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'Stress-busting' groups for consultant psychiatrists

AIMS AND METHOD

To describe the formation and function of 'stress-busting' groups and report a survey on work-related stress among a small cohort of consultant psychiatrists.

RESULTS

Of 37 questionnaires, 25 were returned and 16 respondents (64%) rated their overall level of stress at work as moderate or severe. Stressful factors included lack of staff, paperwork, high-risk patients, difficult/hostile relatives and job demands interfering with family life. The most helpful stress-reducing strategies were talking to colleagues for support and catharsis, outside interests, support from family and friends, effective time management and exercise. Among 15 current members of 'stress-busting' groups, 14 (93%) found these to be helpful. The most successful format in the 'stress-busting' groups was one of 'problem-solving with ventilation of stresses'.

CLINICAL IMPLICATIONS

'Stress-busting' groups may constitute a helpful approach to work-related stress and a utilisation of the skills of psychiatrists to our mutual benefit.

Work-related stress is a common phenomenon that is acknowledged to have adverse effects on both physical and psychological well-being (De Lange *et al*, 2004; Fifield *et al*, 2004; Moller *et al*, 2005). Workers affected significantly by stress include hospital consultants (Caplan, 1994; Ramirez *et al*, 1996; Graham *et al*, 2001; Bruce *et al*, 2005). Specifically, consultant psychiatrists are reported to experience high rates of anxiety and depression, with a significant proportion considering retirement or experiencing suicidal ideation (Rathod *et al*, 2000). Commonly, sources of work-related stress in psychiatry have included dealing with difficult and hostile relatives, paperwork (Rathod *et al*, 2000), work overload (Benbow & Jolley, 1999), changing organisational structure and governmental reforms (Kendell & Pearce, 1997). In the current climate of high numbers of consultant vacancies and recruitment difficulties in psychiatry, studies highlighting the link between stress at work and premature retirement (Kendell & Pearce, 1997) emphasise the need to identify current sources of stress at work for consultant psychiatrists, and so allow the development of strategies to reduce stress and improve job satisfaction. Certain studies have attempted to assess the impact of strategies such as mentoring, changes to working style and/or team structure or referral processing (Kennedy & Griffiths, 2001; Roberts *et al*, 2002), but work in this area remains limited.

Following a continuing professional development seminar in Aberdeen in 1999, which focused on contentment at work, it was proposed that consultant psychiatrists would form groups to attempt to discuss and reduce work-related stress. This paper describes the formation and functioning of these groups and the results of a subsequent survey questionnaire on work-related stress.

Method

Formation of 'stress-busting' groups

In the spring of 2000, all of the 18 consultant general adult psychiatrists working in general adult psychiatry in Aberdeen and Aberdeenshire responded to a brief questionnaire about 'stress-busting' groups. They were asked to rate seven possible functions/formats of such groups on a 0–10 scale with respect to the type of group they might wish to join. In brief, these functions/formats comprised:

- reducing external stressors; identifying these and seeking to reduce them through approaches to the appropriate service managers
- learning how to relax; personal stress reduction through exercise, relaxation techniques, etc.
- ventilation of stresses and difficulties; sharing problems in a mutually supportive group
- identification of personal sources of stress; identifying and understanding what makes us stressed
- problem-solving strategies; discussion of particular approaches to particular stress factors
- personal therapy; looking at our own psychopathologies and their relationship to work stress
- tutorial format; external speakers on stress management, job satisfaction, etc.

The 18 consultants were then placed in three groups with the aim of clustering people with similar predictions about the formats they would find most helpful. The three groups could be characterised as follows:

- group A – reducing external stressors with ventilation
- group B – identification of personal sources of stress with problem-solving strategies
- group C – problem-solving with some ventilation.

The groups were then invited to convene and to meet thereafter as they deemed appropriate.

Survey of work-related stress

A postal questionnaire was sent to the 37 consultant psychiatrists in all specialties working in Aberdeen city and Aberdeenshire in late 2005. This was sent anonymously with one reminder. The questionnaire comprised

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three sections: one covered demographic details including speciality and length of time in consultant post; the second focused on overall levels of stress at work and asked respondents to rate the extent to which specific factors contributed to this (respondents were also asked to cite the single factor that contributed most to work-related stress); the final section focused on membership of 'stress-busting' groups and the impact they might have had on stress levels.

Results

Developments in 'stress-busting' groups

Group A (reducing external stressors with ventilation) met only a few times and then disbanded. Group C (problem-solving with some ventilation) gelled very well, meeting regularly with good attendance. Group B (personal sources of stress/problem-solving) had intermediate success, meeting rather less frequently and with less complete attendance.

