

The burn of burnout: a personal narrative of finding a safe space to care

Matthew Wills

HIV Social Care Coordinator, Homerton University Hospital NHS Foundation Trust,
London, UK

Introduction: caring for ourselves and each other

Since the start of the HIV pandemic medical and allied health professionals have worked in partnership with people living with HIV to ensure that care was person centred and reflective of their needs. Over the past 30 years, HIV treatment and the care offered by healthcare professionals has changed dramatically. It is well documented that having HIV has changed from a life-limiting condition to a chronic manageable one with significant improvements in health outcomes. Despite these changes in the HIV care paradigm, receiving a diagnosis of HIV and living with a stigmatising illness is still a complex phenomenon requiring person-centred support by healthcare professionals [1–3]. In our daily professional lives we have advocated and supported people who may have complex health and social care needs. Within our work we listen to many different stories relating to an individual's diagnosis and the subsequent trauma they may experience. As HIV is a long-term condition this inevitably means we walk alongside the people we are working with for many years, and, in some cases, as healthcare professionals we are the only avenue of support they feel able to accept owing to stigma from the wider society.

Cost of caring and the impact of secondary trauma

The ongoing effects of repeatedly listening to various accounts can be difficult and can leave professionals emotionally and psychologically vulnerable. Within the literature this is often referred to as vicarious or secondary trauma. This concept was first described by McCann and Pearlman in 1990 when exploring the experiences of mental health nurses [4]. Secondary trauma is defined as being a change in the psychological state of a person as a result of regularly witnessing or hearing traumatic experiences of others [4]. Secondary trauma and the ongoing process of listening to other people's suffering and can lead to significant impact on people's physical and psychological wellbeing [5]. The impact of secondary trauma has been identified as being the leading cause of burnout and staff retention issues. The research evidence on secondary trauma suggests that the longer this trauma goes unprocessed the

harder this is on someone's ability to care for themselves and others [5].

Personal narrative of secondary trauma

It is worth noting that secondary trauma can build up over a number of years and, as previously mentioned, can have a negative impact on a professional's mental health and wellbeing. This narrative addresses my experience as an HIV Social Care Coordinator. From my experience of working within the field of HIV for almost 20 years, I am aware that staff tend not to move jobs frequently. This questions whether staff are experiencing greater levels of exposure to secondary trauma compared to other specialties. I remember having a conversation with a friend who worked in Germany in a similar role to myself. When I shared how long I had been working in this care setting and the nature of the work I was undertaking he advised me to '*get out quick, before it is too late*'. At the time I brushed it off, thinking it was just a passing joke among peers, but on reflection maybe I should have listened to his words more carefully and explored this further to see if there was more I could learn, or if there were lessons he could share with me to support my work in HIV social care.

I believe many factors impact how we look after ourselves and each other. I started working in HIV care in 2001 as an advice and support worker for people living with HIV in South Staffordshire, UK. I worked in the voluntary sector alongside healthcare professionals providing support to a small cohort of people in rural and small town populations, starting with 10 clients whom I used to see regularly and support with issues relating to welfare benefits, housing and finances. Over the next 9 years the cohort increased and the models of working also changed, with more interagency working taking place. In 2010, I moved to Homerton Hospital in London to work in a newly-developed role: the HIV Social Care Coordinator. This role aimed to develop the social care service within a busy clinic in East London with a cohort of about 750 at that time. I was tasked with developing the service and supporting people with complex multi-faceted needs. It was quite a change from my previous role, but it fascinated me. There was a greater focus on immigration and poverty

with the people I was working with and I loved it. From 2010 onwards the social care landscape shifted, with funding to social care and support services being consistently cut, as highlighted in the 2016 report, *Cutting the ribbon* [6], with significant changes implemented in the Health and Social Care Act 2012. So at a time of cuts to welfare, benefit reform and austerity were imposed, the availability of specialist support also received financial cuts. This obviously impacted all individuals working in HIV, an area which historically had been well funded with ring-fenced monies in the form of, for example, the AIDS Support Grant. With this change in funding came a significantly different way of working. Reframing expectations became a part of my role for service users and professionals alike. It also brought an inner conflict; wanting to do the best for people against a backdrop of less support and opportunities. These changing expectations also affected my work with some colleagues. For myself, I only realised how challenging things had become when a few, very significant, people asked me if I was ok as they were worried. At the time it was a very difficult conversation, but in effect they had pressed the pressure release button and things started to come out. Thankfully that was the start of my acknowledgment of how bad things had become, how unwell I was, and my journey into recovery. But what if that question hadn't been asked?

