



Psychoeducation as burnout prevention for Hungarian teachers

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Abstract

The aim of this study is to examine the role of psychoeducation in preventing burnout among Hungarian teachers. Psychoeducation is a structured method of delivering professional information, combining elements of education, cognitive-behavioral therapy, and group therapy, with the goal of developing coping strategies to maintain health and ensure therapeutic collaboration. As part of the research, a 30-hour training program was developed and implemented with two groups, consisting of kindergarten and special education teachers (N=35). The core components of the training included self-awareness exercises, autogenic training techniques, and conflict management strategies. Changes in participants' burnout levels, psychological immune systems, coping methods, and perceived social support were assessed using pre- and post-training questionnaires (Maslach Burnout Inventory Educator Survey (MBI-ES), Oláh's Psychological Immune System Survey, Coping Methods Questionnaire, MOS SSS-H Social Support Questionnaire, and Mental Health Test). A significant reduction in burnout was observed. The findings support previous research indicating that psychoeducation can effectively reduce stress and burnout, though its effectiveness may depend on various factors, such as the length and intensity of the program, as well as participants' motivation and commitment. Future research should involve larger sample sizes and longitudinal designs to assess the long-term benefits of psychoeducational interventions more accurately for teacher burnout.

Keywords: mental health, education, autogenic training

1. Introduction

1.1 Definition of psychoeducation

“Psychoeducation is a professional method of imparting information, aimed at expanding patients' knowledge about their illness, teaching them how to manage it, and helping them process the emotional challenges associated with the illness” (Bagdy et al., 2016, p.20). Psychoeducation integrates elements of education, cognitive-behavioral therapy, and group therapy (Sarkhel et al., 2020). Its focus, beyond providing information, is to develop coping strategies. Its long-term goal is not merely to treat symptoms but to preserve health and, if

necessary, ensure therapeutic cooperation, develop skills, and promote a change in attitude. To achieve this, psychoeducation specialists provide information about the symptoms of the illness, available treatment options, and various self-help techniques (Bagdy et al., 2016).

Psychoeducation can be conducted individually or in groups, and family-centered interventions are also common. Psychoeducational groups are organized in a structured format within a pre-planned framework, prioritizing learning. The session goals are defined by the facilitator, who leads the group as an instructor. The number of sessions can range from 1 to 10, and group sizes can vary from a few participants to as many as 50. In addition to imparting knowledge, psychoeducational groups help participants identify their own coping strategies, and if these strategies are maladaptive, introduce new, more effective coping mechanisms (Sallai, n.d.).

Abramovitz et al. (2007) examined psychoeducational methods provided to patients with health anxiety, which included problem-solving strategies and cognitive-behavioral therapy elements. They found that these methods remained effective 1-6 months post-treatment, suggesting that such strategies should be incorporated into psychoeducational programs (Abramovitz et al., 2007).

1.2 The importance of psychoeducation for teachers

The effectiveness of a teacher's work is influenced by students' attitudes, the growth of their knowledge, their academic engagement, and their overall educational progress. Providing teachers with opportunities to participate in various trainings as a means of development and encouragement can significantly enhance their sense of success. A key factor in a teacher's well-being is the extent to which they find joy in the teaching-learning process, making it crucial that the work satisfies their cognitive needs (Tímár, 2006).

Leithwood and Beatty (2008) suggest that when teachers feel comfortable within their institution, it fosters their personal development and enables them to perform at their best (Leithwood & Beatty, 2008). Conversely, if classroom situations seem uncontrollable, it can negatively impact their well-being (Fűzi, 2012). Understanding this, it becomes clear why psychoeducation is included among the intervention techniques used in secondary prevention of teacher burnout.

Psychoeducation helps teachers approach stressful situations not from an emotional standpoint, but from a more rational perspective, thereby reducing their emotional involvement. In the context of teacher burnout, psychoeducation emphasizes the importance of building supportive relationships that share responsibility and reduce tension, while also expanding and strengthening coping mechanisms (Horváth, 2019).

