Psychodynamic Staff Support Groups: Avoiding Burnout

Paul Dennison, Consultant Psychotherapist, S. London & Maudsley NHS Trust
DOI: 10.13140/RG.2.1.2954.5129

Introduction

Several authors (for example Thorndycraft and McCabe, 2008; Aveline, 1995) have stressed the need for employing authorities and managers to recognise their staff as their most important resource, and there is a growing body of evidence that the routine provision of externally facilitated supervision along the lines described in this chapter can support that resource and prevent staff burnout. In addition, burnout (Maslach, 1976) has serious implications for the quality of client care. The following observations are based on experience supervising or facilitating NHS staff groups over more than 10 years: in particular two S. London Community Mental Health Teams (CMHTs) for 5 years, one an Assessment and Treatment team (A&T), the other a Recovery and Support team (R&S, formerly "Case Management"), and secondly a group of Clinical Nurse Specialists (CNSs) working across a range of acute and chronic specialisms that ran for over 12 years.

Burnout as measured by the Maslach Burnout Inventory (Maslach and Jackson, 1986) is characterised by three factors: a high level of emotional exhaustion, a low sense of personal accomplishment and the development of an unfeeling, so-called depersonalised approach towards clients, or in this case service users and patients. Compared to other work groups, such as teachers for example, health professionals in general have higher rates of psychiatric morbidity (see for example Tillett, 2003), and those working in mental health face additional risks of becoming ill or burned-out (Snibbe et al., 1989). These additional risks are related to the often unconscious processes, such as projection, denial or splitting, that can lead to a worker, or indeed the larger organisation, becoming deeply affected (in some cases infected) by the client group's pathologies. In extreme cases the work itself becomes toxic.

Community Mental Health Teams

In a study of community mental health nurses (CMHNs) in Wales in 2000, Hannigan et al. found that 50% reported high levels of emotional exhaustion, 25% reported significant depersonalisation (negative attitudes to clients), and 14% reported little or no job satisfaction. A later study by Edwards et al. (2006) looking at the effects of supervision on a similar group of CMHNs, found overall levels of 36%, 12% and 10% respectively, with lower levels on the burnout dimensions corresponding to positive experiences of supervision.

The bulk of a Community Mental Health Team (CMHT) is made up of mental health nurses and social workers, with typically one or two psychologists, occupational therapists, doctors and consultant psychiatrists. Although some members of the team may have specialist training in cognitive behavioural therapy (CBT), cognitive analytic therapy (CAT), art therapy, family work or groupwork, the bulk of their work is generic, sharing their specialist skills with colleagues in the team when required.

Client groups are complex and challenging, frequently with elements of personality disorder or psychosis to varying degrees, and often with dual-diagnosis issues such as related drug and alcohol dependency, as well as complex social service problems around housing, benefits, children at risk, and so on. A significant proportion of clients are also frequently resistant in varying ways – to medication, to attending appointments, to treatments offered – and a similar significant proportion are long-term service-users whose best hope seems to be management rather than recovery. This latter used to be reflected in the “Case Management” title of some CMHTs, more recently changed to “Recovery & Support” with an accompanying implicit pressure from funding bodies to work towards discharge rather than, as they might see it, “endless” supportive work. Faced with the reality of the complex mental health and social issues of many clients, however, this may seem a forlorn hope where discharge if it does occur is all too often followed by re-referral or another crisis soon after discharge. Not surprisingly, many dedicated CMHT workers have become cynical of these cost-cutting exercises, particularly when the pressure to "throughput" patients is not matched by increased supportive provision in the community.

My role was to offer clinical supervision and staff support to each of two CMHTs for 1 hour each, with space before and after to see individual members on a 1:1 basis if requested, meeting with each team fortnightly. I agree with Thorndycraft and McCabe (*The Challenge of Working with Staff Groups*, 2008), that fortnightly is a minimum practical frequency, and would strongly recommend weekly if resources permit. The teams also acknowledged the importance of my independence from their normal line-management structures, coming in as an external facilitator to provide a safe space for team members to air whatever they choose without fear of any impact on their careers (a study of the effects of trauma on ambulance crews by Alexander and Klein, 2001, for example, noted that crews were deterred from seeking help because of just such concerns over confidentiality and career prospects).

