TREATING **BURNOUT** ON THE FRONTLINE

Frontline NHS workers are at high risk of burnout. ***Gloria Howard*** explains how a trauma-informed approach to treatment can be effective

Frontline roles often attract people who want to make life better for their fellow human beings. The jobs can be fulfilling and a source of growth. But they are also inherently demanding and stressful, involving high-pressure situations, long hours, irregular shifts, unpredictable work schedules and regular exposure to human violence and suffering.

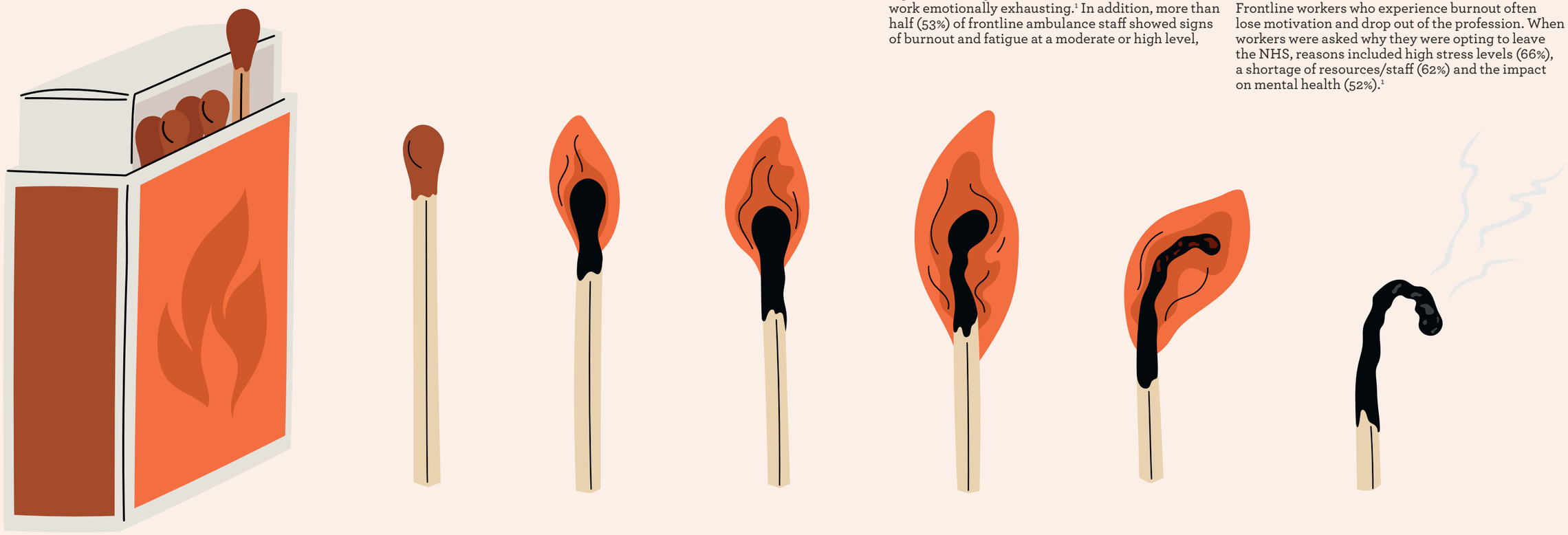
Working conditions can also make it difficult for some staff to prioritise their self-care, seek support, maintain healthy relationships outside of work and engage in leisure activities. As a result, they are potentially more vulnerable to mental health problems and 'burnout'.

In a 2022 NHS workforce survey, 34% of participants reported feeling burned out and 37.4% found their work emotionally exhausting.[1] In addition, more than half (53%) of frontline ambulance staff showed signs of burnout and fatigue at a moderate or high level, with almost nine out of 10 (87%) reporting moderate to high depersonalisation.[1]

The NHS describes depersonalisation as '... the feeling of being outside yourself and observing your actions, feelings or thoughts from a distance'.[2] Persistent exhaustion and burnout experienced by frontline staff are believed to contribute to depersonalisation symptoms.[3]

'Severe burnout typically incorporates elements of trauma'

Frontline workers who experience burnout often lose motivation and drop out of the profession. When workers were asked why they were opting to leave the NHS, reasons included high stress levels (66%), a shortage of resources/staff (62%) and the impact on mental health (52%).[1]



The knock-on effects on the frontline service include staff shortages, premature loss of experienced staff, scarcity of replacements and the high cost of training new staff.

