Students, inclusion, help-seeking and compassionate caring

Nurse shortages and dropout from training have been highlighted (Jeffreys, 2007), amid reports of stress among both qualified and student nurses (Johnston, Jones, Charles, McCann and McKee, 2013; Pulido-Martos, Augusto-Landa and Lopez-Zafra, 2012). Regarding students more generally it is claimed levels of stress and mental distress are high and help-seeking lower than expected (Li, Dorstyn and Denson, 2014). Thus, student nurses may experience pressures associated both with student status and also with their chosen vocational training.

In this paper I discuss three recent journal articles; one about students' attitudes towards help-seeking for mental distress, one about the link between mental health workers' burnout and poor client care and how workers can maintain their capacity to be compassionate with support from their employer or training organisation, and one that describes a way of approaching the initial training of nurses that might maximise their resilience, willingness to seek help when they need it, and ability to cope with their work. I discuss the implications each has for the training of mental health professionals for maximum well-being and ability to deliver compassionate care.

Why might students be slow to seek help for mental distress?

Li et al. (2014) suggest that mental distress is higher in students than the rest of the population, but at the same time students are reluctant to seek professional help. According to Li et al. (2014) previous research on students' help-seeking has found, not surprisingly, that if they believe that professional help will lead to improvement in their difficulties, they are more likely to consider seeking this help. However, intention to seek help tends to be

less when there is stigma (or perceived stigma) about seeking help for mental distress. Social support has been reported as predicting both higher and lower levels of help-seeking in different studies, as has level of distress.

Many studies have used variations on a particular questionnaire, called the Intentions to Seek Counselling Inventory (ISCI, Cash, Begley, McCown and Weise, 1975). Li et al. (2014) note that no meta-analysis (summary of the various studies) had been done, and they set out to do one. They focused on studies reporting predictors of intention to seek help: If we can pin down the main predictors then it may be possible to do something to make it more likely that students will form this intention. Li et al. (2014) chose papers reporting on studies that used standardised measures (tried and tested questionnaires), and involving psychological variables common to several studies. They found 18 papers published between 1990 and 2013. The 18 studies included over 6,000 students altogether, all in the USA and involving more women than men. Three of the papers looked at "Asian cultural values", defined as "collectivism, emotional self-control, and family recognition through achievement" (Li et al., 2014, p. 166).

The two strongest reported predictors of intention to seek help were:

1. If students had a positive attitude towards seeking help.

2. If they expected it to be helpful.

   Three things predicted <u>reduced</u> intention to seek help but not strongly:

3. Adherence to 'Asian values'.

4. Public stigma, i.e. help-seeking being seen as a sign that you are different and not as good as other people.

5. Concerns about possible negative consequences of seeking help.

The level of distress students reported was not linked to intention to seek help. However, Li et al. (2014) point out that other research suggests that intense distress does predict intention to seek help (Norcross and Prochaska, 1986). The 18 studies Li et al. (2014) summarised did not focus on students in intense distress but a wider pool of students. Nevertheless, Li et al. (2014) suggest some interventions in universities and colleges based on their findings. They suggest providing better information about how to get help and about its effectiveness. They suggest this could be done via lectures or online. They highlight the need for culturally appropriate support, including more counsellors from varied ethnic backgrounds. Finally they address the potential shortage of services and how to filter out lower-level problems that could be assisted by self-help packages.

Arguably one could view students in training to be mental health practitioners as a subgroup who might hold values that differ from other students, such as a need to be seen as capable carers rather than in need of help themselves. Next, I discuss the findings of a study on mental health workers including those early in their career, and their reactions to the stresses of their work.

How do mental health workers avoid burnout and loss of compassion?

De Figueiredo, Yetwin, Sherer, Radzik and Iverson (2014) report on the experience of mental health workers working with traumatised children and young people in a US service setting. They point out that people may be attracted to this work because they want to help, but that hearing about people's traumatic experiences and empathising with them has an effect on the worker. 'Compassion fatigue', they explain, is exhaustion and negative

feelings resulting from repeated "empathic engagement" with people's trauma (De Figueiredo et al., 2014, p. 1). Workers may feel distressed at reminders of the trauma and be constantly on alert, much like the client him or herself, and this is sometimes called 'secondary trauma'. Workers may also experience burnout, a form of exhaustion arising from all the work they do, not just from working with trauma.

De Figueiredo et al. (2014) note that some level of compassion fatigue is normal. They also note that it can lead to loss of compassion and poor care if not recognized and addressed. Parallel with compassion fatigue, workers can experience 'compassion satisfaction', arising out of a sense of personal growth following secondary trauma, and from feelings of fulfilment from doing meaningful work. It is thought that compassion satisfaction might protect workers from compassion fatigue, especially if they are able to recognize both and maintain a balance between them, suggest De Figueiredo et al. (2014).