It was also a deliberate choice to provide supervision by a psychodynamic psychotherapist in order to help the

teams reflect on the more unconscious dynamics of their work, and the impact on individuals and each team as a whole. Sessions might typically include one or more team members discussing a client, which would open up to a whole group discussion from their varied perspectives, with myself feeding in the perspective of a psychotherapist and analyst, picking up particularly on unspoken feelings and when appropriate interpreting the unconscious dynamics. During the 5 years of working with both teams, however, major structural changes in mental health provision started to take effect in the background that had profound and disturbing effects on the teams – heightened anxiety over job security; feeling undervalued; not listened to (that decisions had probably already been made); and worried about the impact of the proposed changes on their patients. At times these effects threatened to overwhelm the teams, sometimes dominating supervision to the extent that the existence of clients risked being forgotten. (In terms of Maslach's Burnout Inventory, this would correspond to a high level of depersonalisation on the scale of the whole team, risking burnout of the team-as-a-whole's efficacy.)

Psychodynamics

Many of a case worker's clients have suffered early relational trauma of one kind or another – broken families, inconsistent or dysfunctional or absent parenting, physical or sexual abuse, or both – and these relational patterns are often replayed in their interactions with their case worker, and services generally. This typically manifests as projection, denial and splitting – originally developed as defences of the sense of self to mitigate early trauma or abuse (see Malan, 1979, on psychodynamics), now become habitual character formations or personality disorders of varying degree. A large proportion can be considered to have at least borderline personality disorders.

A common scenario could be a patient who regularly turns up for meetings with his or her care-coordinator describing recurrent and seemingly intractable problems. Nothing the case worker does seems to help, or it is rejected, and even if it does help for a while is soon undermined by a "relapse" or other crisis. The patient rages at "services" and is angry, disappointed or let down by his/her "useless" case worker, while refusing to take any responsibility for the repeated failures. An experienced and resilient case worker will realise this is a projection, and be able to contain the projection and process it internally, rather than becoming overly defensive, confrontative or depressed. If inexperienced, or if depleted through exposure to too many such episodes, it is all too easy to buy-in to the projection. The projection then becomes projective identification and the result is likely to be a replay of the early relational situation – if the case worker becomes defensive and

confrontative they may “become” the abuser themselves; if they withdraw (as an unconscious retaliation) the patient again becomes the deprived child; or if overwhelmed by feelings of failure, the case worker themself becomes the hopeless depressed child.

Another more deceptive scenario might be when a patient seductively idealises their case worker, related to unconscious splitting against bad “others”. This might offer the case worker a respite for a while against the relentless resistance and negativity of other clients, and for the patient is often related to an unconscious fantasy of an endless “special” relationship with a parent, often sexualised. Not far away though is an attempt to control and manipulate the case worker, usually through evoking feelings of guilt if he/she were to abandon or let the patient down. Colleagues’ input and the team “family” are often needed to help the case worker extricate themselves from such collusive 1:1 dynamics.

Within R&S teams in particular, it is not uncommon for such very difficult and challenging patients to make up at least half of a case worker’s typical caseload of 20 or more, which is a huge emotional load to bear. Add to this the frequent disruptions of having to make home visits to non-compliant patients (often not falling within the referral criteria of the separate Home Treatment or Assertive Outreach teams – see below on fragmented services), and it is not surprising that at some point – in fact frequently – most team members struggle to cope, and indeed survive. It is testament to the robustness of the teams as a whole, and team members' support of each other, and the containing qualities of their team leaders, that they do survive.

In terms of burnout, the additional unconscious factors on top of basic stress make a mental health worker particularly prone to the MBI factors of burnout – feeling emotionally overwhelmed and eventually exhausted by the patients’ projections and demands; depersonalisation in needing to withdraw from the impact of those projections, and hence becoming less available or even hostile to their clients; and, inevitably, loss of job-satisfaction.