2. Methods

Our previous research and literature review have confirmed the need for a training program aimed at helping teachers prevent burnout by supporting the development of key resources. This program would assist participants in avoiding burnout, enhancing the personality traits that contribute to their psychological immune system, and improving their emotional regulation, tension management, and conflict resolution strategies. Two 30-hour burnout-related training programs were held in May and June 2023. Teachers voluntarily participated in both the training and the associated research. In each case, we coordinated the program's organization with the head of the respective institution. One training session involved 15 kindergarten teachers (all women), and the other included 20 special education teachers (16 women, 4 men). Both training sessions were conducted over consecutive days.

Participants in the burnout prevention psychoeducational training completed a research questionnaire at the beginning of the training and again one month after its conclusion to assess the effectiveness of the program. Of the 35 questionnaires received, 33 were suitable for data analysis.

The primary aim of the training program was to identify and strengthen participants' personal resources. To support this, the program featured various self-awareness exercises, and participants learned the technique of autogenic training, which is useful for stress management and emotional regulation. We also prioritized the development of conflict resolution strategies, which were incorporated into the program. Based on our research findings, we placed significant emphasis on the role of social support, as the literature and our data both highlight its importance in preventing burnout. The training material was developed with these aspects in mind.

The program's methodological foundation was built around autogenic training, a relaxation therapy that participants progressively learned over the three training days. Autogenic training helps improve well-being and quality of life, reduces stress, aids in conflict resolution, and can be beneficial in treating psychosomatic disorders (Krapf, 1992; Bagdy, 1993; Linden, 1994; Zsombók, 2007; Caponetto et al., 2018; Litwic-Kaminska et al., 2022; Breznoscakova et al., 2023).

1. Maslach Burnout Inventory Educator Survey (MBI-ES) (Maslach & Jackson, 1981)
2. Oláh's Psychological Immune System Survey (Oláh, 1996)
3. Coping Methods Questionnaire (Folkman & Lazarus, 1980)
4. MOS SSS-H Social Support Questionnaire (Sz. Makó et al., 2016)
5. Mental Health Test (Vargha et al., 2020)

3. Results

3.1 Research questions and hypotheses

The following research questions and hypotheses have been formulated in relation to burnout prevention training:

3.1.1 Research questions

Q1: Does the burnout level of the participants, as measured by the MBI-ES questionnaire, change after the training?

Q2: Are there changes in the subsystems of the Psychological Immune System Questionnaire as a result of the training?

Q3: Is there a change in any factor in the MOS SSS-H questionnaire after training?

Q4: Do the coping methods measured with the Coping Methods Questionnaire change after the training?

Q5: Is there a change in the Mental Health Test scores due to the training?

3.1.2 Hypotheses

H1: Burnout prevention training has the effect of reducing the level of burnout in the participants.

H2: Training produces a positive change in all three subsystems of the Psychological Immune System Questionnaire.

H3: In the MOS SSS-H test, a positive change in the Emotional Information Support and the Positive Social Interaction Support Factors is observed, but there is no change in the Instrumental Support Factor after training.

H4: Subscales related to problem coping are altered, whereas subscales of emotional coping are not expected to change after training.

H5: We can measure improvements in all areas of the Mental Health Test after training.

3.2 Answer to the research questions

Contrary to our expectations, there is no significant difference between the pre- and post-training averages for any of the variables studied based on the two-sample t-test result ($p \geq 0.05$) (Table 1).

