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Exploring Burnout Experiences and Wellbeing Nurturing Practices of Mental Healthcare Staff: A Narrative Inquiry.

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ABSTRACT

Existing literature has shown increasing prevalence rates of workplace burnout (Squiers et al, 2017; Johnson et al, 2018). Whilst a wealth of research has identified causing factors and symptoms of burnout, comparatively less research has focused on strategies that best protect against burnout and nurture well-being. Therefore, this study aimed to explore how mental healthcare staff experience burnout, with a specific view of learning what factors they attribute to causing burnout, and what strategies they have found to most effectively reduce burnout and support well-being.

An opportunity sample of four participants completed a professional quality of life questionnaire (PROQOL-5) (Stamm, 2009) and online qualitative survey; responses were analysed using descriptive statistics and narrative text inquiry respectively.

Analysis of participants' narratives revealed a shared sense of being less powerful individuals failed by a more powerful system. Participants felt a lack of resources, reflective supervision, and high work demands that conflicted with internal values to all be significant contributors of burnout. Participants found informal peer support, flexible working, boundaries and exercise to be helpful in reducing burnout.

Participants narratives help to inform best practice strategies. Further studies exploring a wider population of mental healthcare professionals' experiences is recommended to further increase understanding of effective strategies that nurture subjective well-being.

KEY WORDS:	BURNOUT	WELLBEING	SELF-CARE	SUPERVISION	PEER SUPPORT

Introduction

Workplace wellbeing of psychological therapy services and mental healthcare staff is a current key focus within psychological research (Westwood et al, 2017; Johnson, 2108; Oates, 2018) literature (Parry and Gilbert, 2017), editorials (Peate, 2017), professional psychological bodies (British Psychological Society and New Savoy Partnership, 2015), and National Health Service Standard Contract policies (NHS England, 2016). Individuals who pursue a career in healthcare and psychological therapeutic services are often driven by a high level of compassion for, and a desire to help, others (Coates and Howe, 2015). Therefore, healthcare professionals such as nurses, clinical psychologists, and therapists can often feel a sense of fulfilment from their work, however there can also be negative effects (Aronsson et al, 2017; Westwood et al, 2017; Johnstone, 2108).

The term burnout was first identified by clinical psychologist Herbert Freudenberger in his 1974 article 'Staff burn-out' (Freudenberger, 1974). Since that time, burnout has become widely accepted as an emotional and physical response to enduring levels of work-related stress involving three progressive components; emotional exhaustion, disconnection, and a sense of low personal accomplishment (Aronsson et al, 2017; Gajewski et al, 2017; Hall et al, 2016). The first stage of burnout, emotional exhaustion, has been described as the central strain component of burnout and refers to a state of feeling emotionally drained of one's resources; a depletion of mental energy due to work-related and interpersonal demands (Simbula and Guglielmi, 2010; Bakker and Costa, 2014). Disengagement, can be explained as the attitudinal dimension of burnout, in that it refers to a mental distancing, for example, negative and impersonal responses toward a client (Simbula and Guglielmi, 2010; Squiers et al, 2017). Although debate exists to say that perceived low-efficacy is more a consequence than a symptom of burnout (Westwood et al, 2017), a sense of low personal accomplishment is commonly accepted as the final stage of the burnout process and refers to self-doubt in one's competence to adequately complete duties fundamental to their professional role (Aronsson et al, 2017; Squiers et al, 2017).

Notably, beyond the negative impact to personal individual well-being, the implications of burnout are costly to employers as burnout is consistently associated with higher staff turnover and absence rates (Rao, 2018). In particular, the sickness rate of public sector mental healthcare staff is approximately double that of private sector mental healthcare staff, with 26% of mental health doctors and one quarter of mental health nurses taking unplanned time off work due to anxiety or stress related issues (Johnson et al, 2018). Of further concern, burnout has been associated with poor client care and safety (Hall et al, 2016; Johnson et al, 2018; Rao, 2018).

