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Personal resilience in psychiatrists: systematic review

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Aims and method   The concept of personal resilience is relevant to physician well-being, recruitment and retention, and to delivering compassionate patient care. This systematic review aims to explore factors affecting personal resilience among psychiatrists, in particular, those that may impair well-being and those that facilitate resilience practice. A literature search was performed of the Ovid®, Embase®, CINAHL and PsycINFO databases, using keywords to identify empirical studies involving psychiatrists that examined resilience, stress and burnout from the past 15 years.

Results   Thirty-three international English language studies were included, showing that a combination of workplace, personal and non-workplace factors negatively and positively influenced well-being and resilience.

Clinical implications   Given that workplace factors were the most commonly cited, it would appear that any resilience package that predominantly targets interventions at the workplace level would be particularly fruitful. Future research, however, needs to address the absence of a universal measurement of well-being and its moderators so that any potential interventions are better evaluated.

Declaration of interest   None.

Keywords   Psychiatrists; resilience; well-being; burnout; stress.

Physician well-being is considered as one of the cornerstones of professional effectiveness, health and happiness.[1] Psychiatrists, however, have been found to suffer from high levels of poor well-being, being more prone to burnout (characterised by emotional exhaustion, depersonalisation, and diminished personal accomplishment among those who work with people[2]), psychiatric morbidity and suicidal ideation.[3–5] Contributing factors reported to account for such poor well-being include working with patients perceived as aggressive and demanding, resource deficits, staff conflicts, lack of administrative support, responsibility without due authority, lack of experience, female gender, low self-esteem and working longer shifts.[5] Recruitment and retention difficulties are also cited as exacerbating factors of poor well-being among existing staff.[6]

Resilience, defined as 'a dynamic process encompassing adaptation within the context of significant adversity',[7] is often considered an antidote to poor well-being, offsetting workplace stressors,[8] setbacks and trauma,[9] and buffering against adverse events.[10] Four aspects of physician resilience have been identified, relating to attitudes and perspectives (e.g. valuing role), balance and prioritisation (e.g. scheduling time off) practice management (e.g. efficient organisation) and supportive relationships.[11] Moreover, several personality traits have been associated with resilience, including being mature, responsible, optimistic, persevering and cooperative.[1] Physicians also seem to benefit from certain facilitative practices, including mindfulness,[12,13] peer-care,[14] coaching and mentoring,[15–17] Balint group participation,[18] part-time employment,[16] viewing medicine intellectually[16] and viewing medicine as a 'calling'.[19] A strong group identity,[20] peer-caring[21] and mindfulness[22] also appear to increase resilience among medical students. In fact, the General Medical Council calls for UK medical schools to offer a resilience package to equip students with the skills to deal with current and future challenges.[23]

Method

Aim

The aim of this systematic review was to explore factors affecting personal resilience among psychiatrists, in particular, those that may impair well-being and those that facilitate resilience practice.

Search methodology

The Ovid®, Embase®, CINAHL and PsycINFO databases were searched in June 2017 using keywords 'resilience', 'burnout', 'stress', 'strategies' and 'intervention', all of which were combined with 'psychiatry trainees', 'psychiatrist' and 'mental health professional'. Papers were included if they were empirical studies, available in English, and published within the past 15 years. Reference lists of previously published articles were also examined.

Study suitability

The first and last authors independently reviewed the titles and abstracts and appraised each article for inclusion before confirmation by an independent researcher (Rachel Steele, Librarian, Tees, Esk and Wear Valleys NHS Foundation Trust). Data collected included study aims, sample and sample size, study design, response rate, measures or scales used, and outcomes. Discussions between the authors helped to identify common themes as a basis for analysis and synthesis of the findings.

Search outcome

A total of 127 papers were initially identified by the electronic search, and a further 13 by examination of published references. Seventy-two articles were subsequently screened in more detail, of which 33 articles met all the inclusion criteria and were included for qualitative synthesis (Fig. 1). Article summaries are presented in Supplementary Table 1 (available at https://doi.org/10.1192/bjb.2019.12).