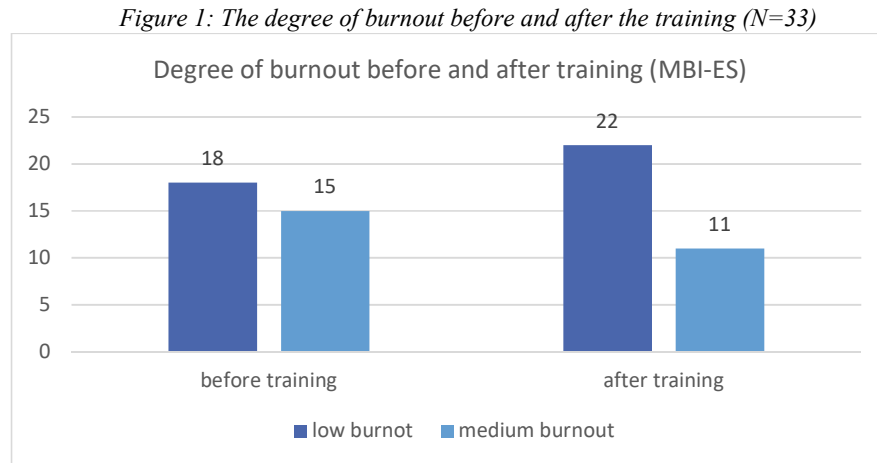
Table 1: Pre-training and post-training results

	Test time	N	Mean	Std. Deviation	Levene test sig.	Two-sample t-test sig.
Burnout total score	before training	33	42,12	19,63	0,536	0,393
	after training	33	38,15	17,84		
MOS SSS-H total score	before training	33	82,03	12,73	0,199	0,265
	after training	33	83,78	9,66		
Instrumental support total score	before training	33	13,63	2,38	0,280	0,386
	after training	33	13,78	1,79		
Emotional-informational support total score	before training	33	36,60	5,77	,512	0,341
	after training	33	37,15	4,99		
Support based on positive social interaction total score	before training	33	31,78	5,06	,068	0,165
	after training	33	32,84	3,57		
Self-regulatory subsystem	before training	33	92,93	11,82	,884	0,461
	after training	33	93,24	13,03		
Mobilizing-creative-executive subsystem	before training	33	77,45	11,21	,821	0,338
	after training	33	78,63	11,59		
Approach-monitoring subsystem	before training	33	14,30	2,84	,769	0,304
	after training	33	14,68	3,08		
Mental Health Test average	before training	33	4,32	0,68	,174	0,428
	after training	33	4,35	0,75		
Well-being	before training	33	4,44	1,04	,743	0,485
	after training	33	4,43	1,19		
Savoring	before training	33	4,80	0,77	,225	0,405
	after training	33	4,85	0,92		
Consecutive-executive efficacy	before training	33	4,49	0,83	,932	0,387
	after training	33	4,43	0,86		
Self-regulation	before training	33	4,16	1,12	,424	0,487
	after training	33	4,17	1,33		
Resilience	before training	33	3,71	1,08	,567	0,265
	after training	33	3,88	1,12		

Source: Self-edited

Q1: Does the level of burnout of the participants measured by the MBI-ES questionnaire change after the training?

Examining the effect of the training on the level of burnout, we can conclude that there is no significant change in the categories of the level of burnout (Figure 1), and this is also supported by the result of the Chi-square test ($p=0.314$).

