Burnout and Compassion Fatigue Among Psychiatric Nurses: A Narrative Review of Prevalence, Risk Factors, and Evidence-Based Interventions

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ABSTRACT

Psychiatric nursing is consistently identified as one of the most emotionally demanding specialties within the nursing profession, requiring sustained therapeutic engagement with patients experiencing acute distress, behavioural disturbance, and, at times, aggression. This narrative review synthesises peer-reviewed literature published between 2016 and 2026 on the prevalence, risk factors, consequences, and evidence-based mitigation strategies for burnout and compassion fatigue among psychiatric and mental health nurses. Drawing on cross-sectional surveys, randomised controlled trials, pilot intervention studies, and systematic reviews from multiple health systems, the review finds that psychiatric nurses report disproportionately high rates of burnout and compassion fatigue relative to nurses in general medical-surgical settings, with prevalence estimates for severe burnout ranging from roughly one-third to well over half of surveyed samples depending on setting, instrument, and country. Key contributing factors include high patient acuity, chronic exposure to workplace violence, inadequate staffing, limited organisational and leadership support, and the emotionally taxing nature of therapeutic relationships with individuals experiencing severe mental illness. Consequences extend beyond individual nurse well-being to affect turnover intention, workforce stability, and the quality and safety of patient care. The review further identifies a growing evidence base supporting mindfulness-based stress reduction, structured resiliency and self-compassion training, peer support programmes, and organisational leadership interventions as effective, low-cost strategies for reducing burnout and compassion fatigue while improving compassion satisfaction. The paper concludes with recommendations for nursing practice, administration, education, and policy, emphasising that sustaining a resilient psychiatric nursing workforce requires coordinated action at the individual, unit, and organisational levels rather than reliance on individual coping alone.

Keywords: psychiatric nursing; mental health nursing; burnout; compassion fatigue; secondary traumatic stress; workplace violence; nurse retention; occupational well-being

INTRODUCTION

Mental health nursing occupies a distinctive position within the broader nursing profession. Unlike many other clinical specialties, the psychiatric nurse's primary therapeutic instrument is the self: the nurse-patient relationship, sustained empathy, and the capacity to remain emotionally present with individuals experiencing psychosis, suicidality, trauma, or severe behavioural disturbance. This relational intensity, while central to recovery-oriented psychiatric care, also places psychiatric nurses at heightened risk of occupational stress syndromes that are collectively described in the literature as burnout, compassion fatigue, and secondary traumatic stress.

Burnout is generally conceptualised as a syndrome of emotional exhaustion, depersonalisation, and reduced personal accomplishment resulting from chronic occupational stress that has not been successfully managed.

The World Health Organization's International Classification of Diseases (ICD-11) frames burnout specifically as an occupational phenomenon rather than a medical condition, arising from chronic workplace stress that has not been successfully managed. Compassion fatigue, by contrast, is more specific to helping professions and describes the cumulative physical and emotional exhaustion that results from prolonged exposure to patients' suffering, often accompanied by secondary traumatic stress — symptoms that mirror post-traumatic stress arising indirectly from repeated exposure to others' trauma narratives. These constructs are frequently operationalised together through the Professional Quality of Life (ProQOL) framework, which measures burnout, secondary traumatic stress, and compassion satisfaction as related but distinct dimensions of a helping professional's occupational experience.

A substantial and growing body of international research indicates that nurses working in psychiatric and mental health settings experience these syndromes at rates that meet or exceed those reported in general nursing populations, despite general nursing burnout already being recognised as a workforce crisis. Reported drivers include high patient acuity, unpredictable and sometimes aggressive patient behaviour, chronic understaffing, limited debriefing structures after critical incidents, and the emotionally absorptive nature of therapeutic relationships with individuals in psychological crisis. The consequences are not confined to individual nurse well-being: elevated burnout and compassion fatigue are consistently linked to increased turnover intention, absenteeism, reduced quality and safety of patient care, and workforce attrition at a time when demand for mental health services continues to rise globally.

Despite this evidence base, psychiatric nursing burnout and compassion fatigue remain comparatively under-addressed within institutional wellness policy, which is often designed generically for the nursing workforce as a whole rather than tailored to the unique occupational stressors of inpatient and community mental health settings. This paper addresses that gap by synthesising recent peer-reviewed evidence on (a) the prevalence of burnout and compassion fatigue among psychiatric nurses, (b) the principal risk factors and organisational conditions that contribute to these syndromes, (c) their consequences for nurses, patients, and health systems, and (d) evidence-based interventions with demonstrated effectiveness in psychiatric or comparable high-stress nursing populations. The review closes with practice, administrative, educational, and policy recommendations intended to inform both frontline psychiatric nursing practice and institutional workforce strategy.

