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Changes of resilience in psychiatric nurses by psychoeducation to improve professionalism: A waiting list controlled trial in Japan

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Abstract

Aim: The present study aimed to examine changes in resilience after a psychoeducational intervention to improve professionalism in psychiatric nurses.

Methods: A psychoeducation program for psychiatric nurses was developed, and 36 participants were randomly allocated to active intervention and waiting list intervention groups. The S-H Resilience Test was used to assess resilience twice (before and after the intervention/control period), and statistical comparisons were conducted according to time point.

Results: Distributions of the resilience scale scores (total and three subscales) in the intervention and control phases were compared before and after psychoeducation or observation. For the intervention phase, total and social support subscale scores significantly increased post-intervention ($p < 0.05$). Resilience types were compared between the two time points in the intervention and control phases, and there were significant changes in the intervention phase (positive type resilience increased).

Conclusion: This psychoeducation approach to improve professionalism in psychiatric nurses may be effective in enhancing resilience, particularly by facilitating social support and positive attitudes in participants.

Keywords: Psychiatric nurse, psychoeducation, resilience, social support

1. Introduction

Psychiatric nurses experience a range of difficulties, including conflicts of mutual understanding with patients, stigma about psychiatric illnesses, and structural inequalities related to mental health^[1-3]. Studies from Japan have identified several factors related to barriers affecting the development of professionalism in psychiatric nurses, such as the complex history of psychiatry, difficulties quantifying psychiatric care, and low social evaluation of psychiatric nursing^[4-7]. These factors mean that psychiatric nurses are vulnerable to burnout owing to ethical dilemmas and psychological distress^[8-10]. Effective training systems specifically tailored to psychiatric nursing are needed to improve professionalism in psychiatric nursing and to empower nurses.

The findings of several studies suggest that psychiatric nurses in Japan require training or education to improve skills and knowledge, interpersonal relationships, and self-esteem, and to reduce anxiety about their identity or value as psychiatric nurses^[11-12]. To overcome these issues, training and education must include both the awareness of self-affection (feeling and emotion) and actual care experiences (practice and coping skills). To encompass these components, effective training programs must address knowledge, self-affection, and behavior.

Psychoeducation is a psychosocial approach to empower people experiencing long-term difficulties or problems that are hard to accept, such as mental illness, chronic disease, or various handicaps^[13-15]. Psychoeducation involves a comprehensive approach that consists of two components: educational programs to provide adequate information or knowledge about disorders or problems with consideration for participants' psychological aspects, and group work or interpersonal support to share participants' difficulties or feelings and to facilitate coping^[16]. There is evidence that family psychoeducation can contribute to positive outcomes (e.g., relapse prevention, symptom reduction, and improvement in quality of life) in individuals with psychiatric disorders, and in Japan a standard program based on the Implementation Resource Kit for Family Psycho-Education (SAMSHA, 2003; 2010).

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[17-18] has been introduced and widely used (COMBO, 2009) [19]. In addition, psychoeducation has also been used for healthy participants to enhance stress coping, for instance, with school children or nurses (Kubota, 2017; Katsuki, *et al.*, 2013) [20-21]. Given the above-mentioned complex difficulties or barriers in improving specialty care or professionalism, we aimed to develop an effective training and educational program for psychiatric nurses. Psychoeducation may be a useful approach in efforts to support psychiatric nurses. Therefore, we developed a psychoeducation approach to improve professionalism in psychiatric nurses (Sakai and Uehara, 2023) [22], and confirmed its efficacy by measuring improvements in the main outcome regarding occupational identity and professional autonomy.

The present study focused on the resilience of participants receiving this psychoeducation approach, because the ability and strength to recover from adverse situations or difficulties is closely related to professional or occupational satisfaction as a psychiatric nurse [23]. The American Psychological Association defines resilience as “the process and outcome of successfully adapting to difficult or challenging life experiences, especially through mental, emotional, and behavioral flexibility and adjustment to external and internal demands” [24]. An integrative review was conducted by Foster, *et al.* to examine understanding of and perspectives on resilience in mental health nursing. They noted that resilience is often reported to correlate positively with hardiness, self-esteem, and life and job satisfaction, and to correlate negatively with depression and burnout (Foster, *et al.* 2019) [25]. They also reported evidence that a resilience program increased mental health nurses’ coping and ability to regulate thoughts and emotions, and helped them to develop their resilience practice. We hypothesized that psychoeducation comprising the two above-mentioned components of educational programs and group work could be effective in facilitating resilience. The present study aimed to clarify changes in the resilience of psychiatric nurses receiving psychoeducation by comparing control nurses using a waiting list (WL) design.

