The role of groupwork in tackling organisational burnout: two contrasting perspectives

Jerome Carson¹ and Paul Dennison²

Abstract: The issue of occupational burnout is a concern to managers as it impacts on the quality of client care. Burnout is said to comprise three elements. These are a high level of emotional exhaustion, a low sense of personal accomplishment and the development of an unfeeling, so-called depersonalised approach towards service users. In this paper, we describe two contrasting approaches that used groupwork to tackle the problem of staff stress and burnout in mental health workers. The first used three-day self-esteem workshops. The second used staff support groups that were run fortnightly over a five-year period. Both approaches have their merits. While the concept of burnout is essentially a negative one, there may be a role for developing alternative approaches based on positive psychology and attachment theory.

Key words: burnout; occupational stress; positive psychology; self-esteem workshops; staff support groups; psychodynamic approaches; attachment theory.

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1. Consultant Clinical Psychologist
2. Consultant Adult Psychotherapist

Addresses for correspondence: Dr Jerome Carson, Consultant Clinical Psychologist, South-West Sector CMHT, 380 Streatham High Road, Streatham, London SW16 6HP, England. jerome.carson@slam.nhs.uk.
Dr Paul Dennison, Consultant Psychotherapist, St Thomas’ Hospital, Westminster Bridge Road, London SE1 7EH paul.dennison@slam.nhs.uk.
The concept of burnout

The term burnout originated in America where it was developed independently by two workers, Freudenberger and Maslach. For Freudenberger, the concept was similar to the dictionary definition of burnout, meaning 'to fail, wear out or become exhausted by making excessive demands on energy, strength or resources' (Freudenberger, 1974). Mental health workers are felt to be especially prone to burnout, as they deal with clients who almost always focus on negative aspects of their lives. Likewise the work may also attract staff who are more sensitive to feelings and may be more prone to the despair that many of their clients present with. Maslach felt that it was the demands of the client work that led to staff losing 'all concern, all emotional feeling for the persons they work with and come to treat them in detached or even dehumanised ways' (Maslach, 1976, p.16).

Burnout is said to lead to low staff morale, higher levels of absenteeism and high job turnover. The most wide ranging and helpful definition of the concept has been provided by Schaufeli and Enzmann. They describe burnout thus

Burnout is a persistent, negative work-related state that is primarily characterised by exhaustion, which is accompanied by distress, a sense of reduced effectiveness, decreased motivation and the development of dysfunctional attitudes and behaviours at work. This psychological condition develops gradually but may remain unnoticed by the individual involved. It results from a misfit between intentions and reality in the job. (Schaufeli and Enzmann, 1998, p.36)

The issue of burnout is one that has attracted considerable attention from mental health researchers. There have been studies of burnout in mental health nurses (Melchior et al., 1999; Killeen et al., 2001), social workers working in mental health (Evans et al., 2006), occupational therapists (Lloyd et al., 2004), psychiatrists (Mears et al., 2004) and clinical psychologists (Ackerly et al., 1988). There have also been several comparative studies which have looked at burnout across mental health professions (Leiter and Harvie, 1996; Onyett et al., 1997). Most of these studies have been cross-sectional questionnaire-based studies that have looked at the assessment and measurement of burnout, the
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majority utilising the Maslach Burnout Inventory (Maslach and Jackson, 1986). There have been a dearth of intervention studies. In this paper we describe two contrasting groupwork approaches towards tackling occupational burnout. The first describes self-esteem workshops and the second psychodynamically based staff support groups.

Case study 1: Self-esteem workshops to tackle burnout (Jerome Carson)

The self-esteem workshops were developed as a way of possibly tackling staff stress. They were grounded in a theoretical model of the stress process. This model postulated three levels to the stress process. The first is that of external stressors. These are said to comprise major life events, hassles and uplifts and specific occupational stressors. For instance, within mental health settings, many British social workers have statutory responsibilities under the Mental Health Act. These may cause them specific stress, such as having to bring patients into mental hospital against their will. The third level is that of stress outcomes. Stressors may have a negative effect on staff in terms of causing psychological distress, low job satisfaction and high burnout. Positive stress outcomes comprise psychological well-being, high levels of job satisfaction and low levels of burnout. Whether stressors have positive or negative effects depends on the mediating or moderating factors available to each individual which are the second level in the model. Factors that have been shown to be important are levels of self-esteem, range of coping skills, social support, hardiness, mastery, emotional stability, happiness, line manager support and physiological release mechanisms (see Carson and Kuipers, 1998 and Carson, 2005 for a fuller description of the model).

