STRATEGIES AND INTERVENTIONS TO IMPROVE NURSE MENTAL HEALTH SUPPORT

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Abstract

This study outlines interventions and strategies designed to enhance the provision of mental health support for nurses. Nurses assume a pivotal position in the provision of primary care and are required to exhibit elevated levels of proficiency, empathy, and vigilance in order to effectively address the escalating needs of healthcare systems. Nevertheless, the augmented workload and heightened pressure often result in occupational stress, psychological ailments, and burnout within the nursing profession. The mental health difficulties experienced by nurses have a significant influence on both their own well-being and the overall quality and safety of patient care. It is important to acknowledge and tackle these concerns in order to improve the healthcare system as a whole. In order to address the adverse effects of mental health concerns among nurses, a range of therapies have been investigated. The present investigation used a methodical methodology to ascertain and assess therapies that especially address the psychological well-being of nurses. A thorough investigation was performed using electronic databases, including works published inside the timeframe of 2009 to 2024. The results highlight certain approaches that have shown potential in enhancing mental health assistance for nurses. The solutions include training programs that prioritize the improvement of professional identity and the mitigation of burnout, with restorative supervision techniques that foster flexibility and well-being within the healthcare profession. The findings suggest that nurses who took part in these treatments had favorable outcomes, including reduced emotional weariness, heightened participation in psychotherapy, and enhanced general well-being.

Keywords: Mental health of nurses, burnout, interventions, training programs, restorative supervision.

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1. Introduction

Primary care is currently a major component of global health-care systems. Major medical and financial shifts stimulate enthusiasm for healthcare revitalization, as do public perceptions regarding their well-being and the treatment they get (1). The public has high expectations of its health-care structure, particularly their health-care personnel, who must be highly competent and experienced, as well as compassionate, empathic, and attentive to their specific preferences and requirements (2,3). Additionally, increased demand for medical care, as well as requests to improve cost and efficiency, put extra strain on medical professionals. With health care doctors in shortage (4,5), emphasis has shifted to how nurses may relieve pressures while adding to enhancing primary care availability and efficacy (6). Nurses have become recognized as essential components of evolving interprofessional health care designs, and their area of expertise has expanded over the last generation (7,8).

Nevertheless, the difficulty of fulfilling increased demands and expectations have raised major concerns regarding nurses' workplace circumstances and abilities to deal with stress-related issues. Systematic studies demonstrate that job stress and psychological issues are common in nursing, including primary care nursing (9,10,11). Health care workers have been reported to experience significant levels of mental tiredness and are more likely to suffer from exhaustion, depression, and anxiety (12,13). Nurses' anxiety and mental health issues have a significant influence on their standard of life and are linked to staff absences and turnover (14,15). Nurses' mental health has an influence on the quality and security of care they deliver, as shown by higher rates of general and prescription administration mistakes, poor cooperation with patients and peers, and worse patient contentment.

Burnout is a condition marked by extreme emotional tiredness and depersonalization, as well as a poor feeling of personal success at work, and it is strongly associated with anxiety (16). The major purpose of the Action Partnership is to reduce physician burnout prevalence in the United States, thereby improving clinician demographic health and ensuring the safety and quality of healthcare. A recent comprehensive analysis found that burnout affects more than half of doctors and nurses. An additional recent research of roughly 1800 nurses from nineteen medical facilities throughout the nation revealed that more than half of them reported poor mental and physical wellness (17).

Depression impacted 25% of the respondents and was the most common cause of medical mistakes, which are currently the third greatest cause of mortality in the United States (18). Nurses in bad physical and mental condition were twenty-six percent to seventy-one more inclined to admit medical mistakes than those in good health. Although doctors and nurses strive to offer outstanding treatment to their individuals, they frequently overlook their personal self-care. As a consequence, healthy lifestyle activities are often given low importance (18). Aside from human variables, there are several healthcare system concerns that lead to clinician stress and depression, such as inadequate staffing structures, persistent issues with electronic medical records, which results in fewer hours with patients, and pressure to raise workloads (19). Managers have to tackle these healthcare system concerns to improve professional well-being and guarantee patient safety.