The study reported by De Figueiredo et al. (2014) involved focus groups with four different professions working in the same setting with babies, children and young people exposed to psychological and physical trauma. There were 25 workers in the focus groups, although 36 workers gave information about their background in an online survey. Among the 36 were 15 staff psychologists, 7 psychology fellows (early career psychologists), 8 case managers, and 6 clinical social workers. The precise numbers of each in the focus groups was not noted in order to preserve anonymity.

Although the average caseload was 21, case managers' average load was highest at 34, and psychology fellows lowest at 13-14. More than 86% of the workers reported having a personal history of trauma. Two thirds of staff psychologists reported having no

supervision, but the majority of others did have it. Nearly two thirds of case managers did not have trauma-specific training. Most staff psychologists and clinical social workers were trained on the effects of working with trauma, but case managers and psychology fellows were less likely to have had this.

Case managers were least familiar with the notion of compassion fatigue, but they could recognise its effect on them when it was explained. Just finding out about compassion fatigue was important for many participants. It enabled them to recognize and accept difficult feelings they had experienced. Most had not heard of 'compassion satisfaction'.

Psychology fellows valued their reflective supervision, which allowed them to process experiences of their work, made them feel validated, and helped them accept their limitations. De Figueiredo et al. (2014) suggest this contributed to their compassion satisfaction. Case managers experienced supervision as more of an administrative exercise. Although all participants felt that co-workers were supportive, they often felt reluctant to take up their time (which in the USA is 'billable') or burden them emotionally, knowing the nature of their work.

There were several ways in which work with clients was reported to contribute to compassion fatigue, including:

1. Clients' complex and repeated trauma.

2. Clients' other many sources of stress such as homelessness, unemployment and family conflict.

3. The need for case managers to hear the traumatic history because they are the first worker to see the client, while lacking the training to manage it.

4. The trauma histories of clients' parents or care-givers.

5. The pull of wanting to help an infant as quickly as possible because early intervention is vital, and sometimes encountering "barriers" (p. 6).

6. Similarly not always being able to help when an adolescent made the transition to adult mental health and did not continue to receive the right support.

7. Clients not seeming to make progress.

However, workers also reported compassion satisfaction from seeing clients grow, and seeing infants and adolescents thrive due to successful intervention.

Workers reported some aspects of themselves as contributing to compassion fatigue or satisfaction:

1. Workers' own trauma history might contribute to compassion fatigue because of what they bring to the encounter with a client.

2. Stress in workers' personal lives.

3. Being the sort of people who like to help could lead to doing too much, although getting the work-life balance right could mean compassion satisfaction.

4. Staff clinicians and psychology fellows both voiced a need to achieve, which could be helpful but also unhelpful if it meant high self-imposed pressure.

   Professional factors reported to be linked with compassion fatigue included:

1. Being early in one's career (case managers and psychology fellows): It could take time to learn to balance idealistic enthusiasm with the need for work-life balance.

2. The need to be seen as competent by other workers and supervisors could make it difficult to seek support. Psychology fellows talked about learning to use supervision and learning that they did not have to appear all-knowing.

3. For case managers, high caseload and repeated hearing about trauma was stressful.

4. Case managers felt further distressed by having to note down what they had heard for the records.

However, variety in the caseload, where not everyone had experienced multiple trauma or people were at different stages, could protect against compassion fatigue. Time out for training events could help but the downside was reduced time for completing routine work.

Organisational factors were reported to contribute to compassion fatigue:

1. Staff clinicians and psychology fellows felt that deadlines and expectations to do more and more led to burnout, and consequently, compassion fatigue.

2. Case managers felt their high caseloads made it difficult to cope.

3. Staff clinicians reported that constant targets were more stressful than the work with clients.

4. Staff clinicians and psychology fellows felt that managers gave mixed messages, telling them to prioritise self-care and also meet targets.

5. Policies and bureaucracy could leave all workers feeling that they were not held in mind by policy-makers and had too little control in their work.

De Figueiredo et al. (2014) suggest a number of ways to address compassion fatigue.

1. Consider how to reduce the impact of organisational factors such as targets, caseloads and paperwork, and be alert for burnout as well as compassion fatigue.

2. Increase opportunities for reflective supervision for processing responses to clients' trauma and fostering an internal sense of meaning (compassion satisfaction). This involves viewing compassion satisfaction as an internal experience rather than only observable client progress.