Over a number of years I have tried to develop interventions that might lead to a reduction in staff stress and burnout. An initial attempt to evaluate the effectiveness of a social support based intervention proved unsuccessful (Carson et al., 1999). Self-esteem workshops seemed to offer a more promising way of addressing these issues and this was confirmed after an initial pilot study (Carson et al., 2001). The self-esteem workshops comprised 10 modules delivered over a three day period. These modules comprised inter alia an introduction
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to the area, achievements and self-esteem, self-image and self-belief, friendships and self-esteem, relationships with clients, affirmations, roles and identity, participant presentations and setting self-esteem goals (see Carson, 2006, for a more comprehensive explanation of the programme components). In the pilot study, staff were given a range of self-report measures at the start of the three day workshop, and were sent follow-up questionnaires some weeks after the end of the programme (80% of participants responded to this request). To test the effectiveness of the self-esteem workshops, a further set of workshops was set up using a randomised controlled design. Staff who volunteered to participate in the self-esteem intervention were either allocated to a set of workshops taking place within the next two months, or else had to wait for six months before joining a workshop. Table 1 presents the results of the workshops. In the self-esteem workshop group, staff were assessed on a range of questionnaires at the start of the workshop and at the end of the three day workshops. In the waiting group, staff were assessed at allocation and then later at the start of the workshops (that is, they had not received any intervention at their two assessment occasions).

Table 1
The effects of self-esteem workshops on psychological distress and burnout

<table>
<thead>
<tr>
<th></th>
<th>Self-esteem workshop</th>
<th>Waiting group</th>
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<tbody>
<tr>
<td></td>
<td>Pre</td>
<td>Post</td>
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<tr>
<td>General Health Questionnaire (GHQ-12)</td>
<td>4.08</td>
<td>2.36</td>
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<tr>
<td>Maslach Emotional Exhaution</td>
<td>23.56</td>
<td>22.28</td>
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<tr>
<td>Depersonalisation</td>
<td>6.19</td>
<td>5.21</td>
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<tr>
<td>Personal Accomplishment</td>
<td>32.89</td>
<td>35.02</td>
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The results show positive changes in burnout as a result of participating in the self-esteem workshops. There was a drop in Maslach Emotional Exhaution scores, a reduction in Depersonalisation and an improvement in levels of Personal Accomplishment. Burnout scores for staff who were in the waiting group were slightly worse. A comparison
of statistical effect sizes showed that these changes were very modest and the biggest changes were in staff levels of self-esteem. A more effective intervention to tackle burnout would therefore need to be more focussed on burnout itself and not just on potential moderating or mediating influences such as self-esteem. While some workers have developed specific burnout based approaches (Pines and Aronson, 1988), empirical data on their effectiveness is lacking.

Case study 2: Psychodynamic based support groups for staff (Paul Dennison)

The following observations are based on experience supervising or facilitating NHS staff groups over the last 10 years, in particular two South 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').

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 or splitting, that can lead to a worker, or indeed the larger organisation, becoming deeply affected (infected) by the client group's pathologies. In extreme cases the work itself becomes toxic.

In terms of the Maslach Burnout Inventory (Maslach and Jackson, 1986), a study of community mental health nurses (CMHNs) in Wales in 2000 (Hannigan et al., 2000) 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 Community Mental Health Teams

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.

The 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 etc. A significant proportion of clients are 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 ‘endless’ supportive work. Faced with the reality of the complex mental health and social issues of some 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.

My role was to offer group supervision to each team fortnightly for 1 hour, with space before and after to meet individual members on a 1:1 basis if requested. I agree with Thorndycraft and McCabe (2008), that fortnightly is a minimum practical frequency, and would strongly recommend weekly if resources permit. It has also been important that I was independent of the teams’ 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. At times these effects threatened to overwhelm the teams, taking centre stage in 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’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 and splitting – originally developed as defences of the sense of self to mitigate early trauma or abuse, now become habitual character formations or personality disorders of varying degree. A large proportion would be considered to have at least borderline personality disorders.

A common scenario could be a patient who presents with 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-into 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 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 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, 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 loss of job-satisfaction. As a comparison, I have also facilitated for over 10 years a ‘rolling’ group of clinical nurse specialists (CNSs) across a variety of mainly oncology specialisms, but also including palliative care, stoma care and other areas. 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 ‘nicely neurotic’, rather than the much more intrusive and borderline psychotic encounters that CMHT workers face.