2. Participants and methods

2.1 Participants

Participants were recruited from psychiatric nurses who worked at psychiatric hospitals in Gunma prefecture, Japan. The first author provided all participants with an explanation of the research and obtained written informed consent from participants. A total of 39 psychiatric nurses participated in the study and each program group contained 4 to 8 participants. A total of eight groups completed the intervention, and data from 36 participants were included in the analysis (cases that dropped out or had many missing values were excluded). The study was conducted from 2018 to 2021 and based on the same data set in a previous Japanese original article (Sakai and Uehara, 2023) [22].

2.2 Psychoeducation program

2.2.1 Purpose

The purpose of the program was to improve the fundamental knowledge and skills of psychiatric nurses, to facilitate self-awareness and understanding of others, and to acquire coping and care skills that contribute to psychiatric care.

2.2.2 Components and structure

The program comprised three components: knowledge (information, theory), emotion (self-awareness, feelings), and motivation (skills, practical ability). The program consisted of four sessions (held once a month from 9:30 to 12:30); each phase lasted approximately 4 months. The first half of each session was composed of educational content and the second half was group work.

2.2.3 Educational content

The first session addressed the ethics of psychiatric nursing, the national mental health strategy, and individual experiences or opinions of actual care related to ethics and the mental health system. The second session aimed to connect practice with nursing theory by focusing on the major theories of psychiatric nursing. Participants were encouraged to integrate actual care experiences and psychiatric nursing theories by reviewing practical theories such as interpersonal theory, self-care theory, and strength theory. The third session focused on patient–nurse relationships with the aim of improving communication skills and facilitating objective self-awareness. The final session comprised a summary of professional autonomy as a psychiatric nurse, and discussed the improvement of professionalism. The educational content was developed by the authors during several discussions based on information from major textbooks and educational papers by the Japanese Association for Psychiatric Nursing.

2.2.4 Group work

Following the educational content, the second half of each session consisted of group work. The group work was based on social skills training (SST) [26] and structured group encounters [27] to help participants to share feelings and emotions and to improve skills and practical ability. Participants were instructed to join a group work discussion based on the content addressed in the first half of the session. Participants were encouraged to comment freely and candidly and to listen to others. Participants sat around a whiteboard, and two facilitators led a group discussion using icebreaking or SST techniques. Participants were facilitated to find strength in and to validate each other. Participation was voluntary and participants’ privacy was protected. The facilitator and all the staffs were trained over several rehearsal sessions, and they had over 10 years of experience as a psychiatric nurse and an SST trainer.

2.3 Procedure

It was considered desirable for all participants to receive the intervention, so a randomized WL design was used to enable comparison of the intervention and control phases. As shown in Figure 1, participants were randomly assigned to one of two groups (active, WL). The active group received the psychoeducational intervention (intervention phase). The WL group was assigned as a control phase during this observational period (approximately 4 months), and subsequently received the same intervention (intervention phase). The intervention phases included a final total of 29 participants (16 from the active group and 13 from the WL group), and the control phase included 20 participants (7 of who completed only the observational phase and dropped out of the intervention).

	1 course		
active group	psychoeducation (intervention phase)		
waiting list group	observation (control phase)	→	psychoeducation (intervention phase)
assessment	↑		↑

Fig 1: Design of the intervention and evaluation

2.4 Evaluations

An explanation of the study was provided to participants at baseline and general information was collected. The active intervention group was assessed twice: before and after the intervention phase. The WL group was assessed three times: before the observational periods (control phase), before the intervention (after observation), and after the intervention.

2.4.1 Background information

Participants’ age, gender, psychiatric nursing experience, and occupational position were recorded.

2.4.2 Resilience

Resilience is defined as “the process of adapting well in the face of adversity, trauma, tragedy, threats, or significant sources of stress, such as family and relationship problems, serious health problems, or workplace and financial stressors” [28]. Resilience was assessed using the S-H Resilience Test parts 1 and 2, which is a commonly used resilience measure. This scale was developed by Sukemune and Hiew (2007) [29] for Japanese adults, and has shown high validity and reliability for its three factors of “social support” ($\alpha = 0.85$), “self-efficacy or problem solving” ($\alpha = 0.81$), and “sociality or cooperation” ($\alpha = 0.77$). Part 1 of the questionnaire consists of 27 self-report items, 9 questions on each of the three factors. Total scores on the S-H Resilience Test part 1 indicate overall resilience. Part 2 consists of eight categories; respondents select the appropriate statement from four descriptions of their own usual behaviors or attitudes. Following the S-H Resilience Test instructions, four type of resilience were also categorized as follows: type I is positive (adaptive and motivated) for internal thinking and external behavior, type II is positive for internal thinking but negative (avoidant or passive) for external behavior, type III is negative for internal thinking but positive for external behavior, and type IV is negative for internal thinking and external behavior. The dimensional scores for part 1 and the respective types that emerged from scores on part 2 were assessed individually.