METHODOLOGY

This paper employs a narrative literature review methodology, appropriate for synthesising a heterogeneous body of evidence — cross-sectional surveys, randomised controlled trials, pilot intervention studies, integrative reviews, and systematic reviews — around a defined set of thematic questions, rather than pooling effect sizes as in a meta-analysis. A structured search of peer-reviewed literature indexed in PubMed/MEDLINE, ScienceDirect, Wiley Online Library, and MDPI journal platforms was conducted for English-language articles published between 2016 and 2026, using combinations of the search terms "psychiatric nurse," "mental health nurse," "burnout," "compassion fatigue," "secondary traumatic stress," "workplace violence," "turnover intention," and "resilience intervention." Studies were included if they reported empirical data (quantitative or mixed-methods) or systematic synthesis specifically concerning nurses working in psychiatric, mental health, or comparably high-acuity, high-emotional-labour care settings. Studies concerning burnout in the general nursing workforce were retained selectively where they offered comparative context or where intervention evidence was directly transferable to psychiatric nursing settings. Exclusion criteria comprised non-English-language publications, conference abstracts without an accompanying full text, editorials or opinion pieces without empirical or synthesised data, and studies concerning non-nursing clinical staff or non-clinical populations. Findings were organised thematically into prevalence, risk factors, consequences, and interventions, consistent with conventional narrative review reporting.

Because this is a narrative rather than a systematic review, study selection prioritised thematic relevance and methodological credibility over exhaustive retrieval. A small number of non-peer-reviewed secondary sources — specifically a research-news summary of a peer-reviewed study (Psychiatry Advisor, 2026) and an unpublished institutional doctoral (DNP) practice-guideline synthesis (University of Texas at Arlington DNP

Practice Guideline, n.d.) — were retained only where a directly citable, peer-reviewed primary source could not be identified at the time of writing. These sources are explicitly identified as secondary wherever cited below, and their findings are interpreted with corresponding caution.

LITERATURE REVIEW AND FINDINGS

A total of relevant primary studies, national surveys, and systematic/integrative reviews spanning multiple health systems — including the United States, Saudi Arabia, Egypt, Pakistan, China, Turkey, Japan, Spain, and Australia — informed this synthesis. Findings are presented below under four thematic headings: prevalence, risk factors, consequences, and interventions. Because part of the intervention evidence (Section III.D) originates from general or geriatric nursing populations rather than psychiatric nursing specifically, studies are identified below as either psychiatric-nursing-specific or transferred from a comparable high-emotional-labour nursing population, and Table 1 marks this distinction explicitly.

Prevalence of Burnout and Compassion Fatigue Among Psychiatric Nurses

Prevalence estimates for burnout and compassion fatigue among psychiatric nurses vary considerably by country, care setting, and measurement instrument, but consistently indicate that a substantial proportion of the psychiatric nursing workforce is affected. In a 2023 cross-sectional study of male psychiatric nurses across public and non-public hospitals in Pakistan's capital territory using the ProQOL scale, 59% of respondents met criteria for severe burnout and 88% were classified as at higher risk of compassion fatigue, while only 12% reported high compassion satisfaction (Haider et al., 2026). A large-scale United States study drawing on the 2023–2024 Penn Nurses4All and American Hospital Association survey data found that nearly four in ten inpatient psychiatric-mental health registered nurses (38%) reported high burnout, with 29.5% reporting job dissatisfaction and 22% intending to leave their employer within a year (as reported in a research-news summary, Psychiatry Advisor, 2026, of Dixon et al.'s peer-reviewed study in the Journal of Psychiatric and Mental Health Nursing; the primary study itself was not directly accessed for this review).

Comparable patterns have been documented outside the United States. A cross-sectional study of 158 psychiatric nurses in Riyadh, Saudi Arabia, using the Arabic ProQOL, reported mean burnout and secondary traumatic stress scores in the moderate-to-high range, with compassion satisfaction scores only marginally higher (Alreshidi, 2023). In China, a study of 309 young psychiatric nurses across three psychiatric hospitals in Heilongjiang province found that compassion fatigue — comprising burnout and secondary traumatic stress — was significantly associated with reduced caring ability, underscoring that the syndrome is not merely a personal-wellbeing concern but one with direct clinical implications (Wang et al., 2023). A Turkish study of 156 nurses working in a mental health and disorders hospital similarly found a significant inverse relationship between compassion fatigue and professional self-concept, professional satisfaction, and professional competence (Durmaz et al., 2024).