A cultural change has been experienced within psychological therapies since the implementation and rollout of the government funded National Health Service (NHS) Improving Access to Psychological Therapies (IAPT) Programme (Binnie, 2015; Steel et al, 2015; Rao et al, 2016). Approved by the National Institute for Health and Care Excellence (NICE), IAPT now provides evidence-based psychological talking therapies as a treatment for a range of difficulties experienced by children, young people and

adults of all ages (Department of Health, 2008a). However, in a bid to reduce unemployment figures, with the specific aim to increase the taxpaying population and reduce incapacity benefit claims, IAPT treatment was initially only intended for working age adults who were suffering with depression or anxiety (Clark, 2011; NHS Choices, 2015).

The implementation of IAPT, together with ongoing austerity measures, have undoubtedly contributed to professionals who work in psychological therapy services to be increasingly exposed to low autonomous roles within target-driven work environments (Binnie, 2015; Mattheys, 2015; Westwood et al, 2017). Despite over forty years of research exploring and identifying various aspects of burnout, the prevalence of burnout continues to increase at a yearly rate (Squiers et al, 2017). Rising demands on staff resources, alongside insufficient protective intervention strategies, ultimately contribute towards the increasing prevalence of burnout among mental healthcare staff (Johnson et al, 2108). Indeed, almost half of NHS staff have had recent experiences of depression (BPS, 2017) and psychological studies have identified rising burnout prevalence rates of up to 67% in mental healthcare staff (Morse et al, 2012), and up to 69% in UK psychological therapists (Westwood et al, 2017). While burnout can be experienced by individuals from a variation of occupations (Simbula and Guglielmi, 2010; Bakker and Costa, 2014), professionals working in mental health care services are particularly vulnerable to experiencing burnout as their characteristics tend to naturally include high levels of compassion and empathy (Coates and Howe, 2015; Parry and Gilbert, 2017:114). Moreover, recognising that characteristics and personality traits of health care professionals have remained constant over time, Squiers et al (2017) surmise that the increased prevalence of burnout can be attributed to situational changes.

In response to the 'Workforce Wellbeing Survey 2014 – 2016' survey results (New Savory Conference, 2017; Parry and Gilbert, 2017:15), the 'Charter for Psychological Staff Wellbeing and Resilience' was developed (British Psychological Society and New Savoy Partnership, 2015) which aims, with staff wellbeing and client outcome in mind, to 're-set the balance' and provide a network that allows professionals working within the psychological therapy services to come together and share their thoughts, experiences, concerns and hopes in relation to issues of staff wellbeing.

Accepted factors that support workplace wellbeing involve person-directed and organisation-directed strategies (Johnson et al, 2018). With a focus on the subjective well-being (SWB) levels of nurses, Oates (2018) study suggests that person-directed self-care strategies such as practicing mindfulness, making healthy lifestyle choices and developing clear boundaries between work and home life help to improve SWB. Clinical supervision is one important organisation-directed strategy that has shown to improve SWB and reduce burnout (Steel et al, 2015; Oates, 2018). Additionally, Klein et al (2017:1) study participants described the "inability to act according to one's own moral judgement" and "a sense of powerlessness" as direct contributors to psychological distress; accepting that well-being is a continuum (Johnson et al, 2018) it makes sense

then that autonomy and flexibility have been identified as effective strategies that protect against burnout (Aronsson et al, 2017; Oates, 2018).

What remains unclear is if person-directed or organisation-directed strategies are most effective burnout interventions, though participant sampling may be responsible for contrasting meta-analysis study findings (Johnson et al, 2018), therefore further research is needed. Moreover, recent psychological literature has identified a lack of research that focuses on effective intervention strategies that reduce burnout, and protective strategies, specific to mental healthcare staff, that increase subjective well-being (Squiers et al, 2017; Johnson et al, 2018; Oates, 2018). Therefore, the overarching aim of this study was to explore how mental healthcare staff who work within psychological therapeutic services experience workplace burnout, and what protective strategies were found to be helpful in reducing burnout. Through analysis of participants' stories as they described and reflected upon their personal experiences of burnout, the specific study objectives were:

- To identify factors that contribute and maintain workplace burnout.
- To identify self-care practices that mental healthcare staff find protective against burnout.
- To identify workplace strategies that may help to reduce experiences of burnout among mental healthcare staff and inform the literature base through novel lived experience accounts.