The supervision group is a chance to process and understand some of the unconscious processes, which often play out in the team discussion. With this kind of client group the discussion frequently becomes heated and the mechanisms of projection and its associated splitting (“good” versus “bad”) may occur in the group. On some occasions the group itself may “split” into two halves seeing completely opposite views and meaning in the case being discussed, struggling to find any common ground. The facilitator’s task at such times may be to

bridge the split. Or on other occasions one member of the team may find their view completely at odds and not understood by the rest of the team – leaving them feeling vulnerable to scapegoating or exclusion, or feeling they themselves have gone "mad". This can sometimes become such an intense focus on a particular team member – who can feel on the receiving end of anger and even hatred, or contempt, from other members – that they may feel driven towards cracking up themselves, as though they carry the madness for the whole team. If the team is a "well-functioning family" – in contrast to patients' own original and usually dysfunctional families – the team as a whole can work to contain these difficult and powerful feelings and survive. In fact the "parallel family" analogy often crops up in sessions and is found helpful, being quickly recognised and understood. Further learning takes place when in most cases links are recognised between the form of the dynamics that have played out "live" in the team, and the background and early family history of the particular patient that the group had been discussing. At such times the team gets a taste of what might have driven some of their clients into psychotic breakdown.

A Reflective Practice Group for Clinical Nurse Specialists

As an interesting comparison to working with CMHTs, I facilitated for over 10 years a group of clinical nurse specialists (CNSs) coming from a variety of mainly oncology specialisms, but also including palliative care, stoma care, chronic and acute pain and other areas. This was a "rolling" group where most members remained in the group for several years, leaving when moving jobs or taking on secondments, or for maternity leave, at which point a new member would join the group.

These nurses too often face highly charged and stressful emotional situations, but the projections and unconscious interactions they face are more in the realm of "normally neurotic", rather than the much more intrusive and borderline-psychotic encounters that CMHT workers face. In their clinical work these nurses were all very highly experienced and reflective practitioners, and in many cases already quite skilled "counsellors" in handling their patients' anxieties, despite having had no formal training in counselling. A main focus of the group developed around extending their reflective practice to better understand the emotional interactions with their patients, and within their individual clinical teams.

Again it was important to have an external facilitator separate from their line management structures, where they could feel safe to express their vulnerabilities which in their normal clinical environment they feared would be seen as weakness. This fear was projected onto me when I first took over the group as their concern that I

would not be able to cope with the explicit rawness of many of the clinical situations they might describe. My willingness to explore their assumption/fear that I might become stressed or overwhelmed helped them recover some of the projection and start to understand their own more hidden fears.

As members gradually became more able to express their true feelings, without fear of being judged as weak or ineffective, the group as a whole became a supportive and safe "container". Coming from different clinical specialisms helped members recognise common themes, and how those themes were related to basic human insecurities rather than as a consequence of any particular clinical scenario they might describe. Themes included:

- difficulties in expressing feelings that could be interpreted as "weakness";
- difficulties in saying No to unreasonable demands – whether from patients, colleagues, management or consultants;
- being vulnerable to self-blame when anything went wrong – losing sight of the larger systemic picture including others' responsibilities;
- difficulties in challenging what might be unreasonable expectations from management and senior staff such as surgeons and consultants;
- and on one occasion the conflicts around becoming a "whistleblower" to unethical practice.

Often this staff group worked well with only occasional input from myself, unlike the much more traumatised CMHTs. A session might start by one or other member "letting off steam", something they had few opportunities to do by virtue of their senior positions in their clinical teams. This might then lead the group to explore what had led that person to become so wound up in the first place, usually involving projections – sometimes of a patient's anger onto the nurse, or of a doctor or consultant's stress or frustration onto someone in the clinical team, or projections of other powerful feelings such as grief or powerlessness. Like the CMHTs they found analogies to family dynamics helpful in unpicking these various scenarios, and the "parent–adult–child" model of communication was also sometimes helpful in thinking about what might be appropriate (adult–adult) or inappropriate (parent–child infantilisation or child–child) communication.

