019).

Consequently, there is strong argument for a requirement for an evidence based mandatory intervention that adopts a preventative approach to managing burnout amongst prison staff within HMPPS. The present findings can be used to guide the development of such an intervention. For instance, it is widely accepted that resilience and EI possess the capacity to be strengthened (Chamorro-Premuzic, 2015). Therefore, mandatory interventions that focus on improving resilience and EI amongst prison staff may underpin the prevention of burnout within HMPPS. Although this may be costly, it can be argued that the long-term benefits of burnout prevention would reap future reward for HMPPS in relation to avoiding the consequences of burnout from an operational perspective. Nevertheless, the methodological limitations of the present study must be acknowledged.

Collectively, the main methodological limitations concern the sample. Firstly, participants were recruited from one prison only. Whilst this decision was made on the basis of academic time constraints for completion of the research, it does give rise to issues surrounding the generalisability of the present findings. Secondly, participants were excluded if they did not have daily contact with prisoners as part of their job role. This decision was made to eliminate ambiguity when responding to items comprising the MBI which could be answered with “Every day”. However, this decision gives rise to issues relating to sample size (which was reduced to 68 from 84), and consequently power and statistical significance.

Conclusions

The present study aimed to examine the mediational role of EI in the relationship between resilience and burnout amongst prison staff within HMPPS. Results revealed a significant indirect effect of Resilience on Personal Accomplishment (Burnout) through Management of Emotion (EI) and Utilisation of Emotion (EI), yielding support for the hypothesis. Firstly, these findings contribute novel insight into the role of personality in reducing burnout susceptibility amongst prison staff within HMPPS, which had previously been unexplored. Secondly, these findings have practical implications for HMPPS in relation to guiding the development of preventative interventions to reducing burnout susceptibility amongst staff. Future research should examine more complex models including additional variables in order to broaden this relatively new area of research, explore the role of resilience and EI across larger samples within HMPPS, and rectify the methodological limitations of the present study.

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The Millennial Burnout – An Important Phenomenon

Pragya Lodha, Clinical Psychologist, Private Practice, Mumbai.

Dr Avinash De Sousa, Consultant Psychiatrist and Founder Trustee, Desousa Foundation, Mumbai

“I have a meeting and then I have to reply to nine emails, post that I am training the campaign volunteers and then will catch up a few colleagues for dinner to discuss the upcoming projects - so, I'll try and get some hours at my pillow but it's going to be very difficult to visit the bank this week”

It's not as if millennials are slacking in the rest of their life. They're working day in and day out, executing a move across the demographics, planning trips, taking care of their expenditures, catching up with social interests and exercising on a regular basis. But when it comes to the mundane, the medium priority, things that wouldn't make my job easier or my work better, they avoid it. I am sure every millennial reading this empathises with the above.

Anne Helen Peterson was the first to introduce this condition as the 'millennial burnout'. In this phenomenon, she also speaks about another introductory notion - 'errand paralysis' which refers to where millennials fail to complete the errand jobs of a diurnal routine. The question is often, "My parents did the errands for the day successfully despite the fact they did not enjoy it, so why cannot I, especially so more when the tasks are even easier?"

The answer to this is that the primary beneficiary of these errands may be the millennials themselves but not in a way that would actually drastically improve their life. Tasks are seemingly high-effort, low-reward tasks, and millennials find it paralysing. Explanations like these are at the core of the millennial reputation: We're spoiled, entitled, lazy, and failures at what's come to be known as "adulting", a word invented by millennials as a catchall for the tasks of self-sufficient existence.

Burnout is a shared, defining generational experience, but that doesn't mean it works or feels the same way for all millennials or that it's limited to millennials. There are various intersectional aspects of millennials that contribute in them experiencing the burnout- religion and ethnicity one is born to, the conditioning, the socioeconomic capability, the cultural environment, exposure to education and the experiences one has over time.