Methodology

Design

A mixed-methods design was employed. The study involved six demographic questions, followed by a qualitative survey that consisted of seven open-ended questions. The survey questions were designed to facilitate explorative and reflective responses from participants who were asked to write about their personal and observational experiences of burnout. The study also involved a quantitative measure; the Professional Quality of Life Scale (PROQOL-5) (Stamm, 2009). The measure is used to monitor the positive and negative effects of helping (Circenis et al, 2013), and consists of three subscale measures: compassion satisfaction, secondary traumatic stress, and burnout. The 30-item Likert questionnaire has a response format ranging from 'Never' (1) to 'Very Often' (5) and is made up of the three 10-item sub-scale questionnaires: 'My work makes me feel satisfied' is an example statement from the compassion satisfaction scale, an example statement from the secondary traumatic stress scale is 'I can't recall important parts of my work with trauma victims', and 'I feel connected to others' is an example statement from the burnout scale.

Participants

Participant recruitment was an opportunity sample that consisted of five Clinical Psychologists. Inclusion criteria involved qualified mental health professionals who have worked in professional psychological therapeutic services in England for a minimum of twelve months, and who self-identified as having personal or observational experiences of burnout.

One participant, Tabitha, gave consent and completed the questionnaire but did not complete the survey. Each of the participants who completed the survey component of the study was aged between 25 and 35 years old, had been working as a qualified Clinical Psychologist, in the public sector, for varying times between one and five years. Three of the four participants were female, and one male.

Data Collection

Online survey website Qualtrics was used for data collection. The study was advertised on online platform Twitter with a study specific tag. Conducting qualitative research online can remove meeting arrangement challenges, geographical restrictions (Synnot et al, 2014), be helpful for participants who are experiencing fatigue (Guise et al, 2007), and help to remove the stigma associated with mental healthcare professionals disclosing their own experiences of mental health difficulties (Johnson et al, 2018). Therefore, the researcher felt that conducting the survey online was the most appropriate for this study, providing participants with full anonymity and the opportunity to complete the survey at a time and location that was most convenient and comfortable for them.

Once self-referred, participants followed the survey link. The study process began with a Welcome Page, followed by a Participants Information Sheet. Participation was voluntary; participants gave their informed consent prior to completion and answered six demographics questions. Followed by the PROQOL-5 scale (Stamm, 2009) and the survey questions. A Debrief Sheet informed participants of their right to withdraw, as well as provide details and links to support services should they have experienced any feelings of distress.

Data Analysis

This study was interested in personal experiences of workplace burnout; therefore, a descriptive statistics analysis was performed to analysis participants' responses to the ProQOL-5 measure. In accordance with author guidelines (Stamm, 2010), participant's score for questions 1, 4, 15, 17, and 29 from the Burnout scale were reversed prior to analysis.

Clandinin and Connelly's (2000) narrative inquiry method was used to analysis participants' responses to the survey questions; participants' narratives were structured chronologically to allow analysis along the temporal dimension (Appendix 9). Less concerned with abstracting themes and more concerned with individual experiences and the meaning attached to them (Stephens and Breheny, 2013) narrative inquiry is a relatively new methodology within qualitative research that offers flexibility within a pragmatic framework (Clandinin and Huber, 2010). In line with the researchers own social-constructionist epistemological position (Andrews, 2012; Willig, 2013), Clandinin and Connelly's (2000) narrative inquiry involves a three-dimensional space narrative structure that facilitates a broader social consideration of participants' stories (Riley and Hawe, 2005) and involves analysis of participants narratives across the personal-social interaction, temporal and place dimensions. The personal-social interaction dimension

considers internal conditions (personal) such as hopes, personality characteristics, morals, beliefs and feelings, as well as their interactions with external conditions (social) such as other people's viewpoints, beliefs, experiences and intentions. The temporal (or continuity) dimension acknowledges the relationship between past, present and future and so engages with participants' narratives from a chronological stance; for example, how participants felt and experiences they have had (past), how they feel and what is happening in their lives now (present) and what their expectations and thoughts are as they look forward (future) (Clandinin and Connelly, 2000; Law and Chan, 2015; Wang, 2017).