Group CounterTransference

Just as the CMHT staff group dynamics sometimes reflected the disturbances (pathology) of their client groups

– extreme emotions such as rage or contempt, and defensive mechanisms such as splitting, or paranoia – the feeling tones of the CNS staff group members' own clinical groups at times reflected the types of medical disturbances of their patients. In individual psychotherapy this is usually described as part of countertransference – the therapist's own feelings giving a clue to the unconscious conflicts and experience of the patient. For example, CNS group members working in palliative care, with dying patients, although coping well outwardly often described scenarios that evoked feelings of exhaustion and hopelessness in those listening, and their own clinical teams when overloaded were vulnerable to feeling depressed and hopeless. In comparison, working with cancer patients appears to evoke anger and sometimes paranoid feelings as a response to being "attacked" by the cancer. Nurses in oncology often find themselves having to be very patient with angry patients and patients' families – in reality angry at the cancer, but sometimes helplessly projecting their anger onto those nearby – the nurses' task being to restrain themselves from being drawn into the projections and becoming angry or defensive themselves.

Nurses working in stoma care sometimes find themselves drawn into a mother role, as the patient, shocked at being unable to manage their own faeces or urine may regress for a while to a more helpless infant state. This role may be appropriate for a while, as the nurse contains the patient's anxieties, and as the patient learns to trust that if they look after their stoma bag it will be able to contain their urine and faeces. The fear of leaks is always close by, however, and sometimes stoma nurses themselves when overloaded would describe scenarios where they became less trustful of their colleagues, as though they feared their colleagues could "leak" and betray their confidences.

Nurses working in chronic pain were the closest in terms of severity of transference pathology to CMHT workers. Many of their patients have long histories of chronic pain where it is difficult to distinguish between the physical clinical reality and underlying psychological factors. As a psychotherapist, many of their clinical scenarios appeared to me as similar to borderline personality disorders. And as with borderline personality disorder, similar themes appeared of confusion (including whether one could "believe" the patient's description or measure of their pain), difficulties around trust, patients playing off one clinical worker against another, and a tendency to paranoia. Often not having a clear origin or explanation of the pain, the paranoid reaction sought to blame someone – who might "not be listening", or wasn't giving enough pain relief. And again with some similarity to the CMHTs, when overloaded the chronic pain teams themselves sometimes showed signs of splitting into "camps" within the overall team, or too easily blaming one of their members for making a mistake

which in other circumstances would be seen as more forgivable.

The benefit of a mixed staff group across a range of specialisms was that members could pick up on themes, and help their colleagues regain their perspectives in a safe and accepting environment. What was particularly satisfying with this group was the interest the members quickly developed in understanding the more unconscious aspects of communication, and mechanisms such as projection, denial, displacement and splitting. This could come through exploring clinical scenarios from their individual teams, but more importantly by exploring the reactions and feelings of group members "live" in the group. Many of the nurses expressed the wish that some basic counselling training should be included in nurses' training, and over the years one or two of the group's members did go on to train as counsellors or psychotherapists themselves in parallel with their work as CNSs.

The risk of burnout was never as blatant as for CMHT team members, some of whose members were frequently near the edge of that risk. For the CNS group, the risk could appear as physical and emotional exhaustion, or the urge to move jobs, but only very rarely would it extend to feeling less interested or caring towards their patients. In terms of the Maslach burnout dimensions, the CNS group members could be vulnerable on the two dimensions of emotional exhaustion and personal accomplishment, but more robust on the third dimension of depersonalisation. Also, the group was usually able to quickly help a struggling member to regain their perspective, and relieve the stress.

The Larger Organisation and Transferred Madness

"Containment" is a constant theme in running staff groups (see also Simpson, 2010, "Containing the Uncontainable", based on working with staff teams from acute psychiatric wards). Containment means providing a safe environment to explore and express otherwise difficult or frightening feelings – to be able to contain and try to understand those emotions rather that deny, avoid or suppress them. For the CMHTs dealing with a largely personality-disordered client group there is always nearby a sense of instability – the threat of collapse or being overwhelmed – and it is a key task of case workers and the team (and its supervisor) to contain anxiety. If a case worker becomes overwhelmed and is not contained, they themselves may use the same mechanisms of defence as their client group – projecting their frustration onto colleagues or the larger organisation, and becoming prone to black-and-white, good versus bad splits in their own views of services, clients and sometimes colleagues. Parallel processes occur at different levels of the organisation, so

that for example when the CMHT teams felt increasingly overwhelmed by the oppressive background of cost-cutting pressures and reorganisation, they themselves would rail against "management" just as their clients frequently railed against "services". In addition, weak points become more vulnerable, as in the parallel of a CMHT patient pushed towards a psychotic relapse through sensing less support from the overstretched team, and a team member becoming increasingly "mad" as though reflecting the precarious state of the team as a whole.