There is ever growing importance and attention to work and most millennials even make it to meeting deadlines, get comfortable working till the last minute and putting in extra hours for better outcomes and greater satisfaction that they derive from the work they do. However, all of this comes at the expense of dwindling social life, errand paralysis and sadly, barely any time for self. The millennial burnout, as explained is like, "You can feel stress, insomnia, self-doubt, cynicism, and as though you're in a void, like, 'How can I possibly succeed when there are not enough resources left for me?' There will be emotional exhaustion, a feeling of dissatisfaction, inadequacy, and also anger, and maybe physical pain that could take the form of fibromyalgia or constant feelings of 'unwellness'. There can be several factors leading to this burnout i.e. over-expectations from parents, careers, and society, constant pressure from social media to be living the best life, which leads to a fear of failure and, conversely, a fear of success: "If I achieve all that, how can I possibly keep it up? I may as well not even try". In extreme situations, it is delineated that millennial burnout can and does lead to depression or suicidal thoughts.

It is reported by millennials that they have internalised this thought that they need to keep working, they cannot be average, they need to be achieving all the times and the banging pressure of social media to portray how great and meaningful their life is (needs to be).

Having understood the phenomenon, there is no withholding reason for millennials to know and practice that taking a break is extremely important and taking a break comes with some great benefits, like:

1. One of the most important reasons to take a break is to make feeble and delay the experience of burnout which mentally and physically drains the millennials, eventually leading to mental health challenges
2. A lapse in between of doing nothing allows creativity to emerge in work
3. Taking a break maintains interest, motivation and productivity on the work front
4. This free time allows millennials to reconnect with family and friends which is an extremely crucial element of socialisation which is needed for us humans to keep going
5. This break can also sometimes be utilised for self-reflection which can allow millennials to pause for a while and think for the greater good planning for the future is sometimes essential
6. Physically the body gets the needed time to rejuvenate in order to keep functioning healthily
7. The break may also prevent emotional distress and any possible mental health challenges which are an extremely common phenomenon in today's time
8. Taking a small break to connect with the nature does a lot of good to the physical and mental health- a small element of well-being that no one prioritises but if one does, can see the benefits on the quality of life.

It is not just okay to take a break but equally important to keep some time off in order to physically and mentally rejuvenate oneself which brings benefits in the longer run to no one else but the millennials.

'If you're tired, learn to rest, not quit'

Basic to generational theory is that each generation is shaped by its own biography, where the biography is comprised of a series of events that people with common birth years relate to and develop common beliefs and behaviours around. These commonly held beliefs and behaviours then form the personality of that generation.

Feeding into the formation of different generations is the concept that the personality of a generation is cyclical. With that, approximately every third generation will closely emulate the values and beliefs of three generations prior.

Perhaps we're trading off boredom for stress. Our jobs are ostensibly less mind-numbing, but more soul-taxing. Maybe the only jobs left, the ones that can't be automated require more concentration than can be sustained for 40+ hours a week by a well-adjusted human.

Disengagement and pressure at work have both risen to unhealthy levels. Researchers are accumulating evidence that stress from our jobs is literally killing us. Employees are spending more time at the office, are more stressed, and have fewer guaranteed benefits like pensions or guaranteed health insurance.

Social media also takes the "grass is greener" effect to a whole new level. We see the idealised versions of everyone else's life; it looks like they are all traveling to exotic places with gorgeous romantic partners, funded by their fulfilling and well-paying jobs. The Internet, moreover, gives us access to a whole new world of opportunities.

We can browse jobs at the most prestigious companies in the most Edenic cities, dreaming about life as an investment banking VP or a catamaran repairman. On Tinder, we can scroll through endless images of beautiful people who we could someday end up with. Opportunity costs have existed forever, but it's only in our era that the fear of missing out (FOMO) and decision paralysis have become catchphrases.