The researcher read participants' stories repeatedly to achieve familiarity, and to gain a holistic understanding of their lived stories; attention was given to various aspects of the participants life, and the interaction and impact they have on each other. The researcher further acknowledged the importance given by participants to the details they included within their stories; in this way, it was possible to achieve a deeper understanding of the complexities of participants stories and relate their language to meaning (Riley and Hawe, 2005; Kim, 2016). As a counselling and psychotherapy student who aims to work within mental healthcare services, it is important to acknowledge the researcher's position within the research and their subjective qualitative interpretation of participants' narratives (Clandinin, 2006; Seidman, 2006).

Ethical Considerations

Following the British Psychological Society (2009) and the university's internal ethical guidelines, the study was approved prior to commencement (Appendix 10). Due to inclusion of participants' direct quotes, confidentiality could not be assured, however anonymity was upheld as participants chose a pseudonym prior to participation.

All data was stored on a secure password protected computer until the submission date of 17th April 2018. Thereafter, the research supervisor will remain the custodian of the data, on the university's staff R-Drive for ten years.

Participants gave their informed consent (PHG Foundation, 2008) and were informed of their right to withdraw; participation was voluntary, and informed consent was obtained prior to participation. Information of support services and website links were provided on the Debrief Sheet. Computerised data complied with the requirements of the Data Protection Act 1998).

Analysis & Discussion

The professional lifestyle questionnaire, which was included in the study to add further context to participants' survey responses and to identify any potential trends and patterns, was completed by five participants. Scores from the descriptive analysis identified each participant's score as average on the Compassion Satisfaction scale, with a mean score of 35.40. Four participants scored within the low range of the Secondary Traumatic Stress scale, one participant (Jenny) scored average, with a mean score of 23.20. Burnout scale results identified each participant scored within the average range, with a mean score of 28.20. The questionnaire scores represent a

snapshot of the participants' feelings over the last thirty days and appear to reflect participants' narratives, which discuss their personal experiences of burnout as in the past and their self-care practices as in the present; suggestive that participants of this study are well positioned to inform effective well-being strategies.

Table 1: Descriptive Statistics among all scales.

Scale	*Minimum*	*Maximum*	*Mean*	*Std.Deviation*
CSS	32	38	35.40	2.30
STSS	17	30	23.20	5.93
BS	22	34	28.20	4.38

As explained by Wang (2017:45), storytelling is 'a fundamental element in narrative inquiry [that] provides the opportunity for dialogue and reflection, both intertwined and cyclical'. Participants reflectively discussed their stories; exploring their experiences of burnout, what factors they felt caused workplace burnout, what they found helpful in nurturing their own subjective well-being and looked ahead as to what they believe might help reduce burnout within the workplace environment. Analysis of participants' stories revealed three narrative threads: burnout experiences, contributing and maintaining factors, self-care practices and external support are important for nurturing subjective well-being, and reflective supervision, increased resources and boundaries are needed to move towards increased well-being levels. These are presented and discussed in more detail within the chapters below. The personal-social interaction dimension discovered participants' viewpoint of burnout had developed through their own lived experiences, the observations of colleagues' experiences, and shared stories within work environments. Participants believed burnout to be heavily developed and maintained by 'systemic failings' that do not sit comfortably with their own moral values. The temporal dimension was shaped by participants narratives as they reflected back to their own experiences of burnout, discussed what they have found helpful in nurturing their own subjective well-being and used their experiences to look ahead at what workplace strategies might be most effective at reducing workplace burnout. The place dimension discovered that participants felt like less powerful individuals working within a powerful system.