Results

Study design

Of the included studies, 28 were quantitative,[24–30,33–40,44–56] two were qualitative,[31,32] one was interventional[41] and two had mixed methodology.[42,43]

Countries of origin

Studies originated from Australia,[29,40,48,55] New Zealand,[28,31,38,39] the UK,[30,34,43,47] the USA,[24,26,52] Canada,[35,50] Italy,[25,54] Finland,[33,36] Portugal[44] and Romania.[27] Several studies involved a combination of countries[40,45,46,49] and six studies did not specify location.[32,37,41,51,53,56]

Populations

Twenty studies involved psychiatry doctors only, comprising psychiatrists,[25,27,31,32,37–41,43–45,47,48,52] psychiatry trainees[35,42,55] or a combination of both.[24,49] Only three studies provided an indication of subspecialty, including child and adolescent,[36,40] adult[36] and forensic psychiatry.[52] Thirteen studies involved psychiatry doctors combined with other populations, including mental health practitioners,[26,29,30,34,46,54,56] general practitioners,[53] behavioural health providers,[51] medical school graduates,[50] other physicians[28,33,36] and psychologists.[26]

Study aims

The main aims of the included studies were factors relating to burnout,[24–26,29–31,35–37,39,44,51,53,54] factors associated with work stress[27,28,33,37,43,45,48,49,52,55] (including how to overcome it)[32] and factors associated with job satisfaction.[25,30,33,34,39,40,45,48,49,55] Additional areas of focus included the efficacy of counselling,[28] trauma,[29] job resources,[33] well-being,[34] whether the Job Diagnostic Survey predicts scores on the Maslach Burnout Inventory (MBI),[38] recruitment and retention,[40] use of a self-care training package,[41] the evaluation of a Balint group,[42] the evaluation of a stress-busting group,[43] morale,[46] the effects of recent National Health Service (NHS) changes,[47] patient suicide and support networks,[50] compassion fatigue and compassion satisfaction,[51] and the investigation of turnover intention.[56]

Measures

The predominant measures were burnout, work-related stress, job satisfaction and well-being. Thirteen studies measured burnout using the MBI,[24–26,30,34,36,38–40,44,46,53,54] while others used the Copenhagen Burnout Inventory,[29] a tailored burnout questionnaire,[35] and another measuring emotional exhaustion.[56]

Work stress was measured by nine of our included studies, utilising several pre-existing scales[37,40,41,43,47] such as the Sources of Stress Questionnaire and the Perceived Stress Questionnaire. Other studies applied more tailored measures, citing a work stress index,[29] a rating scale to evaluate a 'stress-busting' group,[43] a rating scale to measure work-related stress,[55] a postal questionnaire,[48] an online survey[49] and a 90-item stress-related scale.[52]

Job satisfaction was measured in 12 studies, ranging from pre-existing scales[30,34,38,39,41,46] such as the Minnesota Job Satisfaction Scale[46] to combined elements of other scales[33,40] such as the General Health Questionnaire (GHQ-28).[40] More bespoke assessment tools were also employed.[25,48,49,56]

Well-being was measured by six of our included studies, using a number of pre-existing scales[34,46,51] including the GHQ,[25,34,53] and one study used a scale which adopted items from the GHQ.[33]

A range of other variables were also measured, including resilience,[33,41] the efficacy of counselling,[28] team functioning,[30,46] mental health,[29,54] trauma,[29,50] a supportive environment,[26,29] supervisory support, civility and psychological safety measures,[56] relationships and interpersonal skills,[29,41] emotions,[53] job resources,[33] victimisation,[29] ward atmosphere,[32] beliefs,[24,29] suicide,[44] and reasons for career choice.[45,55]

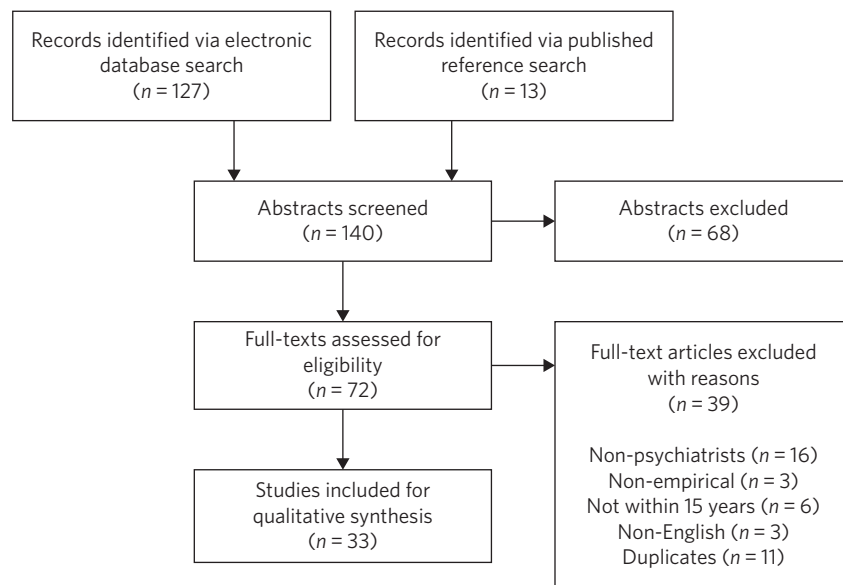Some studies also reported a number of demographic details, including career and military experience, working