Here are some strategies for how to avoid or alleviate millennial burnout and keep oneself on the path to great success:

Take Time

Millennials might not be as lazy or as entitled as the internet claims they are, but they are more accustomed to instant gratification. Do yourself a favour and don't expect to catapult to the top right away. Promotions don't come easy or necessarily at rapid speed. Don't let the fact that you aren't moving up immediately make you feel under-appreciated or unsatisfied. Take a look around at people you admire and find out how long it took them to get where they are. Then give yourself the appropriate time to reach your loftiest goals.

Disconnect

Millennials tend to be utterly glued to their devices and some jobs expect you to be "on" at all times. Find a way to set limits on your time, turn off notifications, or set yourself a few phoneless hours per day.

Say "No"

Perhaps the quickest way to burn out is to say yes to every request that's made of you. You don't have to agree to absolutely every favor asked in order to make it to where you want to be. Set yourself some boundaries. Say yes only when you have the time to do something well — and without resentment.

Monotask

In a culture that prizes multitasking skills, learn how to monotask. You'll be surprised at how much your productivity increases when you slow down and focus on one thing at a time.

Delegate

As much as you want to be in control to make sure things are done right, you can't possibly handle every detail of every project. Learn what others can do and learn to delegate those tasks to them. That way you can concentrate on the really challenging tasks you know you need to oversee. You could even find a buddy to split meeting attendance with — you go to one, they go to the other, and you compare notes, saving yourselves the extra time.

Get Mentored

A little humility goes a long way. Finding a mentor or trusted superior with whom you can confide before you hit the full-on burn-out stage is crucial. Be honest about where you're at and open to figuring out what changes you could make to fix it.

Add Joy

You have to take a business trip or run an errand, try to find a way to make it more enjoyable around the edges. Ask for a day or two on either end of the trip to recuperate or sight see, say. And use your vacation days. When you get back to the desk, focus on what you really love about your job and concentrate on those tasks for a week or so.

Mentor Back

Giving back is a great way to remind ourselves how great we have it. Try to help out or have coffee with someone trying to break into your field. You'll be surprised at the warm fuzzies it could give you to give advice.

Recharge

Find means of recharging daily, set aside at least 5 to 10 minutes to do something that truly calms and satisfies you. It's also extremely helpful to have a creative outlet outside the workplace that has nothing to do with your job.

Be Realistic

Don't set yourself up for failure. Keep those high expectations in check by limiting your to-do list to the realm of reasonable possibility. Figure out the ways in which your expectations are getting the better of you, and trim back a bit. If you give yourself the room to succeed, you will.

The trouble with professional burnout is that it strikes when you least expect it. You're overworked, overstimulated, and striving for excellence in a world that sets the bar high. And as a millennial, you're setting your own bar even higher. We know ourselves better than anyone, yet we internalise societal pressures and put aside our needs. We want to strengthen our personal brand, maintain an active social life, all while striving for that sweet work-life balance when balance means we just sort of never stop working.

Whether you're on the cusp or already drowning in a pool of burnout, it's never too late to take your life into your hands. As millennials, we hate the thought but: sometimes we need to take a step back to move forward.

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Compassion Fatigue in Indian Physiotherapists

Dr Poovishnu Devi, Assoc Professor, Krishna College of Physiotherapy, KIMSDU, India

Abstract: Compassion fatigue is common among health care professionals exclusively among Physiotherapists rehabilitating patients with paralysis, debilitated and progressive diseases. Prolonged treatment for hours together daily with no or significant improvement results in compassion fatigue. In Indian scenario physiotherapists working in ICU setups has preoccupation of absorbed trauma and emotional stress of preceding patients causes secondary traumatic stress. Prolonged exposure to such situations makes physiotherapists working in ICU and rehabilitation setups susceptible to compassion fatigue which can result in burnt out.