By the summer of 2004, some original group members had departed and new consultant colleagues and consultants outside general adult psychiatry were expressing interest in joining the groups. The same brief questionnaire about group formats was sent to those who had not previously completed it, along with a letter to the 39 consultants of all specialties then based in Aberdeen asking if they would wish to continue or to join a 'stress-busting' group. Three groups of seven were then formed, with consultants joining existing groups B and C, and a group being constituted of seven consultants who were relatively new to the local service. It was felt that newer recruits to the consultant establishment might have shared sources of stress.

Survey results

Of the 37 questionnaires distributed, 25 were returned, representing a response rate of 68%. Respondents were working in general adult psychiatry (n=11), child and adolescent psychiatry (n=4), old age psychiatry (n=3), substance misuse (n=2), learning disability (n=2), liaison psychiatry (n=1), psychotherapy (n=1) and rehabilitation psychiatry (n=1). There was a relatively equal gender distribution, with 13 male respondents (52%) and 12 (48%) female.

When asked to rate their overall level of stress at work, 16 (64%) rated this as moderate or severe. Respondents were then asked to rate whether, and to what extent, specific factors contributed to stress levels at work. The results are shown in Table 1. Of note, 7 (28%) rated all factors as causing at least mild stress at work. Asked which single factor caused most work-related stress, 7 (28%) cited responsibility for high-risk or difficult patients, 4 (16%) cited lack of staff, 3 (12%) managing staff, 2 (8%) unrealistic patients or relatives, 2 (8%) inappropriate referrals from general practitioners and 2 (8%) stated that paperwork was the single factor that contributed most to work-related stress.

Respondents were asked to list strategies they used to ameliorate work-related stress; 17 (68%) stated they talked to colleagues for informal peer support and catharsis; 14 (56%) used outside interests (for example, reading, music, gardening); 10 (40%) sought support from family and friends; 9 (36%) made attempts to improve their time-management strategies; 9 (36%) used exercise and 4 (16%) described using humour and/or attempting to keep work demands in perspective; 2 (8%) stated they used annual leave and 2 (8%) cited the option of early retirement as a method of dealing with stress at work.

There were 15 respondents (60%) who were members of 'stress-busting' groups and 10 (40%) who were not. Of those currently in a 'stress-busting' group, 14 (93%) reported that group membership had given rise to at least slight to moderate reduction in stress. Of those currently in a 'stress-busting' group, 9 (60%) rated their overall level of stress at work as moderate, but none rated their stress levels as higher than this. For respondents not currently in a 'stress-busting' group, 5 (50%)

Table 1. Ratings by consultants of current stress factors[1]

Factors	Mild *n* (%)	Moderate *n* (%)	Severe *n* (%)
Inadequate medical staff numbers	4 (16)	12 (48)	5 (20)
Paperwork	8 (32)	13 (52)	1 (4)
Dealing with difficult/hostile relatives	9 (36)	12 (48)	2 (8)
Government policies for care of people with mental illness	8 (32)	10 (40)	4 (16)
Demands of job interfering with family life	11 (44)	8 (32)	4 (16)
24-h responsibility for suicidal/homicidal patients	15 (60)	6 (24)	2 (8)
Working long hours	9 (36)	5 (20)	3 (12)
Interference by managers in clinical matters	11 (44)	5 (20)	2 (8)
Arranging admissions	12 (48)	5 (20)	–
Demands of job interfering with social life	14 (56)	3 (12)	1 (4)
Out-of-hours on-call duties	9 (36)	2 (8)	1 (4)
Days on call	11 (44)	–	–

1. Some consultants did not find these factors stressful hence percentages may not add up to 100.

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rated their overall stress level at work as moderate and 2 (20%) rated their overall stress level as severe. Out of those not currently in a group, 3 (30%) cited time constraints as a significant factor preventing them from joining one.

Discussion

Stress among consultant psychiatrists has been fairly widely studied, but strategies to deal with this stress have received less attention. We describe the formation of 'stress-busting' groups and a small survey on consultant stress 5 years thereafter. The numbers in our survey were inevitably low but the response rate (68%) was respectable. The sources of stress detailed in Table 1 indicate that our sample seemed representative, in that stressful work-related factors accorded with those in previous studies (Kendell & Pearce, 1997; Benbow & Jolley, 1999; Rathod *et al*, 2000; Littlewood *et al*, 2003).

Other studies have questioned psychiatrists about strategies used to ameliorate stress (Rathod *et al*, 2000; Littlewood *et al*, 2003). Most of these findings accord with those identified in our study, with the surprising exception of our most frequently cited strategy of talking to colleagues for peer support and catharsis. This is perhaps all the more surprising in that the Littlewood *et al* (2003) survey of consultants in child and adolescent psychiatry found the presence of a supportive colleague to be a protective factor against work-related stress. The consultants in our survey did not consistently specify whether their supportive colleagues were fellow consultants or other members of the multidisciplinary team. A previous survey found that consultant psychiatrists who were stressed in the aftermath of patients' suicides derived almost equal benefit from consultant colleagues and from other members of their teams (Alexander *et al*, 2000). The majority of respondents in the studies of Rathod *et al* (2000) and Littlewood *et al* (2003) derived benefit from talking to their partners or friends, and this was mentioned by 40% of our respondents.