Fig. 1 Flow diagram illustrating search strategy for the review.

pattern, parental and family factors, and leisure activities.[24,45,55]

Synthesis of results

Factors that may impair well-being
Increasing burnout. Adult and child psychiatrists were found to experience higher levels of burnout versus other physician groups,[36] reporting high levels of emotional exhaustion,[24,39,44,54] depersonalisation[44] and low levels of personal accomplishment.[54] Female psychiatrists,[51,53] psychiatry trainees,[35] those working in rural settings,[51] and those working in the community and on acute general wards[40] were found to be particularly vulnerable to high burnout levels.

Causes of burnout were excessive workload and/or working long hours,[24,25,31,37,44] inadequate facilities and funding,[25] working with patients perceived as aggressive and demanding,[25] an aggressive administrative working environment,[37] job demands,[34] and the absence of support from either a colleague[40] or management.[37] Such causes of burnout also appeared to manifest in job turnover,[56] unhealthy coping mechanisms (i.e. alcohol use, excessive shopping or unhealthy eating)[35] and a lack of empathy for patients.[35]

Increasing stress. Psychiatrists reported higher levels of patient-related stress compared with other physicians,[33] with most psychiatrists rating their stress levels as moderate or severe.[43] Those most vulnerable to stress were new starters,[29] those without children and with academic affiliations/responsibilities,[45] those working with high-risk and difficult patients,[43] and those who expressed job dissatisfaction.[48]

Causes of stress were excessive workload,[40,49] job and training demands,[40] career prospects (notably Modernising Medical Careers),[47] concerns over personal safety,[29] illness,[52] inadequate resources[27,40] and litigation.[48,52]

Psychological illness and other factors. Psychiatrists reported higher levels of depression, psychotropic drug usage and

mental illness compared with other physicians.[36] Moreover, some trainees reported almost clinical levels of emotional disturbance in response to experiencing patient suicide.[50] Psychiatrists were also prone to compassion fatigue,[51] pessimism[48] and the adoption of negative coping strategies, such as excessive worrying, denial and overworking.[47] Perceived status, inadequate decision-making capacities, and poor supervision and feedback also contributed to dissatisfaction.[39,55] Those without a supportive colleague also tended to take more time off and even regretted their career choice.[40]

Factors that may facilitate resilience
Reducing burnout. Factors that made psychiatrists more resilient to burnout included spending less time on the wards by engaging in more discrete work activities (i.e. clinical rounds, consultations) before departing to their offices,[26] the extension of staffing roles and distribution of responsibilities,[30,54] and having more clinical experience and supportive colleagues.[24] Interestingly, forensic psychiatrists suffered less burnout than other subspecialties, possibly because of being adept at maintaining professional boundaries, self-awareness and being better at reflective practice, owing to the moral and ethical challenges they regularly face.[26]

To assist those more vulnerable to burnout, such as female psychiatrists and trainees, several studies proposed interventions that may facilitate resilience,[44,51,54] including psychological support[54] and assessment and treatment skills trainng.[51] Non-workplace factors such as holidays, hobbies and partner support may also improve resilience to burnout.[37]

Reducing stress. In addition to the benefits of a counselling service which encouraged stressed psychiatrists to remain in or return to work,[28] a self-care programme – comprising skills training, cognitive–behavioural therapy (CBT) and counselling – was also reported to reduce job stress.[41] Moreover, increasing stress awareness also allowed trainees and psychiatrists to be better prepared for the difficult aspects of their work, resulting in reduced stress levels.[32,52]

Reporting on the first author's personal experience, for example, one study highlighted the importance of being mindful of how work-related stress arises, how to recognise its symptoms and how to seek help.[32] Actively seeking support, confiding in supportive colleagues and socialising were also recognised as a positive coping strategies.[43,47]

Changes to the workplace environment through better management of economical and administrative measures,[27] as well as the creation of functional teams, having crisis teams as gatekeepers, working in multidisciplinary teams, introducing generic/nurse-led services, and separating in-patient and community roles were also found to reduce stress levels among psychiatrists.[47]

Job satisfaction and well-being. Some studies showed that the majority of psychiatrists were actually more satisfied with their job – finding the role interesting, intellectually challenging, providing good career prospects, and constituting a role that provided a better quality of life – than other physicians such as general practitioners.[49,53,55] Those able to combine children, intimate relationships and academic involvement were found to be the most satisfied,[45] while helping patients get better and thus boosting personal accomplishment also accounted for increased job satisfaction[48] and the offsetting of emotional exhaustion.[39]