3. Ensure all workers have access to trauma-specific training and supervision, and training around the impact of working with trauma on the worker.

4. Include the concepts of compassion fatigue, burnout and compassion satisfaction in qualifying mental health training and the training for case managers.

5. Supervisors and managers could focus more on personal growth in clients and workers, and resilience in the organisation.

6. Supervisors and managers should recognise effort as much as outcomes.

A blue-print for inclusive nurse training?

In her 2014 paper, experienced nurse-educator Marianne R Jeffreys, based in the USA, describes an educational system drawing on evidence about what helps student nurses stay in training. Jeffreys (2014) notes that the traditional approach to nurse education has tended to focus on passing or failing, and on singling out those who are failing for remedial action to get them to 'just pass'. She likens this to reaching for a life-jacket when drowning. In contrast she suggests helping all students to:

"Reach for the stars and be the best you can be, preventing problems, building upon

strengths, urging realistic self-appraisal and help-seeking behaviours especially at key

transition points, empowerment and promoting skills for success" (p. 164).

Jeffreys suggests that success should include retention but go beyond it to improve

every student nurse's achievement. She introduces an acronym: HOLISTIC COMPETENCE.

This stands for:

"Human connectedness, optimisation, learner centred, individualised,

scientifically based, teamwork, integrated, and creative," and "caring, ongoing,

multidimensional, proactive, ethics, trust, education, networks, confidence, and

evaluation" (p. 165).

Whilst I am not overly keen on acronyms I do like many of the words used here.

Based on research on nurse education and retention, Jeffreys takes us through the meaning

of each word and phrase as follows:

Human connectedness refers to ensuring that student nurses feel they belong to a

community with fellow students and staff, through opportunities for continual dialogue

either face to face or online, peer-mentoring, student clubs, professional events, and access

to culturally competent supervision and support.

Optimisation involves encouraging all students to do the best they can, reducing

unnecessary stress, focusing on students' strengths, connectedness (as above), and doing

more of what helps students stay in training rather than fixing dropout. Students should

have access to success stories of student nurses who have graduated, and stories of how

they overcame obstacles. Students are supported in assessing their own strengths and limitations.

Learner centred approaches involve enabling student nurses to immediately be involved in doing things that have relevance to nursing. Jeffreys (2014) suggests providing many opportunities for students to reflect: on their learning and experiences in training, reflection while working, and reflection on what they have done. These all help students to develop the habit of self-awareness and awareness of limitations and further learning needs. Small group work during lecture time is recommended to maintain engagement.

Individualised means recognising each student's strong and weak points and learning styles, and providing different kinds of learning opportunity to develop "critical and creative thinking" (p. 166). Small groups and one-to-one meetings help meet individual needs, and peer-mentoring is recommended.

Scientifically based refers to an evidence-based model of retention devised by Jeffreys (2012). One key element of this model, notes Jeffreys (2014) is professional integration. This again refers to the human connectedness described earlier. A sense of belonging seems to increase the feeling of commitment and reduce dropout. Jeffreys (2014) suggests that nurse trainers have a major role in fostering it.

Teamwork refers to an emphasis on everyone being committed to the success of all students, rather than only someone designated as in charge of retention.

Integrated refers to ensuring that strategies for student retention are built into the fabric of the organisation and are evidence-based, with everyone aware of them. If course marketing mentions retention strategies they must be in place.

Creative approaches are needed to address the complex lives of today's nursing

students. For example, role-plays and discussion to address "self-handicapping" (p. 167)

whereby students do not handle the challenges of their home or family lives and student

lives well.

Caring refers to the need for nurse educators to demonstrate caring towards

students and themselves. Caring may mean referring the student to counselling rather than

"assuming the "nurse" role" (p. 168). Mentoring is recommended to prevent social isolation

and dropout, especially for students underrepresented in nursing. Staff may need training in

cultural competence. Words of praise can enable students to feel cared for.

Ongoing means that these strategies are continuous rather than piecemeal, and that

students are assisted in transitions from one phase to the next.

Multidimensional refers to retention strategies having many components as

discussed here.

Proactive refers to timing of interventions: Educators should not wait for problems

to arise but implement strategies proactively, i.e. before term starts. Waiting for the student

to seek help can mean it is too late.

Ethics refers to the obligation Jeffreys (2014) sees as incumbent on nurse educators

to maximise the potential of each student once they have come through the selection

process.

Trust enables students to "take risks" and "explore new ways of thinking in an open,

caring learning community/environment among diverse student groups" (p. 169).

Education means that all staff are part of the strategy for retention and student achievement and are increasing their understanding about these things through continuing professional development.