When authors advocate changes that might reduce stress in psychiatrists, these changes often focus on external factors beyond the psychiatrists' control. Examples include safer working environments (Guthrie *et al*, 1999), improved organisational structure (Benbow & Jolley, 1999) and reductions in bureaucracy and paperwork (Kendell & Pearce, 1997). The development of new 'progressive' roles might ameliorate consultant stress (Kennedy & Griffiths, 2001; Mears *et al*, 2004), although again this relates primarily to organisational restructuring. Peer support and discussion tend to go unconsidered, or to be mentioned in passing or with reservations. In their study of traditional and new roles, Kennedy & Griffiths (2001) state that 'the psychiatrists were surprised how little they know about how other general psychiatrists were tackling the job'. Benbow & Jolley (1999) suggest the possibility of 'increasing informal contact with colleagues (though depending on the colleagues, some might find this increases stress!)'. Only Littlewood *et al* (2003) clearly advocate cultivation of mutually supportive relationships with colleagues. They suggest that peer groups for continuing professional development could be used for this purpose, but this does not fall within the remit of such groups.

Of those consultants in Aberdeen invited to join or continue in a 'stress-busting' group, 21 wished to participate and 18 did not. Although several non-participants mentioned pressure of time as a reason for not joining a group, it would not be a format for addressing stress that is to everyone's taste and the 93% of respondents who found their groups helpful derive from a selected sample. It is potentially misleading to draw conclusions based on our small cohort of consultants, but it may be noteworthy that the group most focused on identifying and remedying stress through measures external to the group and to themselves was the one that was discontinued. Certainly, strategies for dealing with work stresses that relate to personal empowerment tend to prove most helpful (Alexander, 1993; Florio *et al*, 1998). With respect to our local work culture, it has been helpful to acknowledge, to normalise and to formalise an approach to a shared difficulty. Finally, most consultant psychiatrists should have an understanding of stress, problem-solving and group processes; it is perhaps unfortunate if we do not utilise these skills to our mutual benefit in combating work-related stress.

Declaration of interest

None.

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Patient feedback on services: a questionnaire survey approach

AIMS AND METHOD

The aims of the project were to develop a simple, low-cost patient satisfaction questionnaire with face validity and to obtain patient feedback on a range of service areas in a community addiction team. A questionnaire was designed and revised after feedback from multidisciplinary team members and a pilot sample. The questionnaire was distributed until 100 correctly completed forms were received.

RESULTS

The survey took approximately 30 h of authors' time from commencement to completion and costs were minimal. The majority of the 12 areas evaluated were rated by patients as good or very good. Overall quality of care was rated as good or very good by 88% of participants. There was no enthusiasm in this sample for more active participation in service development.

CLINICAL IMPLICATIONS

All National Health Service staff and services are now enjoined to engage with service users and carers for the purposes of evaluation and development. Simple, affordable methods for obtaining such information about community services can contribute to this process.

Providing high-quality services for the people that need them is the purpose of every public service organisation. According to the principles of clinical governance 'NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which excellence in clinical care will flourish'(http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/ClinicalGovernance/fs/en). The General Medical Council's revalidation process emphasises providing a good standard of practice and care to the patients (http://www.gmc-uk.org/doctors/licensing). Individually, appraisal, revalidation and clinical excellence awards increasingly demand 'evidence' that doctors provide good clinical care. Corporately, organisations increasingly need to demonstrate to commissioners that they are responding to the needs of patients and carers. Patient involvement in service provision is beneficial for the service user as well as the service provider (Department of Health, 2004).

Conducting a patient survey is a simple method for obtaining information from service users about their perception of the positive and negative aspects of a service and might be one of the only means for clients to express their needs and views (World Health Organization, 2000).

Method

An appropriate questionnaire framework was identified (PSQ–18; http://www.rand.org/health/surveys_tools/psq/index.html; see also Marshall & Hays, 1994) and a questionnaire was then designed to cover the most important elements of the service under consideration, recognising the needs to be as succinct and have as much face validity as possible. The questionnaire was revised following feedback from the multidisciplinary team. A pilot survey of 10 patients at one service site showed that participants found the questionnaire understandable, simple and quick (less than 5 min) to complete, requiring no further changes. The final version was limited to 12 questions about different service areas with space for additional comments. (A modifiable electronic version of the questionnaire is available from P.S.K.)