Self-care training was also found to improve job satisfaction among psychiatry doctors, with one study showing that a combination of skills training, CBT and counselling resulted in improvements in overall job satisfaction, as well as in self-efficacy and physician–patient relations.[41] More targeted practices that introduced job variety (i.e. combining teaching, administration and clinical work) were also deemed as factors that raise the job satisfaction of those experiencing high emotional exhaustion.[38]

Changes to the workplace environment involving the extension of staffing roles and distribution of responsibilities,[30] improved job control and better work organisation,[33] and provision of a more civil workplace that provided autonomy and a supportive supervisory environment were also perceived positively and thus increased job satisfaction levels.[56]

Other factors. Although resilience among psychiatrists may to some degree be facilitated by a good team climate with a strong team identity,[33,46] it is also reported that the field may benefit from a number of other practices, including prioritising workload,[40] obtaining multi-source feedback on performance,[39] maintaining good supportive relationships with superiors and colleagues,[25,37] Balint and 'stress-busting' group participation,[42,43] involvement in leadership activities,[47] and training in communication and time management.[46] A more energetic recruitment drive during undergraduate and postgraduate training may also encourage more to enter the profession and thus help with dealing with the recruitment problems the profession faces and relieve the pressure on existing staff.[40]

Discussion

The purpose of this review was to examine those factors that affect psychiatrists' well-being and to identify the practices that promote resilience within this population. Our findings are consistent with previous research showing that psychiatrists tend to suffer from higher levels of burnout, stress and psychological distress/illness relative to other physician groups,[3–5] with female psychiatrists and trainee psychiatrists being particularly vulnerable.[4,5] Of particular concern is the rate of depression reported by this review, as well as the psychotropic drug usage, the almost-clinical-level emotional disturbance caused by patient suicide, and the consequential implications of poor well-being overall, such as a lack of empathy for patients and compassion fatigue.

In terms of the causal factors that affect psychiatrists' well-being, this review also corroborated previous research showing that workplace factors[5,6] and personality traits[1,5] are particularly influential. In an attempt to better frame an explanation of these findings, however, it might be useful to draw upon a theory of well-being such as Seligman's PERMA model,[57] which considers five elements (positive emotions, engagement, relationships, meaning and accomplishments) that can help people flourish and live a more fulfilled, happy and meaningful life.

Given that psychiatrists were reported to exhibit more pessimism, more anxiety and more indecisiveness, as well as a tendency to adopt repressive and avoidant coping strategies, it would seem that they struggle to maintain *positive emotions*, which may be a contributory factor towards the reported high levels of poor well-being. One possible explanation as to why psychiatrists find it difficult to maintain positive emotions is the complex psychodynamic processes that they are personally affected by as a result of their regular interactions with patients in negative emotional states or those who have experienced significant trauma.

Several reported workplace factors such as inadequate facilities and funding, working with patients perceived as aggressive and demanding, and working in an aggressive administrative environment may also fragment the attention of psychiatrists and thus compromise their capacity to fully engage in their workplace activities. This lack of complete *engagement* could be further exacerbated by the difficulty of defining goals and measuring progress within psychiatry, compared with the more acute specialties such as surgery and emergency medicine.

Cultivating positive peer *relationships* may also be difficult for psychiatrists, particularly those who are working in the more isolated settings of geographically disparate community clinics, who were indeed reported to suffer from higher levels of burnout within this review. In addition, the reported lack of administrative support and the high turnover of staff may further contribute to the problem of building positive and supportive relationships that can potentially offset the negative outcomes of poor well-being. It is quite possible that this combination of being unable to maintain a positive emotional approach, being unable to engage fully in a work role, and finding it difficult to cultivate positive peer relations manifests in significant negative outcomes such as compassion fatigue.

However, it is not all doom and gloom. Consistent with previous research,[5,6] this review also reports that psychiatrists do tend to find considerable purpose and *meaning* in what they do, as well as high levels of job satisfaction and personal *accomplishment*. There are a number of factors that may

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account for this, including the role offering intellectual satisfaction, favourable job prospects, strong team identity (at least for forensic psychiatrists), greater job control and a good work–life balance. In terms of the design of any intervention exercises, whether they be resilience workshops or recruitment initiatives, it is imperative therefore that these latter elements are emphasised. Moreover, given that certain psychiatry subspecialties (i.e. forensic) seem to be protected against poor well-being, the basis of this (i.e. strong group unity, maintenance of boundaries) needs to be considered when designing future resilience interventions.