The larger organisation, in our case the NHS Trust or Mental Health Services, is also at risk in how it handles – again whether it can contain and process – the pressures and projections on to it from the different layers – of political pressure, lobbying organisations such as MIND or SANE, funding bodies such as the PCTs, patients and their families, CMHT workers, nurses, and so on. As in the situation for the patient, the same unconscious defences of projection, denial and splitting may occur. This is not to unnecessarily pathologise the organisation, these defences are as basic to the human psyche as the fight–flight response is to stress and attack. The defence is against feeling overwhelmed by demands, or of being attacked (such as being criticised for offering an inadequate service, which may itself be a projection from those criticising to avoid owning their own helplessness or lack of a solution), or feelings of failure. A major way this has played out for mental health services in recent years, in my view, has been in the separation ("splitting") of services – into separate A&T teams, R&S teams, assertive outreach teams, rapid response teams, home treatment teams, for example. This has been rationalised as a response to the ever-growing scale of mental health services, as well as the "lure" of seeing these separated services as "better" because they are "specialised" in specific areas. The reality, however, has become defensive and territorial gatekeeping around referral criteria, and difficult and often acrimonious communication between services. The very separation of services makes projection of unconscious fantasy ("it's their fault") onto the "other" so much easier, and the result risks the organisation as a whole becoming "mad", or burning out, replicating the patients' experiences both in their original families, and now in their experience of mental health services. In the end the patient loses.

The risk in this cannot be overstated, and just as case workers and teams need help in understanding the total dynamics – i.e. including the unconscious processes – so too does the organisation as a whole. Cilliers (2003) also highlights this point as a result of a focus-group study of burnout from a systems psychodynamic perspective, commenting that to cope with burnout of individuals, "the total system [i.e. organisation as a whole] will [need] to become aware of its projections and own its good and bad parts alike".

The CMHT team member in particular is frequently caught in the middle, taking on powerful projections from very ill patients on one side, and from management and above on the other.

Traumatic Incidents, death and suicide

Palliative Care nurse members of the CNS Group were impressive examples of how it is possible to work with expected and non-traumatic death in a caring, respectful and compassionate manner, without being overwhelmed by feelings of hopelessness or failure (see Payne, Seymour and Ingleton, 2008, for an introduction to palliative care nursing). To other members of the CNS Group they were an inspiration and immensely helpful when another member of the Group might be deeply affected by the death of a patient who they had grown close to. Traumatic or unexpected death, however, particularly suicide, is much more difficult.

It is no exaggeration to say that CMHT team members suffer a degree of repeated trauma in their interactions with patients, and patients' suicides often have a powerful impact that can be underestimated by management. The case worker may have worked with the patient for several years, through various crises, ups and downs, and is not infrequently the most significant relationship for the patient. In the aftermath of a suicide he/she will invariably go through a period of self-searching as to whether they had missed anything, and whether they could have done anything better, as part of their personal grieving process. At the same time they are faced with the inevitable inquiry and form-filling, often experienced (whether intended or not) as persecutory and looking for faults or someone to blame.

At these times colleagues and the team can be a huge support, particularly if several team members had known the client, as often used to be the case in the older Case Management model, but less so now in the faster-discharge Recovery model. I have been many times impressed with the ways teams rally on these occasions, often arranging a team member to attend the funeral, and sending a wreath, all of which serve to mark the occasion with respect and give at least a degree of closure.

In the aftermath of a traumatic death, suicide or critical event, both clinical nurses in the CNS Group as well as CMHT case workers described often feeling rushed in having to get back on track in managing their large case loads. One CMHT case worker described feeling guilty that he had "abandoned" his client who had died, leading to difficulty sleeping and rumination about the client. Although team support can be very helpful, it

takes time to "digest" the emotional impact of such events. In a study of the impact of critical incidents on ambulance crews, Alexander and Klein (2001) reported that 69% of the crews felt they had insufficient time to recover between incidents. In addition, whilst 40% experienced their distress easing after a few days, nearly 30% of those interviewed described significant distress lasting several weeks to months.