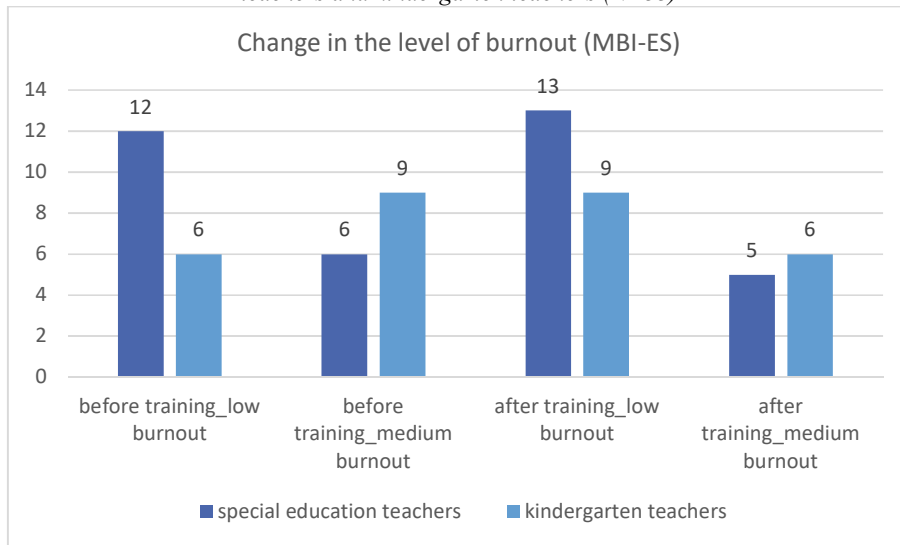


Source: self-edited

It is interesting to note that the results of the two training groups—one consisting solely of kindergarten teachers and the other of special education teachers—differ from each other. Although the sample sizes are small, allowing for only cautious conclusions, some patterns emerge. The level of burnout among special education teachers, both before and after the training, was lower than that of the kindergarten teachers. Before the training, the average burnout score for special education teachers was 34.44 (SD=14.67), and after the training, it was 33.06 (SD=14.01). Overall, special education teachers exhibited low burnout levels. Specifically, before the training, 12 of the 18 participants (66.7%) reported low burnout, which increased to 13 participants (72.2%) after the training.

For the 15 kindergarten teachers, the average burnout score before the training was 51.33 (SD=21.28), decreasing to 44.27 (SD=20.38) after the training. Prior to the training, 6 participants (40%) reported low burnout, while 9 (60%) reported moderate burnout. After the training, this ratio reversed, suggesting a significant reduction in burnout levels (Figure 2). Overall, the average burnout score for the entire sample decreased from 42.12 points (SD=19.63) at the beginning of the training to 38.15 points (SD=17.84) afterward.

Figure 2: The change in the level of burnout as a result of the training in the case of special education teachers and kindergarten teachers (N=33)



Source: self-edited

Q2: Are there changes in the subsystems of the Psychological Immune System Questionnaire as a result of the training?

Contrary to our expectations (H2), no difference can be seen in the results before and after the training in the psychological immune competence as a whole and in its subscales (Table 1).

Q3: Is there a change in any factor of the MOS SSS-H questionnaire after the training?

Based on the results of our previous research, we designed the training program in such a way as to strengthen social support within the group, however, based on the results of our present study, we found no change in the need for and forms of social support (Table 1).

Q4: Do the coping methods measured with the Coping Methods Questionnaire change after the training?

Based on our results, we can conclude that according to the Coping Methods Questionnaire, the coping methods did not change after the trainings (Table 2).

Table 2: The results of the Coping Methods Questionnaire before and after the training

	Recording of the test	N	Mean	Std. Deviation	Levene test sig.	Two-sample t-test sig.
Problem analysis	before training	33	2,38	0,62	,213	0,323
	after training	33	2,44	0,42		
Adaptation	before training	33	1,48	0,60	,152	0,411
	after training	33	1,45	0,46		
Emotionally motivated action	before training	33	0,73	0,54	,400	0,381
	after training	33	0,68	0,65		
Asking for help	before training	33	1,62	0,80	,174	0,286
	after training	33	1,75	0,70		
Purposeful action	before training	33	1,66	0,81	,432	0,154
	after training	33	1,86	0,73		