The fourth purpose of the medical quadruple is to enhance professionals' work-life and well-being (20). If professionals are unwell, healthcare safety and efficacy may decrease. To achieve the quadruple objective in health care, healthcare organizations must invest in infrastructure that incorporates evidence-based treatments that have been shown to foster a culture that promotes clinician health and well-being. NAM developed a model to identify characteristics impacting clinician well-being and resilience (21). This paradigm identifies both external and individual influences. External elements include sociocultural influences, regulatory, corporate, and payer environments, organizational factors, and the learning/practice environment. Individual aspects include the healthcare position, personal characteristics, skills, and capacities. A variety of treatments have been developed to increase clinician well-being, largely via the personal components mentioned in the model. Individual-level therapies concentrate on physical and mental health, awareness, reducing anxiety, adaptability, and various other factors. The National Academy of Medicine has built a website with a knowledge center to enhance clinician well-being and resilience, which includes a variety of tools (22).

A variety of scholarly assessments have been conducted to assess the efficacy of therapies aimed at addressing mental health and stress-related issues among healthcare workers and those in many other professional fields. Nevertheless, the existing literature has primarily concentrated on a restricted array of interventions, neglecting to investigate interventions specifically targeted

towards nurses, or predominantly concentrating on nurses working in hospital or specialized environments. Due to the growing importance of nurses in efficient primary care, it is necessary to discover treatments that may successfully mitigate the mental health issues of these caregivers and enhance their overall well-being.

2. Methodology

2.1. Search Strategy

The present study used a methodical methodology to ascertain and evaluate several methods and interventions designed to enhance the provision of mental health assistance for nurses. The search methodology used in this study included the utilization of electronic databases such as PubMed, CINAHL, PsycINFO, and Scopus. The investigation used a blend of keywords and MeSH phrases pertaining to the mental well-being of nurses, including support, interventions, and strategies. The search was restricted to publications published in English between 2009 and 2024 to guarantee the incorporation of up-to-date and relevant material.

2.2. Inclusion Criteria

The evaluation included studies that included registered nurses, nurse practitioners, or nurses in diverse healthcare settings, as determined by the inclusion criteria. The emphasis was placed on research that examined tactics and measures primarily aimed at providing mental health assistance to nurses. The study focused on evaluating several aspects of nurse mental health, well-being, work satisfaction, burnout, stress reduction, and the efficacy of therapies. Various research methodologies, including both quantitative and qualitative approaches, were taken into account for potential inclusion.

2.3. Exclusion Criteria

In order to guarantee the quality and pertinence of the research included, a comprehensive selection procedure was executed. The titles and abstracts of the discovered papers were evaluated by two independent reviewers according to the predetermined inclusion and exclusion criteria. Any inconsistencies among the reviewers were addressed via deliberation and agreement. The articles that successfully passed the first screening were subjected to a comprehensive examination of their whole text, during which two impartial reviewers evaluated their suitability according to the predetermined criteria for inclusion and exclusion.

2.4. Data Extraction

Data extraction was performed to gather pertinent information from the studies that were included. This included information on the study's attributes, participant attributes, intervention explanations, and documented results. The Cochrane Risk of Bias Tool was used to evaluate the quality and potential for bias in randomized controlled trials, whereas the Joanna Briggs Institute Critical Appraisal Checklist was used for other research types.

By highlighting the strategies and interventions utilized to enhance the provision of mental health support by nurses, a narrative synthesis of the findings from the studies that were included was produced. Also investigated were the efficacy of the interventions, recurring themes, and patterns that were identified throughout the investigations. The purpose of this synthesis was to examine evidence-based strategies that can be applied in healthcare environments to improve the provision of mental health support by nurses.

3. Initial interventions

The first approach focused on specific groups of nurses, while the other two treatments aimed to address the interaction among nurses and the work setting. The research conducted by Isaksson Ro et al. (23) included the participation of groups of nurses in a 5-day training held at a Norwegian Resource Centre for Health Personnel. The primary objectives of this course were to enhance professional identity, foster health and quality of life, and mitigate the risk of burnout. The instructional framework used in this course was grounded on cognitive theory, including meditation and relaxation strategies, regular lectures, the exchange of personal anecdotes, and individual counseling sessions with mental nurses, including a cultural itinerary with social events. Prior to the commencement of the course and over a span of one year (ranging from 43 to 73 weeks), various outcome measures were evaluated. These measures encompassed burnout, as measured by Maslach's Burnout Inventory, which included subscales for emotional exhaustion, depersonalization, and personal accomplishment.