However, again reflective of the broader medical literature,[15–18] this review indicates that the basis of any thorough resilience intervention would have to be the implementation of certain practices at the workplace level. Indeed, organisations that offer the opportunity for psychiatrists to engage in more discrete work activities that incorporate multi-source feedback, maintain a supportive and collaborative working environment, and offer psychological support in the form of Balint group participation, stress-busting workshops and counselling appear to foster higher levels of well-being. Notably, the more vulnerable groups may benefit from specific strategies, for example, female psychiatrists may benefit from more psychological support to boost their ability to deal with particularly difficult patients, and trainees from more skills-based programmes may benefit from help to boost their experience and decision-making skills. On a more personal level, encouraging psychiatrists to be more aware of how work-related stresses arise and how to deal with them accordingly through self-awareness and self-care interventions may also prove protective, as may engagement in numerous non-workplace activities such as taking holidays and spending more time with family or friends.

Strengths and limitations

This review represents one of the very few systematic reviews that have explored the factors involved in the well-being of psychiatrists. It presents evidence from a range of countries, and provides data from a good number of studies. Data collection adhered to the Cochrane level of scrutiny, based on independent extraction by the first and last authors and subsequent review by an independent researcher. Limitations of the review included the restriction of studies to the English language and the limited number of psychiatrists used as the study group. Moreover, there was only one study comparing an intervention with a control group, suggesting a lack of high-quality research in this area. Given that the data taken from the vast majority of studies were based on self-reported questionnaires, there was also the problem of self-report bias. The heterogeneity of instruments used to assess well-being made it difficult to compare across studies, thus jeopardising generalisable conclusions.

Implications

Understanding how resilience relates specifically to psychiatrists may lead to the implementation of more effective and potentially targeted interventions to help psychiatrists improve their resilience. Reducing the incidence of poor mental health and coping strategies may help doctors to

> **BOX 1.** Resilience interventions
>
> - **Workplace level**
>   - Discrete working activities
>   - Extending staff roles
>   - Distributing responsibilities
>   - Multi-source feedback
>   - Facilitating a supportive environment
>   - Championing appeal of psychiatry
> - **Personal level**
>   - Counselling
>   - Self-awareness/reflection
>   - Self-care training
>   - Skills training
> - **Non-workplace level**
>   - Taking holidays
>   - Partaking in hobbies
>   - Family/social life
>   - Receiving support from partner

thrive in the face of adversity and lead satisfying careers that consequently have positive effects on the care of their patients and working relationships with colleagues. While targeting the individual is important, this review shows that it is imperative for resilience or well-being packages to address a number of workplace factors. However, this review also highlights the lack of high-quality research within this area, underpinned by the absence of a universal measure of well-being; this needs to be addressed in order to better evaluate the efficacy of potential interventions. Only then will we be able to thoroughly address the fundamental causes of poor well-being among psychiatry doctors and implement the strategies necessary to move towards a more effective, healthier and happier psychiatric workforce.

Supplementary material

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The London memory service audit and quality improvement programme

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Aims and method Memory services have expanded significantly in the UK, but limited performance data have been published. The aim of this programme was to determine variation in London memory services and address this through service improvement projects. In 2016 London memory services were invited to participate in an audit consisting of case note reviews of at least 50 consecutively seen patients.

Results Ten services participated in the audit, totalling 590 patients. Variation was noted in neuroimaging practice, neuropsychology referrals, diagnosis subtype, non-dementia diagnoses, waiting times and post-diagnostic support. Findings from the audit were used to initiate four service improvement projects.

Clinical Implications Memory services should consider streamlining pathways to reduce waiting times, implementing pathways for patients who do not have dementia, monitoring appropriateness of neuroimaging, and working with commissioners and primary care to ensure that access to post-diagnostic interventions is consistent with the updated National Institute for Health and Care Excellence (NICE) dementia guideline.

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Keywords Dementia; memory assessment service; audit; service improvement.

The Prime Minister's challenge on dementia 2020[1] emphasises timely diagnosis, high quality care and research participation. Furthermore, the government has set the first ever national ambition on dementia diagnosis; that two-thirds of the estimated number of people with dementia should receive a diagnosis. The government's 2018/2019 mandate to NHS England also sets an expectation to improve the quality of care and support for people with dementia.[2] For these commitments to be realised, greater numbers of patients will need to be assessed in memory services, placing additional demands on a sector that has already undergone rapid expansion since the National Dementia Strategy was published in 2008.

Although dementia diagnosis rates for clinical commissioning groups (CCGs) in England are published monthly by NHS Digital, limited data on memory service performance are available. The London Dementia Clinical Network has a remit to reduce variation in care in London memory services