Together, these findings — spanning South Asia, the Middle East, East Asia, North America, and Europe — indicate that elevated burnout and compassion fatigue among psychiatric nurses is not an artefact of any single health system but a broadly replicated cross-national occupational health concern.

Risk Factors and Contributing Conditions

The literature identifies a consistent cluster of risk factors that predispose psychiatric nurses to burnout and compassion fatigue. Foremost among these is chronic exposure to workplace violence. A multicentre cross-sectional census survey of 171 psychiatric nurses across three facilities in northern Saudi Arabia found that most nurses had experienced at least one workplace violence incident, most commonly verbal abuse, in the preceding twelve months, and that burnout statistically mediated the relationship between workplace violence exposure and turnover intention (Alruwaili, 2026). Younger age, male sex, shorter psychiatric nursing experience, and lower perceived staffing adequacy were identified as factors associated with greater workplace violence exposure in that same study. Earlier research in Japan similarly found that psychiatric nurses' perceived risk of workplace assault was directly associated with intention to leave their position, while supervisor support and job satisfaction helped offset that intention (Ito et al., 2001).

Staffing adequacy and workload emerge repeatedly as structural contributors. Inadequate nurse-to-patient ratios on acute psychiatric units limit the time available for therapeutic engagement, increase the cognitive and emotional burden of managing multiple high-acuity patients simultaneously, and reduce opportunities for debriefing after distressing incidents such as seclusion, restraint, or self-harm events. Organisational and leadership factors also play a substantial role: a burnout-bundle guideline synthesis for psychiatric nursing units found that when nurse leaders regularly evaluated and responded to staff needs and feedback, the majority of nurses reported this support meaningfully helped in managing and preventing burnout, whereas absent or inconsistent leadership engagement was associated with persistently elevated burnout (referenced in an unpublished institutional DNP practice-guideline synthesis, University of Texas at Arlington DNP Practice Guideline, n.d. — a secondary, non-peer-reviewed source — drawing on Jaber et al., 2025, and Razai et al., 2023).

A further contributing factor specific to psychiatric settings is the emotional labour inherent in therapeutic relationships with patients experiencing severe mental illness, trauma, or suicidality. Nurses are required to maintain empathic engagement while regulating their own emotional responses to patients' distress, a demand that, absent adequate supervision, peer support, or reflective practice structures, contributes cumulatively to secondary traumatic stress. Professional seniority (with less experienced nurses at higher risk), being unmarried or without strong social support networks, and male gender have also been identified in meta-analytic evidence as correlates of burnout among mental health nurses, alongside general work overload and work-related stress.

Consequences for Nurses, Patients, and Health Systems

The consequences of unaddressed burnout and compassion fatigue extend well beyond individual nurse distress. Turnover intention is among the most consistently reported outcomes: workplace violence exposure, occupational stress, and burnout have each been shown, both independently and through mediating pathways, to elevate nurses' intention to leave their current position or the profession altogether (Alruwaili, 2026; Ito et al., 2001). At a systems level, the American Hospital Association reported that more than 100,000 registered nurses left the United States workforce during the COVID-19 period, with over 600,000 more indicating intention to leave by 2027 — a trend to which psychiatric nursing, given its elevated stress exposure, is understood to disproportionately contribute.

Compassion fatigue and burnout have also been associated with reduced quality of patient care, based on cross-sectional data that cannot establish causal direction. The Chinese study of young psychiatric nurses found that compassion fatigue significantly diminished nurses' caring ability, with burnout acting as a partial mediator between compassion satisfaction and caring capacity (Wang et al., 2023). Reduced professional self-concept and competence associated with compassion fatigue have similarly been documented (Durmaz et al., 2024), suggesting a plausible pathway by which nurse-level occupational stress translates into diminished therapeutic engagement, reduced vigilance for early warning signs of patient deterioration, and, potentially, compromised safety on psychiatric units where therapeutic rapport and careful risk assessment are clinically essential.