There are implications for the service user and society, too, such as reduced availability of services and risk of inadequate treatment.

'Frontline workers are also exposed to the suffering of others'

Frontline workers tend to avoid or minimise the extent to which they are affected by their work.[4] They operate in a culture where it is often considered a weakness to require or seek emotional support. In my experience, they also fear that recognition of their problems will make them bigger and less bearable.

What is burnout?

Burnout can be defined as a syndrome resulting from unmanageable, chronic stress in the workplace. It is characterised by emotional exhaustion, feelings of cynicism and detachment from the job, as well as a sense of ineffectiveness or lack of accomplishment.[1]

Burnout is recognised as an 'occupational phenomenon' by the World Health Organisation (WHO).[5] However, it is not classified as a mental health disorder in diagnostic manuals, such as the Diagnostic and Statistical Manual of Mental Disorders.[6]

Severe burnout typically incorporates elements of trauma, such as emotional distress, physical and psychological exhaustion, intrusive thoughts, mood changes, depersonalisation, avoidance, disruption of social connections and hyper-vigilance.[6]

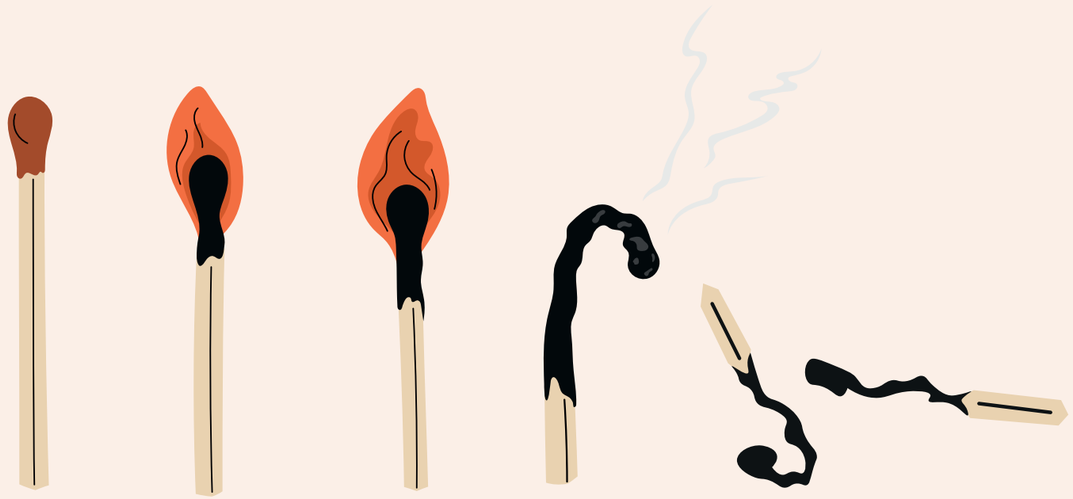
Burnout, like trauma, is not a psychological deficiency or a weakness of character. It is a terrifying and disturbing experience or series of experiences that overwhelms the nervous system, with the result that information is interpreted and stored in a way that becomes dysfunctional in the long term and overwhelms the individual's ability to function.[7]

Frontline workers are also exposed to the suffering of others, which can lead to vicarious or secondary trauma, depleting the worker's resources and causing psychological and physiological distress, disruption to daily life and feelings of helplessness and fear.

The susceptibility to vicarious trauma is particularly acute if the frontline worker has a vulnerability or an unresolved issue that connects in some way to that of the patient.[8]

It makes sense to deal with trauma or burnout as early as possible, not only to alleviate suffering but also to minimise the risk of the distress memory becoming deeply ingrained and more resistant to change.

Given the overlap between burnout and trauma, a trauma-informed approach to therapy can be effective in working with frontline NHS staff.[9] Symptom relief might take priority for an initial period. But, in my opinion, for healing to take place, therapy needs to also treat the root cause of the distress.



Neuroscience tells us that the nervous system remains in hyper-alert or survival mode,[10] unless it can find a safe, protected and calm space.

The priorities when addressing trauma or burnout are, therefore, safety and self-stabilisation. Treatment begins by facilitating orientation in the present and fostering a sense of control and distance. The trauma can then be experienced as a discreet, past episode, rather than a constant, present threat.

Burnout, however, is often a result of current, ongoing stress in the working life of frontline staff. It is therefore important not only to process past stressors but also to implement systemic changes in the workplace.

Burnout treatment also aims to equip frontline staff with the resources they need to build resilience, such as body or sensorimotor awareness exercises or mindfulness, which help staff connect with and regulate their physiological responses to trauma triggers.