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. Or 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’. If the team is a ‘well-functioning family’ – in contrast to the patient’s own original and usually dysfunctional family – it can 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 in the team, and the particular patient’s early family history.

The larger organisation and transferred madness

Containment is a constant theme. When dealing with a largely borderline client group there is frequently a sense of instability – the threat of collapse or being overwhelmed is not far away 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 – 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.

The larger organisation is also at risk in how it handles – again whether it can contain and process – the pressures and projections onto 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, and so on. As in the situation for the patient, the same unconscious defences of projection 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 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 – 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 [organisation as a whole] will [need] to become aware of its projections and own its good and bad parts alike’.

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

It is no exaggeration to say that 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 is often the case. I have been impressed many times 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 suicide or critical event, the case worker can often feel rushed in having to get back on track in managing their large case load. One 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 – burned out. They also link the vulnerability to burnout to
the early attachment experiences of workers, a paradigm useful in this
discussion of CMHT team members’ experiences.

Attachment viewpoint

As an external supervisor, I have been repeatedly struck and impressed
by the high levels of competence, dedication and flexibility of 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.

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),
and Malan’s (1979) ‘helping profession syndrome’ suggests that
many healthcare professionals may suffer at least a degree of early
insecure attachment. Repeated negativity and rejection of help by
patients challenges the capacity of the case worker to maintain his/
her own 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 withdrawn, leading to emotional exhaustion and depersonalisation, the beginnings of burnout. Team support and the function of the supervision group can provide a counteracting securely attached ‘family’ to mitigate the risks.

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. 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 discussing, 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.

**Conclusions**

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 here can support that resource and prevent burnout. (For a fuller description of Team Development and Reflective Practice [TDRP] groups see Thorndycraft and McCabe, 2008.) Psychotherapists are particularly suited to this role because of their in-depth training in understanding unconscious dynamics; however, a detached stereotyped ‘analytic’ stance would be wholly inappropriate – the supervisor needs to be active and involved in the group process.

Because of the complex and often very damaged client group, case
workers could benefit from more training and workshops on Personality Disorder and Attachment Theory to inform and help working with this client group.

Also, I would personally like to see a reappraisal of the effects of splitting services, with moves towards reintegration, to avoid the larger organisation itself becoming dysfunctional and mirroring some of the characteristics of the client group.

Additional support might or should include:

- Praise and acknowledgement of work well-done. 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 client suicides. Recognition of the traumatic effects of such incidents on 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. The unconscious pull to seek ‘blame’ needs to find a better balance in understanding and learning from such events.

- Occasional provision to CMHT members of ‘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.)
Discussion

We have presented two contrasting groupwork approaches towards tackling burnout. The first was a short-term three-day workshop that tried to boost the self-esteem of staff. The approach was very strong methodologically, using robust standardized questionnaires and a randomised controlled design, but had only a limited effect on staff levels of burnout. The second described staff support groups facilitated by a consultant psychotherapist, run over a five-year period for the two teams in a CMHT. No quantitative data were presented to demonstrate whether this approach was more or less efficacious. However the fact that the groups were run over such a long period and attended by most of the CMHT clinical staff, suggests that at least the staff found them helpful in dealing with the series of organizational changes that they had to adjust to. Several studies were cited that confirm the value and effectiveness of group supervision, but in an increasingly evidence based culture in mental health, more work needs to be done to better understand the efficacy of groupwork-based approaches. In addition to the annual administration of measures such as the Maslach Burnout Inventory, audits could also be conducted of participants’ views of how beneficial they have found the support groups or whatever groupwork intervention that is utilised.

Inevitably, when presenting two such diverse approaches towards groupwork, it is harder to tease out areas of similarity. How do we best use groupwork to tackle the issue of burnout? From a staff perspective the area of positive psychology may also be relevant (Seligman, 2002). As well as raising awareness of burnout, including the multilayered dynamics described in the second case study, we might also help staff connect with their strengths and help them find evidence of their personal effectiveness at work (for an example of the strengths approach take the test at www.viastrengths.org). What factors help prevent burnout developing? What factors strengthen staff resilience? Finally, the suggestion that attachment theory offers a better understanding of what may be happening in burnout, is an approach that other workers are already exploring (Seager, 2007).
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References


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