Beyond clinical and workforce outcomes, burnout and compassion fatigue carry direct costs to nurses' own mental and physical health, including elevated depressive and anxiety symptoms, sleep disturbance, and, in cases of chronic unaddressed workplace violence exposure, longer-term psychological distress persisting six to twelve months after a violent incident. These personal health consequences compound workforce attrition risk and underscore that psychiatric nurse well-being is inseparable from sustainable, safe mental health service delivery.

Protective Factors and Evidence-Based Interventions

A growing intervention literature offers encouraging evidence that burnout and compassion fatigue among nurses in high-stress specialties, including psychiatric nursing, are modifiable rather than an inevitable occupational cost. Mindfulness-based interventions have accumulated the strongest evidence base. In a randomised controlled trial of an online mindfulness-based programme for nurses caring for institutionalised

older adults with dementia — a population with comparably high emotional-labour demands — the intervention group showed statistically significant reductions in compassion fatigue and burnout relative to a wait-list control group, with improvements sustained at three-month follow-up (Pérez et al., 2022). An integrative review of nine peer-reviewed studies published between 2019 and 2024 similarly found that mindfulness-based stress reduction (MBSR) programmes, ranging from brief daily mindfulness huddles to structured eight-week courses, consistently reduced emotional exhaustion and perceived stress while improving job satisfaction, professional efficacy, and compassion satisfaction across nursing populations.

Structured mindful self-care and resiliency (MSCR) programmes combining a psychoeducational workshop on compassion fatigue with subsequent mindfulness practice sessions have shown particularly strong results specific to compassion fatigue prevention. In a pilot evaluation among nurses at a Western Australian teaching hospital, the proportion of participants with high burnout scores fell from 45% pre-intervention to 15% post-intervention, alongside significant improvements in compassion satisfaction and reductions in negative affect and stress (Craigie et al., 2016). A subsequent controlled trial of the same intervention model, comparing an active intervention group with a wait-list control group, found significant reductions in burnout and depressed mood that persisted at six-month follow-up, together with improvements in compassion satisfaction, self-compassion, and subjective quality of life for nurses who completed the programme.

Beyond individual-level psychological interventions, organisational and peer-based strategies show promise. Formal peer support and "buddy system" programmes — in which nurses are paired for mutual support and trained to create safe spaces for colleagues to process distressing clinical experiences — have been identified as effective strategies for fostering connectedness and reducing compassion fatigue on psychiatric units. Leadership engagement is similarly protective: in survey data cited within the same secondary, non-peer-reviewed psychiatric nursing burnout-bundle guideline referenced above, the large majority of nurses indicated that active leadership recognition of, and responsiveness to, staff needs would meaningfully aid burnout prevention, while access to professional development and training resources was associated with improved engagement, confidence, and motivation, indirectly mitigating burnout risk. Taken together, the evidence suggests that the most effective approaches combine individual-level skills training (mindfulness, self-compassion, resilience) with structural and leadership-level support (adequate staffing, peer support systems, responsive supervision, and workplace violence prevention protocols), rather than relying on either approach in isolation.

Table 1 summarises the principal studies underpinning this synthesis, including country/setting, design and sample, population, and key findings, to allow readers to assess heterogeneity across the evidence base directly.

Table 1. Summary of Key Primary Studies

Study (Author, Year)	Country / Setting	Design & Sample	Population	Key Finding(s)
Haider et al. (2026)	Pakistan (capital territory hospitals)	Cross-sectional; ProQOL scale	Male psychiatric nurses, public & non-public hospitals	59% severe burnout; 88% higher compassion-fatigue risk; only 12% high compassion satisfaction
Dixon et al., as summarised in Psychiatry	United States	Secondary analysis of 2023–2024 Penn	Inpatient psychiatric-mental health	38% high burnout; 29.5% job dissatisfaction; 22% intended to leave employer within a year