Networks refers to educators being connected up both inside and outside their own setting, with access to resources and sharing of knowledge and experience in person or online.

Confidence refers to the need to enable students to avoid being too low or too high in confidence, and to develop realistic self-efficacy that will help them overcome challenges and seek help when necessary.

Evaluation is important to keep improving retention and success.

Conclusions

The paper by Li et al. (2014) on student help-seeking suggested that students may be more likely to consider seeking help for mental distress if they have information about how the available help might be useful to them and can see it as a good thing to do when the need arises. The paper by Figueiredo et al. (2014) illustrated how early-career mental health workers might feel that seeking help would mean they would appear less competent to other workers and supervisors. However, reflective supervision enabled them to talk through the difficult feelings arising from work with trauma and to accept their limitations. Just knowing that compassion fatigue is a normal response to engaging empathically with clients enabled many participants of the study by de Figueiredo et al. (2014) to feel less worried about their negative feelings and more likely to take them to supervision where they could be addressed.

Jeffreys (2014) has devised a detailed package for enhancing the culture of nurse training as a result of research on retention of nursing students. There may be a need for research on how similar the retention issues are in nurse-training across different countries, and how well Jeffreys' (2014) model might translate outside of the USA. However, a major part of her model is to instil feelings of belonging to the profession in students from early on, and to enable them to develop skills in reflection and self-awareness. The whole-organisation culture Jeffreys advocates could counteract reluctance to seek support early on in a variety of areas, including mental distress, as well as preventing many problems from developing in the first place.

The messages from these three papers, although they each tackle a slightly different issue, seem to fit together well: It is worth making it seem normal and even 'smart' for students and trainee mental health professionals to seek help early when they need it. It is worth having good counselling services and also self-help provision available. It is worth informing trainee mental health professionals that the emotional work involved in empathising with clients, especially hearing many stories of trauma, may lead to compassion fatigue and that this is normal. It is worth providing safe spaces in which the arising difficult feelings can be processed. It is worth the supervisors of trainee mental health professionals knowing about compassion fatigue and either being able to help trainees process the effect of their work with clients, or that there is other provision, such as reflective groups with appropriately trained professionals.

All these measures seem likely to reduce the social exclusion that can occur when students delay seeking help and end up dropping out of their course and perhaps given a

mental health diagnosis that might have been averted. Many professionals may be drawn to their work due to their own difficult histories, as participants surveyed by de Figueiredo et al. (2014) reported. This may give them particular ability to empathise, but they must have a place to process the material they hear, and be able to experience personal growth and the compassion satisfaction that enables them to continue to deliver good care.

References

Cash, TF, Befley, PJ, McCown, DA, and Weise, BC (1975), "When counselors are heard but not seen: Initial impact of physical attractiveness," *Journal of Counseling Psychology,* Vol. 22, pp. 273-279, DOI: 10.1037/h0076730.

De Figueiredo, S, Yetwin, A, Sherer, S, Radzik, M, and Iverson, E (2014), "A cross-disciplinary comparison of perceptions of compassion fatigue and satisfaction among service providers of highly traumatised children and adolescents," *Traumatology: An International Journal,* retrieved 1 February 2015 from http://dx.doi.org/10.1037/h0099833.

Jeffreys, MR (2014), "Student retention and success: Optimizing outcomes through HOLISTIC COMPETENCE and proactive inclusive enrichment," *Teaching and Learning in Nursing,* Vol. 9, pp. 164-170, DOI: 10.1016/j.teln.2014.05.003.

Jeffeys, MR (2007), "Nontraditional students' perceptions of variables influencing retention: A multisite study," *Nurse Education,* Vol. 32, Iss. 4, pp. 161-167.

Johnston, DW, Jones, MC, Charles, K, McCann, SK, and McKee, L (2013), "Stress in nurses: Stress-related affect and its determinants examined over the nursing day," *Annals of Behavioral Medicine,* Vol. 45, Iss. 3, pp. 348-356.

Li, W, Dorstyn, DS, and Denson LA (2014), "Psychosocial correlates of college students' help-seeking intention: A meta-analysis," *Professional Psychology: Research and Practice,* Vol. 45, Iss. 3, pp. 163-170.

Norcross, JC and Prochaska, JO (1986), "The psychological distress and self-change of psychologists, counselors and laypersons," *Psychotherapy: Theory, Research, Practice, Training,* Vol. 23, pp. 102-114, DOI: 10.1037/h0085577.

Pulido-Martos, M, Augusto-Landa, JM, and Lopez-Zafra, E (2012), "Sources of stress in nursing students: A systematic review of quantitative studies," *International Nursing Review,* Vol. 59, Iss. 1, pp. 15-25.