Key words: ICU , rehabilitation , compassion fatigue ,burnt out

Compassion Fatigue is the emotional and physical anguish caused by treating and serving patients, which can challenge Physiotherapists causing them a dearth of empathy for prospective patients. ¹ The two important components of Compassion Fatigue: burnout and secondary traumatic stress. ²

Burnout should not be confused with Compassion Fatigue, but symptoms remain the same. Burnout is the stress and mental exhaustion caused by inability to cope with the environment and continuous physical and mental demands ³.as part of a rehabilitation team, with its tremendous physical and emotional demands, naturally predisposes physiotherapists to compassion fatigue. Among Physiotherapists the important component for suffering from compassion fatigue is burnout. ⁴

Compassion fatigue is epidemic today, due in part to the demands of managed care. Physiotherapists treat patients for longer duration, do more paperwork in terms of daily assessments, preparing and modifying exercise protocols and home exercise programme schedules, long shifts, less sleep, preparation for higher studies, negotiate more deals and have less autonomy than ever before. Added to that chosen pressure to live up to their own high morals and when practicing the same physiotherapists feel like they are going up in burst into flames. It is hard to believe that in spite of practicing physiotherapy for a long time compassion fatigue is more observed in young physiotherapists. ⁵

Additionally, corporate sector hospitals focus more on patient and medical documentation as they are expected to know aggregate amount of medical information along with experienced high ethical dilemmas/medical demands. This has created a workload or reward imbalance or decreased compassion satisfaction. Compassion satisfaction relates to the positive payment (either monetary or mental satisfaction) that comes from caring ⁶ with little compassion satisfaction, and above said leading factors are the reasons for developing burnout and compassion fatigue among physiotherapists. ⁷

Secondary traumatic stress: It is work related secondary exposure to extremely traumatic stressful events where the physiotherapists cannot take it anymore as it comes from within like the therapists beats up when patient vitals fluctuates or the symptoms does not improve in spite of best therapy, constant failure of the patient to thrive or cope with the therapy and decrease of adolescent or pediatric patients. Secondary traumatic stress is more common in physiotherapists working in intensive care units and palliative care. Critical care therapists have the highest reported rates of burnout compared with other Physiotherapists; a syndrome associated with progression to compassion fatigue. These providers witness high rates of patient disease and death, leaving them to question whether their work is truly meaningful. ⁸

Physiotherapists experiencing trauma will have a change in outlook of the world they visualise it more unconstructively. It can pessimistically affect the worker's sense of self, safety, and control. ⁹

Overall burnout and secondary traumatic stress has been associated with decreased quality of care and patient satisfaction, as well as increased erroneous assessment, diagnosis and mounting complications making situation crisis.

Factors affecting compassion

Therapists with enhanced ability to empathise effortlessly and be compassionate at all situations are at higher risk of augmenting compassion fatigue. Physiotherapists working in ICU, rehabilitation and terminal care units are regularly exposed to death, trauma, high stress environments, long workdays, difficult patients, pressure from a patient's family, and conflicts with other staff members are at higher risk.¹⁰ These exposures increase the risk for developing compassion fatigue and burnout, which often makes it hard for therapists to stay in the career field.

Outcome of compassion fatigue

Physiotherapists who continue the same line of work after developing compassion fatigue or burnout are likely to experience lack of energy, difficulty concentrating, unwanted metaphors or thoughts, insomnia, stress, desensitisation and irritability and later develop substance abuse, depression and suicide¹¹.

Scope of research on compassion fatigue in physiotherapists:

Clinical bio ethics is an emergent expansion in Indian health care profession, but numerous research has been conducted and published in the western world and interpretations were drawn from their statistics and it is not unconvincing as it may or may not be relevant to Indian physiotherapists. Owing to our own socio cultural uniqueness. Recent Studies on compassion fatigue revealed that they felt as they have become pessimistic, anergic, and less sympathetic towards their patients. They realised as they were distancing from patients and even from their colleagues. Many studies showed that specialty, duration spent with patients and treatment outcomes has a profound impact on developing compassion fatigue⁹. Till date research on compassion fatigue is not yet conducted among Indian physiotherapists who are tortuous in treating long term conditions (stroke, spinal cord injuries, cerebral palsy), progressive conditions (COPD, cancer, heart failure) and degenerative conditions (muscular dystrophy, Parkinson's disease, arthritis) and remain associated with the patient for hours and also have an elusive bonding with patients.