Study (Author, Year)	Country / Setting	Design & Sample	Population	Key Finding(s)
Advisor (2026) ††		Nurses4All / AHA survey data	registered nurses	
Alreshidi (2023)	Saudi Arabia (Riyadh)	Cross-sectional, n = 158; Arabic ProQOL	Psychiatric nurses	Mean burnout & secondary traumatic stress in moderate-to-high range; compassion satisfaction only marginally higher
Wang et al. (2023)	China (Heilongjiang)	Cross-sectional, n = 309	Young psychiatric nurses, 3 hospitals	Compassion fatigue significantly associated with reduced caring ability; burnout a partial mediator
Durmaz et al. (2024)	Türkiye	Cross-sectional, n = 156; ProQOL compassion-fatigue subscale + Professional Self-Concept Scale	Psychiatric nurses, mental health hospital	Significant inverse relationship between compassion fatigue and professional self-concept, satisfaction, and competence
Alruwaili (2026)	Saudi Arabia (northern region)	Multicentre cross-sectional census, n = 171	Psychiatric nurses, 3 facilities	Most nurses experienced ≥1 workplace-violence incident in past 12 months; burnout mediated the violence–turnover-intention link
Ito et al. (2001)	Japan	Cross-sectional	Psychiatric nurses	Perceived assault risk associated with intention to leave; supervisor support and job satisfaction offset that intention
Craigie et al. (2016) †	Australia (Western Australia)	Pilot pre–post intervention, n = 21 (no control group)	General teaching-hospital nurses (not psychiatric-specific)	High-burnout proportion fell from 45% to 15% post-intervention; improved compassion satisfaction, reduced negative affect
Pérez et al. (2022) †	Spain	Randomised controlled trial vs wait-list control	Nurses caring for institutionalised older adults with dementia (not psychiatric-specific)	Significant reductions in compassion fatigue and burnout vs control, sustained at 3-month follow-up

Conducted in a general or geriatric nursing population rather than psychiatric nursing specifically; evidence transferred by analogy to comparable emotional-labour demands (see Discussion). †† Findings accessed via a non-peer-reviewed secondary (research-news) source rather than the primary study directly (see Limitations).

DISCUSSION

The synthesised evidence points to a coherent picture: psychiatric nurses operate in an occupational environment characterised by chronic emotional labour, elevated risk of workplace violence, and — in many health systems — persistent staffing shortfalls, all of which converge to produce burnout and compassion fatigue at rates that meet or exceed those documented in the general nursing workforce. This pattern is consistent with stress-process frameworks such as the Conservation of Resources model and the stressor-strain-outcome (SSO) model, both of which conceptualise burnout as the outcome of sustained resource depletion — emotional, cognitive, and organisational — without adequate replenishment. Within these frameworks, workplace violence and understaffing function as chronic stressors; emotional exhaustion and secondary traumatic stress represent the resulting strain; and turnover intention, reduced caring ability, and diminished patient safety represent the downstream outcomes.

A notable feature of the reviewed literature is the consistency with which burnout has been reported to mediate the relationship between upstream stressors (such as workplace violence) and downstream outcomes (such as turnover intention), rather than acting as a mere correlate. It should be noted that these mediation findings derive from cross-sectional mediation models (e.g., Alruwaili, 2026; Wang et al., 2023) rather than longitudinal designs, so they indicate a statistically plausible pathway rather than confirmed causal sequence. With that caveat, this mediating pattern has practical significance if borne out in future longitudinal research: interventions that reduce burnout — whether through individual resilience training or organisational support — may help attenuate the downstream workforce and patient-safety consequences of stressors, such as workplace violence, that cannot always be eliminated outright in acute psychiatric care environments. This tentatively reframes burnout reduction as potentially more than a wellness initiative, with possible relevance to workforce stability and patient safety, pending confirmatory research.

At the same time, the review highlights an important tension in how the field has historically responded to psychiatric nursing burnout. Much of the available intervention literature emphasises individual-level psychological interventions — mindfulness, self-compassion, resilience training — which, while evidenced and valuable, risk placing the burden of adaptation disproportionately on individual nurses rather than on the organisational conditions that generate chronic stress in the first place. The studies examining leadership responsiveness, staffing adequacy, and peer support structures suggest that sustainable reductions in psychiatric nursing burnout likely require parallel investment in structural and organisational change, not individual coping skills alone.

A further interpretive caution concerns the origin of the intervention evidence itself (see Table 1). The prevalence and risk-factor findings summarised above derive directly from psychiatric or mental-health nursing samples. By contrast, two of the more rigorously designed intervention studies — the mindful self-care and resiliency pilot (Craigie et al., 2016) and the mindfulness-based randomised controlled trial (Pérez et al., 2022) — were conducted in general hospital nursing and dementia-care nursing populations respectively, not in psychiatric nursing settings. Their inclusion is justified on the grounds that both populations share comparably high emotional-labour demands with psychiatric nursing, but the magnitude and durability of these effects should be regarded as plausibly, rather than directly, transferable until replicated in psychiatric-nursing-specific trials.