2.5 Analysis

At first, to examine differences between the intervention and control phases, background factors (age, gender, psychiatric nursing experience, and occupational position of participants) were compared between the two groups (using

Fisher’s exact probability). For reference, resilience scores were compared for gender and occupational position of participants, and Spearman correlations were calculated to examine the associations among age, nursing experience, and scores on each scale.

Total scores and scores for the three subscales of the S-H Resilience Test part 1 were compared before and after the intervention or observational periods (pre- and post-assessments) using the Wilcoxon signed-rank test for paired samples of the intervention and control phases.

The numbers and percentages of the respective four types of the S-H Resilience Test part 2 were compared before and after the intervention or observational periods for the intervention and control groups using the χ^2 test.

The analyses included data from participants who attended all sessions. Active intervention participants who dropped out any of the four sessions before completion were allowed to join the remaining sessions, but their data were excluded from analysis.

2.6 Ethics

This study was approved by the institutional review board of Takasaki University of Health and Welfare. Written informed consent was obtained from all participants. The privacy policy, free participation, and withdrawal rights were explained to participants.

3. Results

3.1 Background factors

Age, gender, psychiatric nursing experience, occupational position, and numbers of intervention/control phases are shown in Table 1. A total of 16 participants completed the intervention phase as the active intervention group, 13 completed both control and intervention phases as the WL group, and 7 completed only the control phase. There were no significant differences between intervention and control phases on any of the background factors.

Scores on the self-efficacy subscale were significantly correlated with age ($r = 0.35, p < 0.05$ at the pre assessment; $r = 0.42, p < 0.01$ at the post assessment), but resilience scores did not correlate with any of the other background factors. Gender, education, psychiatric nursing experience, and occupational position were not related to S-H Resilience Test dimensional scores or categories.

Table 1: Background information of participants

		Intervention	Phase (N=29) *	Control	Phase (N=20) **
		N	(%)	N	(%)
Gender	Male	16	55.2	9	45.0
	Female	13	44.8	11	55.0
Ages	20-	10	34.5	7	35.0
	30-	9	31.0	7	35.0
	40-	7	24.1	4	20.0
	50-	3	10.3	2	10.0
Education	Postgraduate	3	10.3	1	5.0
	4 years college or university	9	31.0	11	55.0
	3 years nursing school	9	31.0	5	25.0
	2 years nursing school	6	20.7	2	10.0
	High school	2	6.9	1	5.0
Position	Staff	26	89.7	18	91.0
	Chief	1	3.4	1	5.0
	Leader	2	6.9	1	5.0
Experiences	Until year	6	20.7	4	20.0
	2 yrs.	3	10.3	0	0
	3 yrs.	3	10.3	1	5.0
	4 yrs.	2	6.9	4	20.0
	5-10 yrs.	9	31.0	7	35.0
	over 10 yrs.	6	20.7	4	20.0

N.S.

*; Participants in active group were 16(44.4%) and those in WL group were 13(36.1%)

**; Participants of only control phase were 7(19.4%) in all participants of WL group

3.2 Changes in resilience scores

To clarify changes in the resilience scale scores (total and three subscale scores) across the two time points in the intervention and control phases, the distributions of each type of score were compared before and after psychoeducation or observation (Table 2). For the

intervention phase, total scores and social support subscale scores significantly increased post-intervention ($p<.05$, Figure 2-3), but the distributions of the other scale scores did not change significantly. In the control phase, there were no significant changes in any of the scores.

Table 2: Changes of the resilience dimensional scores

	Before Intervention			After Intervention			P
	Median	Max	Min	Median	Max	Min	
Total scores of the resilience	104.0	121.0	85.0	106.0	135.0	85.0	0.018 *
social support	49.0	59.0	39.0	51.0	60.0	44.0	0.013 *
Self-efficacy	35.0	42.0	25.0	37.0	50.0	22.0	0.056
Incorporation	19.0	25.0	13.0	20.0	25.0	14.0	0.406
Control Phase							
	Before Observation			After Observation			P
	Median	Max	Min	Median	Max	Min	
Total scores of the resilience	101.0	113.0	83.0	100.5	120.0	83.0	0.366
Social support	48.5	54.0	39.0	49.5	58.0	39.0	0.361
Self-efficacy	34.0	41.0	27.0	34.0	44.0	25.0	0.858
Incorporation	18.0	25.0	15.0	19.0	25.0	13.0	0.509