I am not aware of any similar study for mental health workers, although a study by Whealin et al. (2007) of the effects of trauma on US services medical personnel also highlights the need to address the aftermath of trauma more fully. They comment that all too often intervention or help is offered too late, by which time the affected worker may already be diagnosed with PTSD and on the way to discharge from the service – i.e. burned out. They also link the vulnerability to burnout to the early attachment experiences of healthcare workers, a paradigm useful in this discussion of nurses' and CMHT team members' experiences.

Attachment Viewpoint

As an external supervisor, I was often struck and impressed by the high levels of competence and dedication of CNSs and CMHT workers. At the same time, these admirable character traits may add to their vulnerability to burnout. Psychodynamic theory would suggest that individuals choose (largely unconsciously) occupations that reenact childhood dynamics, with the hope (again largely unconscious) of resolving issues of self-worth and "place" in the world. Malan (1979), for example, referred to the "helping profession syndrome" of compulsive giving and availability, unconsciously related to unresolved early childhood issues of guilt and reparation. If the career is "successful", in satisfying others' needs, then the professional's own existential needs may be satisfied, but if the strategy "fails", the individual may be vulnerable to a sense of failure and depression. Both groups – CNSs and CMHT teams – came to recognize the link from this to their difficulties in saying No to unreasonable demands.

According to attachment theory (see for example Ainsworth, 1991), adult relational styles develop from our earliest experiences relating to our primary caregivers, particularly our mothers. "Good-enough", warm and responsive mothering leads to a "secure attachment" of trust, that care and love will be there when needed, without over-dependence. In adulthood this transfers into a secure attachment style where appropriate care can be given to, and expected from, others. If the primary care is ambivalent, unpredictable or dismissive, the attachment is described as insecure, and the infant shows similar avoidant or ambivalent traits in its attempt to make at least some connection to the caregiver. At worst a more disorganised or even chaotic relational

pattern may develop and be the forerunner of personality disorder.

Attachment theory provides a useful paradigm to understanding some of the relational factors that may contribute to burnout (see Ma, 2006 and 2007, for an introduction to its relevance to psychiatry; also Seager 2007). Malan's "helping profession syndrome" suggests that many healthcare professionals may suffer at least a degree of early insecure attachment, and hence repeated negativity and rejection of help by patients will challenge the capacity of the case worker to maintain a secure and healthy attachment style. If this is aggravated by a **non-empathic organisation**, ever alert to individual failure, the case worker may become insecurely attached both to his client and the larger organisation, becoming distrustful and withdrawing, leading to emotional exhaustion and depersonalisation – the beginnings of burnout. During my time working with the CMHTs, the introduction of the "electronic Patient Journey System" (ePJS) seemed to symbolise the non-empathic organisation. With only minimal consultation, case workers over quite a short period of time were required to enter every "event" onto the new computer system (summaries of all face-to-face meetings, of all phone contacts, and all paperwork – which had to be scanned in) with little or no extra admin help. It was explained that this would increase efficiency (time, costs) and address risk (more joined-up services for the patient), perfectly rational aims – for management. For case workers, however, this was a huge and time-consuming additional load. It was also introduced too rapidly and computers were frequently very slow. Case workers worried the data might be used to analyse whether they were using their time efficiently, as in time-and-motion studies, and felt "checked up on"; and were cynical about the issue of risk – that the exercise was more to cover the Trust's back in case of a serious incident, than to improve the patient's experience. In fact patients suffered because their case workers had less time for direct clinical work, as well as being more stressed and therefore sometimes less emotionally available to them – hence increased risk. Team members felt threatened on all three of Maslach's burnout dimensions. In such situations the supervision group's task is to provide a counteracting securely attached "family" where these fears and feelings can be expressed safely. In this case the Group – after a long and difficult struggle against feeling powerless and hopeless, finally decided to express some of their feelings, together with some positive suggestions, in a joint letter to management, who responded by coming to talk to the teams more openly about the changes. This helped, but only to a small extent, as many team members felt their trust in the larger organisation had been irreparably damaged. As noted earlier in the chapter, it is at such moments that one cannot help but notice the parallels in how patients' experiences – in their dysfunctional families – can be projected and played out across different levels of the organisation.