Implications for Psychiatric Nursing Practice, Education, And Policy

For clinical practice, unit-level implementation of brief, low-cost mindfulness practices (such as pre-shift mindfulness huddles) and structured debriefing after critical incidents (seclusion, restraint, self-harm, or violent episodes) offers an accessible starting point for psychiatric nursing teams, supported by evidence that

even brief interventions produce measurable short-term reductions in stress and burnout symptoms. Formalising peer support or "buddy" systems, with designated and trained peer supporters, can provide a low-cost, sustainable structure for ongoing emotional processing among psychiatric nursing staff.

For nursing administration and leadership, the evidence supports prioritising adequate psychiatric unit staffing, responsive and visible leadership engagement with frontline staff concerns, and robust workplace violence prevention and response protocols as core components of workforce retention strategy rather than as separate initiatives from clinical operations. Given that burnout has been reported to mediate the relationship between workplace violence exposure and turnover intention in cross-sectional models, investment in violence prevention (de-escalation training, adequate security response, post-incident support) may yield workforce retention benefits beyond the immediate safety gains.

For nursing education, integrating structured content on compassion fatigue recognition, self-compassion, and resilience skills into pre-registration and postgraduate psychiatric-mental health nursing curricula may better prepare novice nurses — identified in the literature as a higher-risk group — for the emotional demands of the specialty before burnout symptoms become entrenched.

For health policy, the cross-national consistency of findings suggests that psychiatric nursing workforce sustainability should be treated as a distinct occupational health priority within national nursing workforce strategies, with dedicated funding for staffing ratios, violence prevention infrastructure, and evidence-based wellness programming tailored to mental health care settings rather than generic hospital-wide wellness initiatives.

LIMITATIONS

This review has several limitations characteristic of the narrative review method. First, because studies were not pooled statistically, the review cannot provide a precise, weighted estimate of global burnout or compassion fatigue prevalence among psychiatric nurses; the wide range of reported prevalence (approximately 38% to 59% for severe or high burnout, depending on setting and instrument) reflects genuine cross-study heterogeneity in populations, instruments, and thresholds rather than a single definitive figure. Second, most primary studies included were cross-sectional, limiting causal inference regarding the direction of relationships between stressors, burnout, and outcomes such as turnover intention, although several studies employed mediation analysis to strengthen causal plausibility. Third, intervention studies reviewed here were predominantly conducted in general or geriatric nursing populations rather than psychiatric nursing specifically — notably the mindful self-care and resiliency pilot conducted in a general teaching-hospital nursing sample (Craigie et al., 2016) and the mindfulness-based trial conducted among nurses caring for institutionalised older adults with dementia (Pérez et al., 2022) — meaning transferability of intervention effect sizes to acute psychiatric settings, while plausible, remains an area requiring dedicated psychiatric-nursing-specific trials. Fourth, this review relied at two points on non-peer-reviewed secondary sources — a research-news summary of a primary study (Psychiatry Advisor, 2026) and an unpublished institutional DNP practice-guideline synthesis (University of Texas at Arlington DNP Practice Guideline, n.d.) — because the underlying primary sources could not be directly accessed or identified at the time of writing; findings drawn from these sources should be treated as provisional until verified against the primary literature, and reference details throughout should be checked against publisher records (including DOIs) prior to submission. Finally, publication bias toward statistically significant findings cannot be excluded.

CONCLUSION AND RECOMMENDATIONS FOR FUTURE RESEARCH

Burnout and compassion fatigue represent a substantial and well-documented occupational health concern among psychiatric nurses internationally, driven by a combination of high emotional labour, workplace violence exposure, staffing inadequacy, and variable organisational support. The consequences extend from individual nurse well-being to workforce turnover and, plausibly, to the quality and safety of psychiatric patient care. Encouragingly, a growing evidence base — spanning randomised controlled trials, pilot programmes, and organisational research — demonstrates that both individual-level interventions

(mindfulness-based stress reduction, self-compassion and resiliency training) and structural interventions (adequate staffing, workplace violence prevention, responsive leadership, and peer support systems) can meaningfully reduce burnout and compassion fatigue while improving compassion satisfaction.

Future research should prioritise psychiatric-nursing-specific randomised controlled trials of combined individual and organisational interventions, longitudinal designs capable of establishing causal pathways between workplace stressors and workforce outcomes, and comparative cross-national studies to clarify which contextual and health-system factors moderate intervention effectiveness. Continued investment in psychiatric nursing workforce well-being is not merely a matter of occupational welfare; it is a prerequisite for a stable, skilled, and compassionate mental health nursing workforce capable of sustaining the quality of care that individuals with severe mental illness require.

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