Additionally, negative life events, duration of vacation, mental wellness therapies obtained, work-related dispute, number of job hours, and work hour declines were also subject to assessment. Following the completion of the course, nurses saw a decrease in emotional tiredness (mean score at initially: 2.87; following up: 2.52, $p < .001$) and detachment (mean score at initially: 1.77; follow-up: 1.63, $p = .001$). Additionally, the percentage of nurses engaging in

psychotherapy increased twofold from 17% to 34% (p <.001). There were no apparent alterations in the other outcomes. Further examination of subgroups indicated that nurses who continued to have job-related issues after the intervention failed to observe a decrease in emotional tiredness compared to nurses who did not encounter work conflicts.

The training of health visitor leaders in a supervisory approach known as'restorative supervision' was the focus of study conducted by Wallbank (24). The therapeutic monitoring approach was developed with the purpose of providing assistance to professionals who are involved in dealing with families that have intricate care requirements. Its objective is to enhance the adaptability, health, and well-being of experts, along with their ability to make intricate clinical judgments within their professional setting. The intervention used a train-the-trainer methodology, whereby health visitor leaders underwent training in rehabilitative monitoring. This training enabled them to effectively provide this kind of supervision to their coworkers, including midwives, nurses, and other professionals within their respective organizations. In the pilot research conducted in 2011, a total of 22 health visitors underwent training. This training consisted of a half-day course focused on the theoretical and practical aspects of rehabilitative supervision. Subsequently, these health visitors were assigned to undergo supervision instruction from an individual of the monitoring team (25).

The training program underwent additional updates, which included the extension of the first training period to a full day. Additionally, the program included the option of group training exercises under supervision, as well as to individual workshops with a supervisor. Wallbank and Woods (26) presents findings pertaining to a sample of 1805 health visitors who underwent training in the supervision model. The health visitors underwent evaluations both before and after their sixth supervisory session. These assessments included the Professional Quality of Life Scale, which included subscales for compassion satisfaction, burnout, and compassion fatigue, as well as the Impact of Event Scale, which was used to evaluate stress levels. The researchers documented reductions in stress and burnout among health visitors by 43% and 63% respectively. However, they did not see any impact of the intervention on compassion satisfaction, since the findings for compassion fatigue were not given.

4. Subsequent Interventions

The three trials that assessed secondary treatments focused on individual nurses who were facing work-related stress. The impact of 8-week meditation training programs on nurses' levels of burnout and psychological consequences were investigated in two separate studies conducted by Goodman and Schorling (27) and Bazarko et al. (28). The solution implemented by Bazarko et al. (28) included several components, such as guided practice in mindful meditation, moderated group chat sessions, mild stretching and yoga sessions, regular job and residence tasks including DVDs, CDs, as well as workbooks, as well as access to personalized training and support. The teacher conducted a limited number of in-person lessons, substituting the majority of weekly sessions with group teleconference calls. The outcome measures were evaluated before to the commencement of the training (Time 1), after a duration of 8 weeks (Time 2), and subsequently at 6 months (Time 3).

A substantial decrease in nurses' reported stress (the perceived Pressure Scale, average score at Time 1: 20.64; Time 2: 12.39, p <.001) and levels of burnout (Copenhagen Burnout Inventory; A decrease in intimate, job, and customer exhaustion of 41%, 24%, and 27%) were noticed at Time 2. Additionally, advancements were noted in self-rated overall wellness (SF-12v2, mean rating at Time 1: 46.12, Moments 2: 49.41, p <.05) and psychological well-being (SF-12v2 MCS, mean rating at Duration 1: 38.23, Time 2: 51.39, p <.001). Positive results were sustained at Time 3 and shown additional enhancement in relation to the assessment of work exhaustion.

The investigation conducted by Goodman and Schorling (27) yielded comparable findings. Their mindfulness intervention consisted of face-to-face sessions with instructors lasting 2.5 hours per week to acquire mindfulness techniques, application of these techniques in both professional and personal settings using a CD, and interactive sessions during meetings. The impact of the intervention was documented individually for individuals who were physicians and those who were non-physicians, including nurses. Following an 8-week period, the non-physician group showed notable decreases in all three subscales (mental fatigue, detachment, and subjective achievement) of the Maslach Burnout Inventory. Additionally, there were enhancements in self-rated psychological well-being, as indicated by the mean scores of 43.8 and 50.0 on the SF-12v2 MCS at Time 1 and Time 2, respectively (p <.001).