The Whealin et al. (2007) study of US service medical personnel confirmed a link between early insecure attachment to parental figures, and a later propensity towards poor coping and PTSD after traumatic incidents – that is, less resilience to stress. It also highlighted that critical incidents posed a threat to group cohesion (attachment), and that the group as a whole may need help in surviving these threats; which, as we are suggesting, can be provided by external supervision.

On the positive side, if the staff team, supervision group and larger organisation can function as "securely attached" groups, individual workers have a containing structure that can help them weather the ups and downs of their emotionally challenging work. An Israeli study (Pines, 2004) on adult attachment styles and burnout confirms that a secure attachment style correlates to less risk of burnout, with the converse for insecure (anxious/ambivalent, or avoidant) attachment.

Recommendations/Closing Comments

The role of "containment" has been mentioned several times in this chapter. Whilst psychotherapists are very familiar with establishing a safe and trustful environment when working with individuals, working with staff groups in large organisations – in this case the NHS – highlights the multi-dimensional nature of containment needed for such organisations. My experience is that even sensitive line-management is not sufficient given the emotional demands senior nurses and frontline mental health staff face, as well as the external pressures the organisation as a whole faces. Independent supervision along the lines of Team Development and Reflective Practice (TDRP) Groups (Thorndycraft and McCabe, 2008), as described in this chapter, can be highly effective in addressing this need. Although those who have participated in these groups – both facilitators and group members – can attest to their value, there is an urgent need to establish an evidence base to justify funding in future, and I would urge all facilitators to adopt an appropriate measure – such as the Maslach Burnout Inventory – administered when someone joins the group, and at (say) 6-monthly intervals thereafter. Facilitators already experienced in running such groups are also aware of the need to offer training to others interested in TDRP groupwork (more information on training can be obtained from the author).

Personal therapy throughout their training is considered essential for psychotherapists to be able to understand and work with mental disorder. Both clinical and mental health nurses, on the other hand, as well as most other CMHT staff, are expected to cope in highly stressful emotional situations without that benefit.

Because of their in-depth training in understanding unconscious dynamics, psychotherapists are therefore particularly suited to helping staff groups understand the deeper emotional issues that can lead to burnout. However, a detached stereotyped "analytic" stance is inappropriate – the facilitator/supervisor needs to be active and involved in the group process, far more active than they might be in more orthodox psychotherapy, whether individual or group.

From my own experience I would also highlight a need for the following, particularly within NHS organisations:

- Praise and acknowledgement of work well-done; easily overlooked in overstretched and stressed organisations. Such positive reinforcement mirrors good parenting in infancy that fosters a secure attachment pattern, and can support a resilient attachment style for the work team. Duxbury et al. (1984) note that autocratic leadership styles such as "I'll tell you if you've done it wrong" are associated with high levels of burnout for intensive-care nurses.
- Clearer protocols after traumatic deaths and client suicides, including recognition of the traumatic effects of such incidents on nurses and case workers, and the need to allow case workers time and space to process their grief, with sensitive debriefing and access to confidential counselling if required – to mirror an empathic organisation. The risk at such times is that managerial anxiety might overwhelm clinical and personal anxiety, creating a non-empathic organisation – for example in an unconscious pull to seek "blame" rather than understanding and learning from such events.
- Because of their complex and often very damaged client group, CMHT case workers could benefit from more training and workshops on Personality Disorder and Attachment Theory to inform and help working with this client group (as of 2009/2010, such workshops, case discussions and seminars are being offered by the St Thomas' Psychotherapy Department within the S. London & Maudsley NHS Trust).
- Provision to frontline health workers of at least occasional "alternative" stress-reduction services such as relaxation or meditation/mindfulness workshops, reflexology or massage, even if only once or twice a year. Such interventions can be surprisingly effective in raising morale and team well-being. Mindfulness training (now recognised by NICE guidelines as effective in reducing relapse rates for chronic depression) may be particularly helpful in developing resilience to burnout.
- The provision of regular and confidential health checks with appropriate follow-up advice and treatment where necessary for early recognition of stress-related symptoms. (This would probably be taken as given in equivalent private-sector stressful occupations.) The Whealin et al. (2007) study of Services medical

personnel mentioned earlier highlighted that interventions were often too late to prevent PTSD.