Chapter One: Burnout experiences, contributing and maintaining factors *"I worry that in a few years I will be too tired to continue caring" (Sam).*

Participants described how they felt during times of feeling burnout, and the negative implications it had on their mental and physical health, as well as in their work and personal life. Wayne described "difficulties in personal relationships" as one way burnout impacted his life and Zoe explained that "sometimes people in my personal life do not get the best of me, which I don't always feel comfortable with". Looking at the personal-social interaction dimension, Zoe and Wayne's narratives open their identity beyond their professional role and suggest an internal moral distress as their external workplace demands appear to conflict with their individual internal values. Moral distress was further suggested when participants considered how burnout had impacted

colleagues “People are overstretched and unable to complete paperwork due to striving to do the best for those they support” (Sam). In addition, Zoe expressed how burnout has affected colleagues outlook:

> I have also worked on wards where I have felt the majority of staff have burnt out, where they are going through the motions but not going above and beyond, and seemingly hopeless about the possibility of possible change for clients.

Participants discussed how burnout impacted on their mood, motivation and energy levels. Jenny explained that at times she has ‘felt in low mood’ and ‘found it difficult to do things outside of work due to levels of tiredness and feeling unmotivated”. Similarly, having a “lack of energy/enthusiasm” was how Wayne described his experience and explained that he had “low motivation to go to work – i.e. getting up in the morning”, “poor sleep”, “problems in ‘switching off’, and had experienced “not feeling like I’m doing a good enough job at anything”. Thinking ahead, Sam talked about her “worry that in a few years I will be too tired to continue caring” and added:

> I never want that to happen – I came into this job to help people understand their difficulties and to find ways to overcome problems.

Participants also described the negative impact burnout had to their physical health, Jenny explained “I quite often get tension headaches and these really impact on my work” and went on to add that she would “have to go home and go to sleep”. Other physical symptoms included, “physical symptoms of stress, teeth grinding, gastro problems, pain” (Wayne).

Drawing on the place dimension, an overall sense of feeling let down by organisational systems came through. Participants narratives revealed they viewed the key contributing and maintaining factors of workplace burnout to be grounded in systemic failings, specifically to be associated with high demands placed on individuals’ resources that were not equally matched with supportive organisational resources. Jenny said that one contributing factor of her burnout experiences was the “political issues around the NHS and mental health care”. Wayne talked about the “culture of service (just get on with it); it not being okay to acknowledge when struggling” as contributing to his burnout, and went on to add that:

> Being around colleagues who were similarly burnt out/ground down because of wider pressures, systemic failings and poorly resourced services certainly had an impact.

The need for a “supportive team who understands” was further discussed by Jenny, who explained that “there is often a lot of emotions within a secure setting which can get projected into staff”. Sam mentioned a lack of support, along with lack of praise, recognition and control, as well as a “lack of support to prioritise self-care” and “a lack of training” as significant contributing factors to burnout. Although it was unclear if Sam

was referring to a lack of general job training or a lack of training more specific to self-care practices, recent research has acknowledged a lack of job training as a cause of burnout, it sensibly follows then that organisational-directed job training and education has shown significant effectiveness in reducing burnout (Johnson et al, 2018).

Participants burnout experiences are consistent with those discussed across existing literature. Research acknowledges the negative impact to individuals' psychological wellbeing as including feelings of hopelessness, anxiety and depression (Gajewski et al, 2017; Simionato and Simpson, 2017). Caused by conflicting internal values and external work environment demands, moral distress among healthcare professionals has been consistently associated with burnout within mental healthcare literature (Maslach et al, 2012; Whitehead et al, 2015; Manankil-Rankin, 2016). Concurrently, low level workplace support, high workload and a lack of reflective supervision have also been consistently identified by psychological literature as significant contributors to burnout (Aronsson et al, 2017; Simionato and Simpson, 2017). Indeed, alongside high workplace demands and inadequate resources that include insufficient staffing, 'excessive workload', a lack of support and 'lack of opportunity for skills development', a further accepted cause of burnout specific to mental healthcare professionals is the level of 'emotional labour' involved in caring for patients and clients (Johnson et al, 2018:22). In addition to, physical symptoms that can include sleep disturbance, respiratory infections, and cognitive depletion such as memory and attention difficulties (Bakker and Costa, 2014).