Trauma-informed therapy avoids treating defences exclusively as pathology, since some defences can serve a protective and adaptive function, at least in the short term. They can, for example, provide a breathing space that allows staff to concentrate, make quick decisions and cope with emotional strain. It's important to attend to safety, self stabilisation, resilience and defences before work begins with the trauma itself, so we can minimise the risk of re-traumatisation and allow for deeper and more constructive exploration.

The trauma work relies on the activation of the distressing memory in multiple areas of the brain, working together co-operatively. A traumatic experience might initially be linked to a specific sense, yet it is likely to have affected the other senses (and corresponding areas of the brain), to a greater or lesser degree. For trauma-informed work to be effective, each of these sensory experiences requires processing.

Clinical insights

I started my practice in 1996, working psychodynamically and psychoanalytically with adults and children. I later incorporated eye movement desensitisation and reprocessing (EMDR) into my clinical approach. In 2010, I developed and implemented intensive interventions, which are informed by psychodynamic and neuroscientific principles for addressing trauma. Then, during the pandemic, I founded Therapeutic Journeys CIC, in order to expand the provision of low-cost therapy.

The effectiveness and versatility of the intensive interventions led me to create The Worry's Journey, which is a comprehensive programme of therapeutic support for people of all ages.

The Worry's Journey is typically a residential programme, involving a minimum period of four days away from routine pressures and distractions, in surroundings of peace and natural beauty.

Residential interventions allow participants to focus on the therapeutic process, without interruptions. They also suit people for whom ongoing therapy is not practical, due to shift work, as well as people who prefer a clear separation between the workplace and therapy.

Most of our service users join our programmes in search of a breakthrough in their healing or to complement one-to-one work with a Therapeutic Journeys counsellor. We accept referrals from other counsellors, as long as the referring therapist co-ordinates treatment with us.

The Worry's Journey combines one-to-one therapy with group therapy. It starts with a triage diagnosis and risk assessment to establish readiness for groupwork, which involves psychometric tests and an individual session.

'It makes sense to deal with trauma or burnout as early as possible'

A psychodynamic approach is embedded throughout the programme. So, during the preparation and any one-to-one sessions, the therapist encourages the client to:

- reflect and gain insight into who they are
- build up awareness of any patterns from past relationships that are connected to what is happening at work (work relationships)
- reflect on feelings that they consider unacceptable
- use free association.

The programme includes desensitisation and reprocessing. It also includes the facilitation of self-empowerment through psychoeducation and awareness of body sensations.

We create resources and build resilience by providing instruction and practice in self-soothing techniques, including an understanding of underlying factors, such as how one relates to oneself and the environment, as these can influence the maintenance of distress. In addition, there are opportunities to maintain and increase self-empowerment through peer interaction and support.

A nurse's experience of burnout

Leyla* is a dedicated and compassionate nurse, who started her career with high expectations and a strong desire to make a difference. She works in an A&E department, where colleagues admire her commitment and patients often express gratitude for her care.

However, A&E is busy and staff shortages have led to longer shifts and a higher ratio of patients to nurses. Leyla struggles to keep up with the workload and feels increasingly overwhelmed.

She also realises that she is deeply affected by the suffering around her and constantly worries that her patients will die. She senses, too, that she is reacting to the situation by numbing her emotions.

Leyla begins to experience depersonalisation, detaching from her actions and emotions. At times, she feels as though she is watching herself from outside her own body.

Leyla's younger brother recently died from a drug overdose, though he was not a regular drug user. Leyla has not yet processed the loss and finds it difficult to connect with patients who are struggling with substance abuse. She wants to remember her brother as special, but she can't stop thinking that he behaved irresponsibly.

During one shift, Leyla is assigned a patient, Rick, who has taken a drug overdose – and memories of her brother flood back, triggering a wave of grief. To protect herself, she avoids any in-depth discussion with Rick about his addiction and homelessness. She focuses on the clinical tasks, evading any emotional connection. Rick senses her detachment and his feedback states that he felt unsupported.

Leyla has a similar experience with another patient. The encounters erode her confidence, to the point where she starts to fear that she is no longer a good nurse or, even worse, that she could be a danger to her patients.

Leyla's recent bereavement also makes her susceptible to vicarious trauma. So, when she is caring for a patient who has been involved in a car accident with his young children, she is overwhelmed by a sorrow that mirrors the patient's own, imagining that the children will not survive their injuries, even though they are minor.