*; $p<0.05$

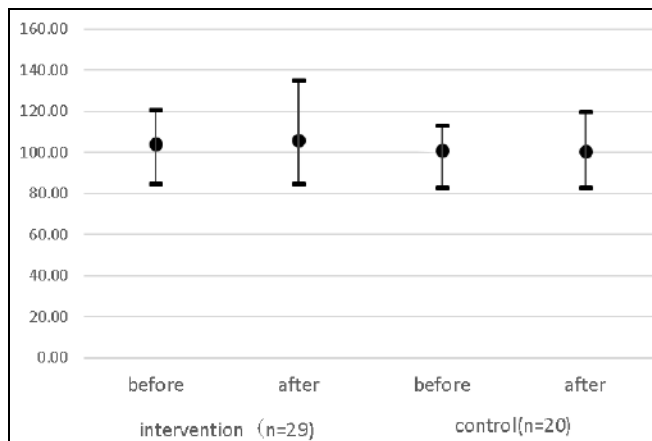


Fig 2: Total score of resilience

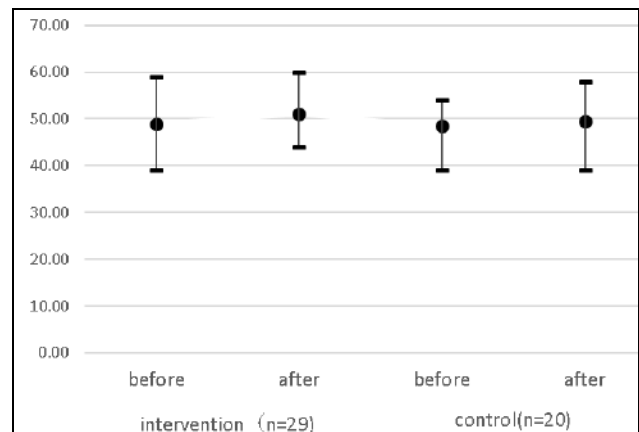


Fig 3: Social Support Subscale

3.3 Changes in resilience types

To examine changes in type of resilience according to the part 2 scale, the numbers and percentages of types I, II, III, and IV were compared across the two time points in the intervention and control phases. As shown in Table 3, there were significant changes in the intervention phase; the percentage of participants with type II resilience decreased but the percentage of participants with type I resilience increased. In the control phase, there were no significant changes across the two time points.

Table 3: Changes of the resilience types

Intervention Phase					
Resilience type		I	II	III	Total
Before intervention	N	16	7	6	29
	%	55.2%	24.1%	20.7%	
After intervention	N	20	1	8	29
	%	69.0%	3.4%	27.6%	
$X^2=9.83, p=0.043$					
Control Phase					
Resilience type		I	II	III	Total
Before Observation	N	9	4	6	19
	%	47.4%	21.1%	31.6%	
After Observation	N	7	3	9	19
	%	36.8%	15.8%	47.4%	
$X^2=7.72, ns$					

4. Discussion

The results suggested that psychoeducation for psychiatric nurses to improve professionalism was effective in enhancing resilience overall. In particular, social support scores significantly increased post-intervention. There are several causes of resilience that involve a complex series of internal and external characteristics; these include personality traits that help individuals to remain calm in the face of challenges^[30], physical fitness, internal locus of control or high emotional intelligence, and environmental aspects^[31]. Social support is another critical variable that contributes to resilience; more resilient individuals tend to have the support of family or friends who help them in difficult times^[32]. During the psychoeducation, participants were empowered by peer support. The provision of detailed knowledge and information in the educational sessions may have helped to strengthen participants' resilience. The increased sense of social support following interpersonal support through group work can be considered a non-specific effect of psychoeducation.

Changes in resilience type were indicated only for the intervention phase. Type II (positive for internal thinking but negative for external behavior) resilience decreased but type I (Positive for both thinking and behavior) resilience increased. These results indicate that resilience based on positive and adaptive behavior was facilitated after the intervention. This may be because psychoeducation enhances coping and behavioral aspects. The present findings suggest that psychoeducation is very useful for nurses as an educational and training approach that helps them to share knowledge and experience and empower each other. Brolese, *et al.*^[33] argue that it is important to understand the process of resilience to improve the quality of life of mental health workers in psychiatric hospitals, and increase professionals' commitment to developing competencies, teamwork, and positive attitudes to life.

These factors are essential in developing training to improve resilience in psychiatric nurses.

There were several study limitations that should be noted. Participant numbers were limited, and the program did not completely control for gender, age, or position. Additional, more rigorous studies are needed. In addition, only self-efficacy and problem solving subscale resilience scores increased according to age. The relationships between resilience and Sociodemographic or other psychosocial factors remain to be investigated. Several of our previous studies have investigated the value of this type of psychoeducation by examining meaningful changes in occupational identity, professional autonomy, efficacy, and effectiveness (Sakai, *et al.*, 2023)^[22].

The present WL controlled trial indicated that psychoeducational training to improve professionalism in psychiatric nurses may be effective in enhancing resilience, particularly by facilitating social support and the positive attitudes of participants.

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