Chapter Two: Self-care practices and external support are important for nurturing subjective well-being *"taking time for myself to focus on self-care" (Zoe).*

Analysis of participant's stories revealed that each participant's narrative was heavily shaped by what they had found to be helpful in nurturing their subjective well-being, particularly Sam and Zoe, whose scores were two of the highest on the Compassion Satisfaction Scale, and lowest on the Secondary Traumatic Stress and Burnout Scales. Participants were clear that helping clients was one area of their work that they felt helped to reduce burnout. Wayne explained that he did not attribute stress and burnout "to direct experience with patients" rather he found direct experience with patients to be "one of the restorative aspects of the role". Likewise, Jenny explained that:

> when someone is helped to change or sharing a formulation helps someone be better supported then this is very rewarding and helps those feelings of burnout.

Self-care practices such as "engaging in my own therapeutic activities (usually CFT)" (Zoe), "reading around empathy and compassion fatigue" (Jenny), and "focusing on the positive work I have achieved" (Sam) had been found to be helpful. For Jenny and Zoe, physical exercise helped to reduce burnout, "looking after myself (doing yoga..)" (Jenny) and "doing exercise, especially things like yoga" (Zoe).

Drawing on Clandinin and Connelly's (2000) place dimension a need for boundaries and 'space' emerged as a common self-care strategy across participants' narratives. Participants acknowledged the important role creating distance from workplace demands had to their subjective well-being, though admitted that it is not always clear at the time (Wayne):

> not recognising how stressed I was, and not putting in place enough self care (this being almost impossible to recognise when things are difficult – it was only when I changed jobs I came up for air and realised how bad things had been).

Zoe commented that "taking time out for myself to focus on self-care, be that a glass of wine and some chocolate", "connecting with friends" or "doing something completely unrelated to my role, e.g. crafts or playing the piano" were some of the activities that she found to be helpful at times of experiencing burnout. Jenny found "having breaks" and "using leave" helpful. For Sam, creating space involved having a "boundaried lunch break" or "leaving the desk and getting some fresh air".

Sam reflected upon her own experiences and advocated "enforced lunch breaks with staff rest areas big enough for the team to sit together" as one ideal organisational-directed protective strategy. Jenny agreed that "having breaks" were helpful in nurturing well-being and Zoe discussed the need for workplaces to encourage "actually taking a lunch break".

Overall, participants outlook appeared to be one of disappointment with their workplace. Despite a common feeling of lack of organisational support, participants discussed how they have found support from peers to be helpful, (Zoe):

> There is a general sense that we look after each other, but I'm not sure how much this translates into practice.

Participants explained the benefits of connecting with colleagues about work related difficulties and getting peer support. For Jenny, "a supportive team who understands" helped to maintain her well-being, and "Speaking to peers within the team and finding out that others had similar feelings" was helpful for Wayne. Likewise, Zoe discussed the value of talking with colleagues:

> Being able to talk to people in the same profession who really understand the demands and expectations of the role, as my partner does not really understand it.

It might be that the activities discussed by participants helped to provide a restorative space that facilities reflexivity, for example Yoga has been recognised as promoting mental, and physical, health through its 'mind-body practices' that include relaxation, mindfulness, and a 'cultivation of positive values, thoughts and attitudes' (Manincor et al, 2016:817). Marley (2011) suggested that the benefits of reading literature around a

subject can help to develop self-awareness, improve self-care and support feeling positive; whereas drinking alcohol or eating chocolate can be a relaxing activity that helps to achieve a sense of calm, although perhaps there could be an element of numbing as well.