The research conducted by Brunero et al. (29) used a sample of 18 recently graduated nurses

employed in an Australian healthcare system. These nurses were provided with an 8-hour interactive session that incorporated cognitive behavioral therapy (CBT) techniques. The workshop encompassed an educational segment on workplace stresses and the use of Cognitive Behavioral Therapy (CBT) to address these stressors. It also provided an elucidation of the concept for mental and behavioral disturbance, followed by a collaborative role-play exercise to hone the application of the model in a professional environment. In addition, participants were provided with further reading materials and self-directed learning resources subsequent to the workshop. The participants in the study, who were nurses, were administered stress evaluations and the Nurse Stress Scale (NSS) both prior to the workshop and again after a period of 6 weeks. The results indicated modest yet noteworthy decreases in work-related stress, stress experienced outside of work, and overall stress levels. Additionally, there were improvements observed in the NSS subscales pertaining to dealing with passing away, as well as disagreements with nurses and doctors.

5. Collaborative Interventions

The research conducted by Bakker and de Vries (30) exhibited notable distinctions from the other investigations included in this review, particularly in relation to the extent of investigation and the quantity of treatments assessed. The research was carried out in the Dutch nursing home industry, including 81 organizations and more than 26,000 nurses who carried out client-focused duties. At foundation and 2.5 years later, nurses were administered surveys to evaluate work features, including job responsibilities, social assistance, choice latitude, and skill privacy, as well as workplace stress, specifically the emotional fatigue subscale of the Maslach Stress Scale. Within that period, 58 out of the 81 organizations executed a range of workplace health measures for their employees. These interventions included individual-group measures such as employee benefits, provision of mobile phones, and job mobility programs. Additionally, worker-environment measures included increased resources for training and education, training in task-related difficulties, and social skills instruction. Organizational measures included new protocols for resolving workplace conflicts and hiring additional personnel to reduce workloads.

Other interventions included printed information about working conditions and promoting workplace safety. The majority of organizations introduced multiple interventions simultaneously, with an average of 19.5. The findings indicated a statistically significant impact of time on all variables. Specifically, nurses observed a reduction in work demands and emotional tiredness, as well as a rise in degrees of social support, choice flexibility, and skill discretion throughout the follow-up period. The amount of interventions implemented did not have a linear relationship on outcomes. In contrast, the impact of work stress, job demands, and social support was shown to be influenced by the quantity of organizational treatments applied, whereas other interventions did not have a moderating effect. Specifically, the results were found to be more favorable when organizations adopted four or more interventions at the organizational level.

6. Discussion

The objective of this research was to examine the data about the efficacy of treatments designed to enhance or advance the mental well-being of general practitioner nurses. A total of seven studies were identified, using pre-post intervention designs, which assessed the impact of main, secondary, or combination treatments on psychological consequences among nurses or a diverse group of professions, including nurses. The findings of all seven studies indicate that treatments had favorable effects on some outcomes. However, it is important to exercise care when evaluating these results due to the moderate to inadequate empirical quality of the research. Based on our research, we have made the following conclusions.

The mental health outcomes of stress and burnout were often tested in various researches, with six studies examining burnout and four studies examining stress. These outcomes were shown to be ameliorated by a variety of primary, secondary, or mixed therapies. The results presented in this study align with prior research reviews that have reported similar outcomes, indicating that various interventions can effectively mitigate exhaustion (31) and tension (32,33). The present evaluation included an analysis of four of the seven studies that investigated the impacts of individual treatments aimed at addressing exhaustion or anxiety in both individuals and groups. The therapies used in all four researches were centered on practicing mindfulness or cognitive behavioral therapy.

According to previous studies (31,34), cognitive behavioral techniques have demonstrated greater efficacy in addressing burnout and stress compared to other interventions targeting individuals. Additionally, mindfulness approaches have shown effectiveness in managing stress, especially when used in conjunction with mental

restructuring methods (32). In a study of moderate-level proof effectiveness, Bazarko et al. (28) demonstrated that mindfulness exercises can effectively address burnout and stress, even when administered in group settings and primarily through telephone communication. This finding is significant considering the high number of patients and scarce resources in many community-based medical centers.