References

Ainsworth, M. (1991) "Attachments and other affectional bonds across the life cycle", in C.M.Parkes, J. Stevenson-Hinde and P. Marris (eds), *Attachment Across the Life Cycle.* London: Routledge.

Alexander, D.A. and Klein, S. (2001) "Ambulance personnel and critical incidents: Impact of Accident and Emergency work on mental health and emotional well-being", *The British Journal of Psychiatry*, 178, 76–81.

Aveline, M. (1995) "Occupational stress and performance in mental health workers", *Current Opinion in Psychiatry*, 8, 73–75.

Cilliers, F. (2003) "A systems psycho-dynamic perspective on burnout", S*outh African Journal of Industrial Psychology*, 29, 4, 26–33.

Duxbury, M.L., Armstrong, G.D., Drew, D.J. and Henly, S.J. (1984) "Head nurse leadership style with staff nurse burnout in Neo-Natal Intensive Care Units", *Nursing Research*, 33, 2, 97–101.

Edwards, D., Burnard, P., Hannigan, B., Cooper, L., Adams, J. and Juggessur, T. (2006) "Clinical supervision and burnout: The influence of clinical supervision for community mental health nurses", *Journal of Clinical Nursing*, 15, 8, 1007–15.

Hannigan, B., Edwards, D., Coyle, D., Fothergill, A. and Burnard, P. (2000) "Burnout in community mental health nurses: Findings from the All-Wales Stress Study", *Journal of Psychiatric Mental Health Nursing*, 7, 2, 127–34.

Ma, K. (2006) "Attachment theory in adult psychiatry. Part 1: Conceptualisations, measurement and clinical research findings", *Advances in Psychiatric Treatment*, 12, 440–49.

Ma, K. (2007) "Attachment theory in adult psychiatry. Part 2: Importance to the therapeutic relationship", *Advances in Psychiatric Treatment*, 13, 10–16.

Malan, D. (1979) *Individual Psychotherapy and the Science of Psychodynamics.* London: Butterworth.

Maslach, C. (1976) "Burned Out", *Human Behaviour*, September, 16–22.

Maslach, C. and Jackson, S.E. (1986) *The Maslach Burn-Out Inventory Manual* (2nd edn). Palo Alto, CA: Consulting Psychologists Press,

Payne, S., Seymour, J. and Ingleton, C. (2008) *Palliative Care Nursing: Principles and evidence for practice*, 2nd edn. New York: McGraw-Hill

Pines, A.M. (2004) "Adult attachment styles and their relationship to burnout: A preliminary cross-cultural investigation", *Work and Stress*, 18, 1, 66–80.

Seager, M. (2007) *"National Advisory Group on Mental Health, Safety and Well-Being. Towards Proactive Policy: Five Universal Psychological Principles",* National Advisory Group, London.

Simpson, I. (2010) "Containing the uncontainable: A role for staff support groups", in *Psychological Groupwork with Acute Psychiatric Inpatients.* London*:* Whiting & Birch, pp. 87–105.

Snibbe, J.R., Radcliffe, T., Weisberger, C., Richards, M. and Kelly, J. (1989) "Burnout among primary care physicians and mental health professionals in a managed health care setting", *Psychological Reports*, 65, 775–80.

Thorndycraft, B. and McCabe, J. (2008) "The challenge of working with staff groups in the caring professions: The importance of the team development and reflective practice group", *British Journal of Psychotherapy*, 24, 2, 167–83.

Tillett, R. (2003) "The patient within – psychopathology in the helping professions", *Advances in Psychiatric Treatment*, 9, 272–79.

Whealin, J.M., Batzer, W.B., Morgan, C.A. III. and Detwiler, H.F. Jr (2007) “Cohesion, burnout and past trauma in tri-service medical and support personnel”, *Military Medicine*, March.