In addition, participants from Oates' (2018) study on nurses' SWB, also acknowledged physical exercise and clear boundaries between work and home life as supporting increased well-being. With clinical psychologists in mind, workplaces ensuring staff have a healthy work life balance was one of the recommendations put forward at the recent British Psychological Society Wellbeing Conference (Rao, 2018).

Research continues to acknowledge a lack of workplace support as a cause of burnout (Johnson et al, 2018), understandably then, accepting burnout and well-being to be at opposite ends of a continuum (Maslach et al, 2012; Johnson et al, 2018) staff will likely feel heightened well-being levels from peer support. Notably, the level of support in the workplace has also been acknowledged as a significant contributor to staffs' subjective sense of role competence (Ben-Porat, 2017).

Chapter Three: Reflective supervision, increased resources and boundaries are needed to move towards increased well-being levels *"More understanding about the need for reflective spaces" (Jenny).*

When considering what workplaces could offer to promote staff well-being, organisational-directed interventions promoted by participants included "regular CPD" (continued personal development) (Sam), "ensuring there are opportunities or avenues for people to give feedback" (Zoe), "more flexible working where possible" (Jenny), and "supporting flexible working" (Wayne).

Further suggestions included increased funding and resources and reflective supervision sessions. The "impact of nursing staff shortages" was acknowledged by Jenny, and Wayne discussed the need for "recognition when services are under-funded/under-resourced" and to recognise burnout "as a systemic problem rather than an individual failing of a staff member for not being resilient enough". Sam talked about the "systems not working together (health staff having to do social worker roles due to lack of social care resources". Understandably then, a need for increased resources and funding "money available for training" (Sam) and "more resources, enough nursing staff" (Jenny) were areas that participants felt should be addressed.

Inadequate supervision emerged across participant narratives as central to contributing to burnout. Participants talked about a lack of clinical supervision, explaining that most supervision time was devoted to managerial issues rather than providing a space for reflexivity. A lack of a "'restorative' component" within supervision settings was put forward by Wayne, who went on to add that during supervision sessions too much focus was on "managerial/practical aspects of work" rather than being an "explorative space to discuss emotional responses to work". Likewise, Zoe commented that although she does have regular supervision it can be "difficult to prioritise and make space in it to

discuss clinical issues rather than professional/managerial issues". Jenny explained that "more understanding about the need for reflective spaces and impact of therapy on staff higher up in the NHS" would further support well-being.

The lack of adequate supervision came through as a real sense of a failing system and so was presented as an organisational intervention that needs to be central in moving forward. Wayne sought therapy outside of work which he found to be "helpful in normalising/stepping outside the culture of the service/department", therefore he suggested staff would benefit from having "separate management/reflective supervision; ideally by two different people". Zoe agreed that "ensuring everyone has adequate clinical supervision" could promote staff well-being and suggested "having things like supervision built into our clinical contracts" would also serve to better recognise the responsibilities of supervising staff members. Wayne suggested that one way workplaces could support practical self-care was through 'supporting flexible working'. Indeed, Jenny has found that the "flexible working" and "lots of ad hoc supervision" have helped to support her well-being and so feels that "more flexible working where possible" would further promote staff well-being.

Other workplace interventions that promote self-care and well-being were put forward, such as "facilitating things like yoga, mindfulness, walks etc in breaks or after work" (Zoe). Mindfulness has consistently been recognised as nurturing well-being (Pakenham, 2013; Oates, 2018).

Participants narratives are in line with current research literature that has noted mental healthcare staff who do not have regular supervision perceive it as 'a failing of their service or organisation (Oates, 2018:38). Participants further discussed underfunding and under staffing issues; the importance of workplaces providing adequate resources that match workloads is recognised by current literature which associates both of these workplace environments with increasing stress levels and demands on staff (Johnson et al, 2018) that may ultimately lead to negative impact on patient safety (Hall et al, 2016).