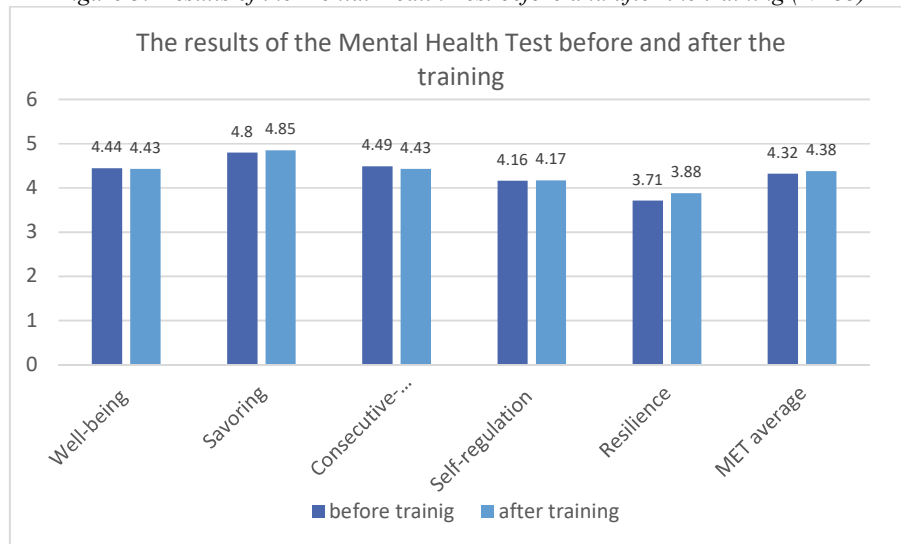
	Recording of the test	N	Mean	Std. Deviation	Levene test sig.	Two-sample t-test sig.
Searching for emotional balance	before training	33	1,21	0,82	,199	0,084
	after training	33	1,47	0,67		
Withdrawal	before training	33	1,22	0,58	,785	0,272
	after training	33	1,31	0,62		

Source: Self-edited

Q5: Is there a change in the results of the Mental Health Test as a result of the training?

We used the Mental Health Test to examine social support (Oláh et al., 2018; Vargha et al., 2020). No significant difference was found between the results before and after the training in any of the five areas examined in the questionnaire. The biggest increase can be seen in the area of resilience, but this difference is not significant either (Figure 3).

Figure 3: Results of the Mental Health Test before and after the training (N=33)



Source: Self-edited

4. Discussion

A review by Awa et al. (2010) concluded that personalized burnout prevention programs are effective in the short term (6 months or less), while programs targeting both individuals and organizations show positive effectiveness in the long term (12 months or more). Garssen and Visser (2005) conducted burnout prevention training based on transpersonal psychological principles for engineers over a 3-month period, totaling 10 sessions. They assessed burnout levels, happiness, and emotional intelligence at the beginning, end, and 9 months after the training. Their results indicated that the training effectively reduced burnout, increased happiness, and enhanced emotional intelligence.

Similarly, after a three-week stress management training for a patient experiencing high stress and at risk of burnout—focused primarily on relaxation and physical exercise tasks—perceived stress, burnout, and the number of sick days decreased, while well-being improved, as demonstrated in a follow-up assessment 6 months later (Stier-Jarmer et al., 2016).

The primary aim of our burnout prevention training was to enhance individual resources. We anticipated that this would lead to measurable changes in the clinical questionnaires used

during the study and also emphasized strengthening social support. Our hypotheses were as follows: we expected a decrease in burnout and depression levels, an improvement in psychological immune competence, and a shift from emotion-focused to problem-oriented coping strategies. However, the statistical analysis—complicated by the small sample size—did not yield the expected results. No significant changes were observed in any of the assessed areas.

As a result, we must reject our first hypothesis (H1), as there was no significant reduction in burnout levels. Similarly, our second and third hypotheses were rejected, as no significant changes were found in the three subsystems of the Psychological Immune System Questionnaire (H2) or in the factors of the MOS SSS-H (H3). For our fourth hypothesis (H4), we anticipated an increase in problem-oriented coping methods (Problem Analysis, Purposeful Action), but this was not confirmed. Although average scores showed slight increases, these were not statistically significant ($p \geq 0.05$). In terms of the emotion-focused subscales, our assumption held true, as there were no significant changes before and after the training ($p \geq 0.05$) (Table 2).

Finally, we must also reject our last hypothesis (H5), as no significant changes were found in the Mental Health Test, though we did observe a slight increase in resilience.

5. Conclusion

Although we did not observe any significant changes, we are confident that the impact of our trainings will be reflected in teachers becoming more aware of their own mental health status and recognizing the need for change. Additionally, we believe the trainings will have a positive influence on the workplace climate.

The limitations of our research include the small sample size and the short follow-up period. Therefore, our future plans involve conducting additional training sessions and implementing follow-up assessments over longer and varied periods.

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