Compassion fatigue in ICU physiotherapists: Physiotherapists in ICU are directed in preventing ICU-associated complications like deconditioning, ventilator dependency, respiratory conditions, prevention of secondary complications and progress to mobility, improving patient's quality of life. The main reasons for compassion fatigue are sudden decline in health status drive the patient to further medical intervention like intubation, reconnecting to ventilator, ventilator acquired pneumonia, hospital acquired infection etc which deteriorate the patient status, likely to interrupt with the physiotherapist treatment protocol planned for the patient.

Compassion fatigue in Oncology physiotherapists: Inpatient oncology units have mixed-model setting. In the course of one shift, physiotherapists provide care to patients who are receiving active curative treatment, at the same time helping patients who are receiving palliative or end-of life care, depending on their assigned patient load¹⁰. Chemotherapy sessions with its own complications like anorexia, weakness further deteriorate the patient functional status. By moving continuously from one situation to another they do not feel in control or supported, he or she is at risk for compassion fatigue.

Compassion fatigue in Inpatient physiotherapists: Often patients look out for a quick fix and it is very difficult to convince that physiotherapy will be beneficial until they experience it, patients breaking during the treatment into traditional medications during the initial stages and expecting full recovery in degenerative stage, physician interference with patient physiotherapy protocols and finally dealing with google patients exhausts the physiotherapists.

Compassion fatigue in Rehabilitation physiotherapists: Patients in rehabilitation setup (paralysed, amputate) are likely to be depressed or anxious to some extent, lot of motivation is needed to carry out exercise and glue with the protocols. Patients prefer passive modalities rather than active exercises which prolong the treatment duration and recovery time, not adhering with the home exercise regime which delay the progression, frequent quires about expected time for full recovery in conditions like paraplegic, transverse myelitis bases burnout leading to compassion fatigue.

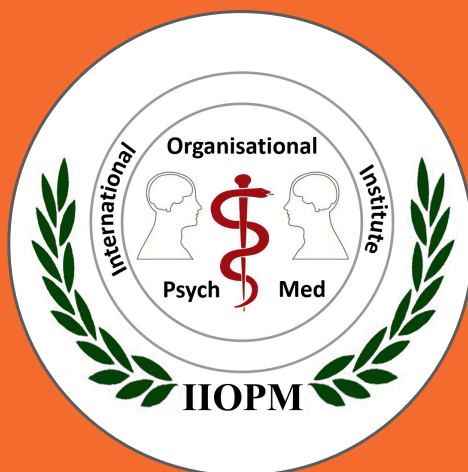
In geriatric rehabilitation set up, Physiotherapists focus on rehabilitation and rehabilitating the patients with symptoms, disabilities and pain syndrome, Elderly patients in the midst of their own personal loss, relational troubles and difficulty to cope up with aging all contribute to reduction in training sessions participation and poor prognosis ¹¹. Exercise protocols to improve balance, coordination, range of motion, muscle strength which require long period of training and patience, even a single episode of illness can deteriorate the patient to the baseline level.

When physiotherapists try to deal with compassion fatigue by themselves, they are exposed to trauma possibly pushing them out of their career field. In spite of staying in the profession for various other needs it can negatively affect the therapeutic association they have with patients because it depends on forming an empathetic, trusting relationship that could be difficult to make in the midst of compassion fatigue ¹².

To embark upon the problem of compassion fatigue, first it should be properly assessed based on their profession not in a wide view of health care profession, sound planning parameters need to be developed for which basic data from each own set up is needed and proper management to be followed.

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Registered Offices

Australia

71 Cleeland Street
Melbourne, Victoria,
3175Australia

UK

Cheswold Park Hospital,
Cheswold Lane, Doncaster,
South Yorkshire, DN5 8AR

USA

545 N Wickham Road,
Suite 110, Melbourne,
Florida 32940 USA

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