Similar to a recent review conducted by Guillaumie et al. (35), both trials examining secondary mindfulness therapies (27,28) reported enhancements in nurses' self-assessed mental well-being. Wallbank (24) conducted two studies that focused on the worker-environment interface as a strategy to avoid burnout and stress, rather than individual nurses. The authors' endeavors to advocate for a clinical supervision model that enhances personal resilience and the ability to effectively handle families with intricate care requirements bore resemblance to the methodologies employed in previous research aimed at augmenting professionals' particular tools and resources in order to effectively cope with the more demanding aspects of their profession (36).

According to Richardson and Rothstein (36), the aforementioned treatments were also seen to be efficacious in mitigating stress levels. Our analysis only included one research that examined the impact of various therapies on burnout and stress (30). While Bakker and de Vries (30)' study did find notable decreases in stress and burnout during the follow-up period, it is challenging to make definitive conclusions regarding the efficacy of individual, worker-environment, or organizational interventions due to the extensive range of methods employed by the participating organizations (mean > 19 interventions).

The absence of assessments of objectives including signs of depression or anxiety in the research represented in the study is unexpected, given that these outcomes have been the subject of multiple workplace psychological treatments (33). Furthermore, the research encompassed a diverse range of person-oriented results, including self-assessed general or physical wellness in two investigations, peer support in two studies, happiness with empathy in two studies, acceptance of pharmaceutical or psychotherapeutic therapy in one study, compassion in one study, tranquility in one study, self-compassion in one study, and adverse life circumstances in one study. The treatments had different impacts on different results. The mindfulness program developed by Bazarko had a substantial positive impact on the levels of tranquility, empathy, and self-compassion among nurses (28). In opposition to Goodman's meditation assistance, which did not have any impact on self-rated physical health, the program additionally resulted in an improvement in nurses' self-rated general health (27).

According to Isaksson Ro et al. (23), the implementation of a course including cognitive therapy, mindfulness methods, and counseling sessions resulted in an increase in the percentage of nurses who sought psychotherapy. However, it did not have any significant effect on the consumption of antidepressant medications. The implementation of integrated therapies in Dutch home care organizations resulted in an enhancement of social support (30), however Brunero's CBT-based workshop did not have the same effect (29).

Three of the studies evaluated the impact of treatments on work-related or organizational outcomes. The two investigations conducted by Isaksson Ro et al. (23) and Brunero et al. (29) did not see any significant impacts on vacation time, payment of disability payments, number of hours labored, work problems, or stress. Brunero and colleagues (29) observed that their workshop, which used Cognitive Behavioral Therapy (CBT), effectively decreased disputes between nurses and between doctors and nurses, as assessed by the Nurse Anxiety Index. Workplace disputes are well recognized as factors that contribute to stress and burnout, and their prevalence has been on the rise due to the growing interprofessional character of clinical practices \. According to the findings of Isaksson Ro et al. (23), it was shown that the presence of continuous work problems after receiving treatments might diminish the positive outcomes associated with these interventions.

The evaluation only included the research conducted by Bakker and de Vries (30) to evaluate the impact of organizational interventions. Notably, this study was the sole one that shown positive impacts on various organizational outcomes. The implementation of combination interventions inside home care organizations resulted in a reduction of job demands for nurses, such as the requirement to work quickly. Additionally, these interventions led to an increase in decision latitude for nurses, allowing them to have a voice in choices that impact their work. Furthermore, nurses were able to exercise skill discretion by acquiring new knowledge and skills in their professional roles. Significantly, the authors also found that the implementation of organization-level treatments, but not other interventions, resulted in greater improvements in

outcomes pertaining to work demands, psychological weariness, and social support.

Organisational actions have been suggested as a promising approach for enhancing employee wellness because they can effectively address the root causes of unhealthy work environments. However, these measures have received less attention compared to interventions that focus on people or the interaction between workers and their environment (32). Bakker and de Vries (30)' research identified many prevalent organizational strategies, such as implementing policies to address workplace violence and harassment, augmenting the workforce to reduce workloads, conducting organized meetings to strategize assignments and shifts, and enhancing employee involvement in the process of planning and making decisions. Additional research from academics is required for these treatments, which have been shown to have positive impacts in previous studies (e.g., self-scheduling of shifts, progressive retirement procedures, interpersonal instruction) (33).