Leyla unconsciously amplifies the suffering of patients with her own unresolved grief. The displacement allows her to avoid dealing directly with her own painful feelings.

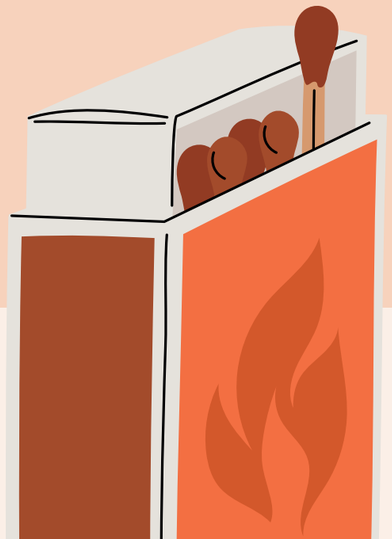
Then, an elderly patient in a critical condition is brought to A&E. The patient's ventilator malfunctions and she dies, despite Leyla's frantic efforts to save her. The incident is traumatic for Leyla. She vividly remembers the sound of the machine beeping erratically, the sight of the patient's expression of panic, her lifeless body and the sterile smell of the hospital room. The experience haunts her, replaying in her mind and affecting her hearing and vision every time she enters A&E.

Leyla's burnout begins to affect her life outside of work. She becomes irritable and withdrawn, losing interest in activities she once enjoyed. Her relationships with family and friends deteriorate and she becomes increasingly isolated.

She starts experiencing general anxiety and is always on edge, unable to relax, even at home. She becomes hyper-vigilant, constantly checking and rechecking things around the house, and struggles with insomnia and numbness. Her partner notices she is often lost in thought, staring blankly and failing to engage in conversation.

Leyla is frustrated, tired and has an overwhelming sense of dread. She has some awareness that she rationalises her emotions: 'I'm just feeling this way because it's been a long shift and I'm tired. Everyone feels a bit off at the end of their shift.' But her burnout is getting worse. Leyla does not realise – or she denies – the extent to which she uses displacement and rationalisation, or the impact they have on her wellbeing and her ability to recover the sense of fulfilment she had previously gained from her work.

*Leyla is a fictional case study, based on my own experience of working with frontline staff.



A worksheet, inspired by the EMDR group traumatic episode protocol (G-TEP),[11] is one the main components of the programme. The design and sequencing of the worksheet take into account the 'bottom up' approach to healing trauma.[12]

Traditional top-down approaches emphasise cognitive processing. The bottom-up approach prioritises the regulation of the nervous system and the awareness of sensory and somatic experiences, as crucial first steps towards distress management and healing. So, stabilisation is prioritised before any desensitisation and reprocessing are undertaken.

Memory reconsolidation[13] is another key element of the programme. Reconsolidation is the process of deliberately integrating a traumatic memory with new, more realistic and healing information, so that it can be stored, together with positive memories, as a healthy, updated memory.[14]

The worksheet guides participants through the steps of the programme, allows them to use graphics or text to represent elements of their trauma (thus creating distance and containment) and monitors their progress and levels of stress at each stage.

It is highly interactive and involves participants in reflective and sensory-based tasks. It is structured, but allows for flexibility to adapt to different contexts.

'Symptom relief might take priority for an initial period'

A self-soothing module, the Soothing Bubble, is another important component of the programme, though it can stand alone. The Soothing Bubble encourages a calmer state by creating a space for reflection and for developing the ability to interpret body sensations and experience the body as a safe container for strong feelings.

By integrating psychodynamic and neuroscience-informed models, the intensive interventions address immediate distress and build long-term resilience, ensuring frontline staff are better equipped to handle the ongoing stressors inherent in their roles. We can thereby provide holistic care that addresses both their immediate and long-term challenges.

There is a strong link between burnout and trauma, as they both activate the same survival neuropathways. Early intervention is crucial, not only to provide prompt relief from suffering but also to provide prevention strategies, stress management techniques and effective trauma and burnout therapies.

In the search for good therapeutic outcomes, I would suggest that complementing the psychodynamic model with trauma-informed insights and techniques offers a helpful approach to treating burnout among frontline staff.

Gloria Howard *is a psychodynamic psychotherapist, person-centred counsellor, EMDR therapist, supervisor and trainer, who founded Therapeutic Journeys CIC. If you would like to get in touch, please email: team@therapeuticjourneys.co.uk If you would like to get in touch, please visit the website: www.therapeuticjourneys.co.uk*

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