Low job control has shown to be a key factor in contributing towards the development of burnout (Aronsson et al, 2017) and one way to reduce that is through flexible working which can increase job satisfaction, provide a sense of increased autonomy, particularly in achieving a work-life balance, and result in a less demanding workload, although it is worth noting that a possible downside of flexible working can be work intensification, fewer career opportunities and reduced pay scales (Kelliher and Anderson, 2010; Piasna, 2018).

Limitations

The findings of this inquiry are not intended to be generalised across all mental healthcare staff. It is important to note that Clinical Psychologists have implicit and explicit training on self-care strategies (Pakenham, 2015), and therefore may have increased awareness of well-being issues and protective strategies than other mental healthcare staff. However, their stories serve well to inform clinical practice of what

strategies and interventions do work effectively in enhancing subjective well-being in the workplace, and consequently reducing burnout.

Conclusion

Participants' narratives from this study suggest that informal peer connectedness, developing a work and home life balance, and reflective supervision are central to reducing experiences of workplace burnout and effectively nurturing subjective well-being. Fitting with the positive psychology approach of Oates' (2018) refreshing study, and in order to be able to move forward in reducing the growing prevalence of burnout in mental healthcare staff, it is important to listen to, and learn from, the stories of individuals who have successfully recovered from it. Workplace burnout continues to be a relevant and current focus of psychological research and interest; participants' narratives of present study support previous study findings of what factors contribute to and protect against experiences of workplace burnout (Squiers et al, 2017; Johnson et al, 2018; Oates, 2018). Participants reflective accounts of their past experiences of workplace burnout, and discussions of what they found to be helpful in overcoming burnout, can serve to help other healthcare professionals to develop successful self-care strategies, inform employers of workplace strategies that have shown to be effective in reducing burnout. It is a recommendation of this study that future research leans towards further exploration of what self-care practices and workplace interventions staff working within psychological therapeutic and mental health services have found to be helpful in reducing experiences of burnout and promoting subjective well-being.

Reflexive Analysis

Following Willig's (2013) model of personal reflexive analysis, this section is a critical reflexive analysis of how I as the researcher have been a part of the research process, contributed to the interpretation and conveying of participants narratives and meanings throughout this research project and how this research project has impacted me, at both a personal-development level and as researcher.

At first thought, I could not see how I was involved; the participants were recruited online so we neither knew each other or have ever met. I have no recent relevant work experience within mental healthcare, so I saw myself as 'outside' of that aspect as well. However, as I reflected more deeply I thought about why I had conducted this research in the first instance. As a counselling and psychotherapy student, I hope to have a career as a helping professional and so have a personal interest in learning how professionals who work in therapeutic and mental healthcare settings manage their own well-being in respect of the emotional involvement associated with caring for people who are experiencing distress (Parry and Gilbert, 2017). As previously mentioned, online participation has some benefits to participants and to achieving succinct and relevant responses (Synnot et al, 2014), however during analysis of participants narratives there were many times when I, as the researcher, would have liked to have had the opportunity to learn a little more about participants stories and this is something that I would give much thought to when conducting future research.

Reading literature around burnout and well-being prior to conducting the study, I had expected participants responses to talk about self-compassion as a self-care practice (Parry and Gilbert, 2017) and was surprised when it was not mentioned. However, because of conducting this research project, my own awareness of the importance and value of self-compassion has developed and has already proven to be helpful in my own life.

I have enjoyed reading positive mental attitude and self-help books for quite some time (over 25 years), and for me, Oates' (2018) study that looks at what makes nurses happy was a bit of a lightbulb moment in how I presented my own subjective interpretations of participants stories in my own research project. I had already noticed participants responses were heavily focused on what they find helpful in nurturing their own well-being. In line with positive psychology, a perspective that 'feels comfortable' to me, I wanted my research project to present not only what is wrong, but to also focus on what is right. In this way, I hope that I have produced research that is in keeping with my own stance as a researcher, but also has an integrity and transparency that respects the participants stories.

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