Furthermore, we were taken aback by the absence of any research expressly carried out in conventional primary care settings. The nurse participants who participated in the research were recruited from diverse community-based healthcare organizations. However, a particular amount of participants who were genuinely employed in medical practices or general practice-type clinics remained uncertain. Therefore, the extent to which our results may be applied to nurses employed in these particular contexts may be constrained. Additional methodological constraints of the research included in this analysis prevent us from making definitive conclusions based on the available literature. The pre-post intervention studies exhibited moderate methodological rigor in three studies and poor methodological rigor in the other four investigations. This was primarily attributed to potential discrepancies in recruiting participants and the absence of sufficient control groups.

A lack of randomized controlled studies examining treatments was observed. In addition, it is worth noting that the duration of follow-up periods in the majority of research was rather brief, with less than six months in five out of seven investigations. Furthermore, a limited number of studies took into account the possible impact of confounding variables in their analysis, which is a frequently encountered issue in existing research (32). Insufficient execution of workplace interventions can ultimately curtail their advantages. However, it is worth noting that only one of the reviewed studies provided data on the participants' actual adoption of the intervention. This study specifically examined the total duration of time participants dedicated to engaging in in-person and telephone conversations, as well as practicing mindfulness techniques independently (28).

It is important to highlight many limitations of our review. Initially, a comprehensive search was conducted across several article databases, with the exception of the British Nursing Index. Consequently, it is possible that some intervention studies with a focus on the United Kingdom were not included in the CINAHL database. Furthermore, the first title screening was conducted by just one review author. The inclusion of an additional review author might have reduced any possible biases in the selection process. Ultimately, despite the absence of a rigorous evaluation, our research indicates the potential presence of publishing bias in favor of studies that provide favorable outcomes. Awa et al. (31) have also observed the absence of published assessments of burnout or stress prevention methods. As previously stated, there is a need for more thorough assessments of treatments for mental health in nursing, as well as clear and open reporting of the outcomes

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7. Implications of the Study

The significance of primary care services in contemporary health care systems is well acknowledged (1), with nurses assuming an increasingly crucial role within the primary care workforce. The available evidence indicates that nurses are increasingly becoming an important component of medical professionals (37). Furthermore, nurses who possess more advanced skills, such as nurse practitioners, have the ability to provide primary care services ranging from 67% to 93% (38). According to Bodenheimer and Bauer (37), nurse practitioners are experiencing an expansion of their roles as they assume more duties in the avoidance and control of patients with persistent illnesses, the management of complicated treatment groups to enhance care for individuals with high utilization of medical services, and the facilitation of coordinated care among physicians and other healthcare providers.

In light of the dynamic nature of the current environment, it is essential to not only observe but actively advocate for the well-being, specifically the mental health condition, of nurses employed in primary care environments. Nevertheless, our analysis reveals a scarcity of research assessing treatments aimed at enhancing the mental well-being of primary medical nurses, with none of

them being undertaken in conventional primary care clinical settings. The existence of this significant knowledge deficit underscores the need for the adoption and assessment of novel approaches specifically designed for community-based nurses operating in environments that vary fundamentally from hospital-based settings in terms of staff dynamics and organizational resources. The data in this study indicates that many treatments have the potential to effectively reduce stress and burnout among nurses. However, the specific effects on mental health symptoms or work-related outcomes are still uncertain.

The utilization of cognitive-behavioral therapy (CBT) or mindfulness-based interventions at the individual level holds significant potential for nurses working in primary care settings. These interventions can be integrated with strategies that focus on work environments, such as interactions with doctors or additional primary care professionals, as well as organizational practices, including workplace security, interaction, and decision-making. Implementing such tactics would align with current initiatives aimed at assisting primary care clinics in attaining the triple aim: augmenting patient satisfaction, enhancing population health, minimizing expenses, and enhancing the professional well-being of healthcare practitioners (20).

8. Conclusion

The comprehensive review revealed that main, secondary, and combination therapies have the potential to mitigate burnout and stress among nurses working in community-based medical environments, with the evidence being moderate to poor. The impact of interventions on different outcomes linked to psychological wellness and well-being, whether they related to individuals or organizations, varied and relied on the particular intervention being assessed. The emotional well-being of nurses in primary care settings is becoming more worrisome due to the expanded responsibilities they have in providing regular patient care. There exists a distinct need for more comprehensive investigations pertaining to the psychological well-being of nurses, as well as the possible ramifications that individual and combination treatments could have on nurses, job environments, and the quality of patient care.

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