Creating a culture of support

Throughout our work we are regularly assessing the mental health wellbeing of our cohort, with referral pathways having been developed within our work settings. In my work I am regularly discussing people's mental health wellbeing as a part of the wider context of living well with HIV. We promote positive mental health and destigmatise in our approach, and work with our mental health colleagues proactively in doing this. But, how effective are we at identifying our own and our colleagues' mental health needs in this process? Are we providing a 'safe space' for these things to be discussed? Or does self-stigmatisation with regards to mental health restrict people from accessing the support they need and deserve?

It raises further questions of how we as professionals may need further support to enable us to ask those difficult questions of ourselves and our colleagues. It may be that part of the challenge of asking the question: 'Are you ok?' is what we would do if the answer is 'no' and whether we can access the appropriate support. Sometimes it can be as simple as providing a listening ear, a bit of TLC etc. Certainly from my experience, the offer of a cuppa and kind face goes a long way. But we are not always effective at 'checking in' on colleagues in our ever busy working days or, sometimes more importantly, checking in on ourselves.

Obviously writing this narrative has encouraged me to reflect on my experiences, which have been heightened during the Covid-19 pandemic. Personal wellbeing is now an active discussion that we are having with our colleagues, exploring how we are feeling in incredibly

challenging circumstances. Everyone's experience is individual and it is valid. For myself, I have been working from home since March 2020. I'm lucky that I can do that and that my role is adaptable enough to work remotely. Initially I did not find lockdown too difficult, partly because last year when I was particularly unwell I self-isolated. By the time lockdown happened, I was well practiced. But as the length of lockdown and its restrictions became more apparent, I became frustrated that I wasn't in control of the situation. This mirrored how I was feeling at the beginning of my recovery, I wanted to be out doing things, but it took significant effort, an external influence impacting on my choices and autonomy.

Resilience is a word that is thrown around to describe how we as professionals cope with stressful situations [7], but it's not something that sits comfortably with me. Maybe I'm over sensitive to these things, but it places the responsibility to be resilient on the individual rather than looking at it as a structural issue. Saying that people needed to be more resilient fed into the feelings I held of not being good at my job, that I should be able to cope and that I had failed. Not everyone would feel like this I'm sure, but in the time of being aware of the language used with our patients, we should afford ourselves the same consideration and respect.

The burn of burnout

The World Health Organization defines 'burnout' as:

'A syndrome conceptualised as resulting from chronic workplace stress that has not been successfully managed. It is characterised by three dimensions:

- feelings of energy depletion
- increased mental distance from one's job, or feelings of negativism and cynicism related to one's job; and
- reduced professional efficacy.' [8]

For myself there were a variety of symptoms that on reflection demonstrated that I was burnt out. I was constantly tired, which I attributed to really poor sleep patterns (energy depletion). I would have episodes of waking up in the middle of the night, either having had a nightmare, or the first image that would appear in my mind would be anxiety about a task I needed to finish, or a task that I had forgotten about (reduced professional efficacy). I started having a note pad next to the bed, so I would write these things down for fear of forgetting them again when I was in work. Realistically this isn't a healthy tool, as it was the first thing I would see when I did wake up, compounding the dread and anxiety of work (feelings of negativism and cynicism related to one's job). I also stopped looking after myself, poor diet, no regular exercise and a lack of motivation to do anything about it. I reduced time with friends and family for fear of them noticing and asking that question that I really didn't want to answer, 'Is everything ok?' Primarily for myself, I stopped laughing and taking enjoyment in doing things. People who know me, know that I always try and see the humour in situations, I used to love nothing

more than a proper belly laugh with people, but that wasn't on my agenda, I just wanted to get through the day. Then, one morning I woke up, sat on the edge of my bed and started crying.

Once I had started I couldn't stop. It felt like a pressure valve bursting and everything started to come out. I sent an email to work explaining that I wasn't feeling well so wouldn't be in, then curled back up in bed and cried. The next few days were, and still are, a bit of a blur.

Being vulnerable and authentic

Since I've started talking about my experiences I have been contacted by colleagues in various settings saying that they too have, or are, struggling with their mental health as a result of work and other pressures. People have stated that they are worried about speaking out for fear of being judged by others. Some have also highlighted that by saying something they are admitting defeat and their own self-perceived shortcoming, or failure to do an effective job, or that there is a weakness on their part. This makes me believe that we need to look at how we support each other in what can be very challenging circumstances and ever increasing stretches on services. What we do know is that silence and not being able to tell people what has happened to us adds to internal feelings of shame, which compound peoples' psychological wellbeing and prevent them accessing the support they need.

Role for formal support

The world in which we are working is getting busier and busier; we get caught up in endless to-do lists and often there is not a lot of time to think. We feel the pressure to keep up with the demands of our workload while providing the best care possible. Reflective practice provides us with an opportunity to explore difficult situations to which there are no easy answers in a safe and supportive way. Reflective practice enables us to better understand our thought processes and develop new strategies and frameworks for complex situations [9].

Reflective practice is not a new phenomenon as it was first introduced into clinical practice in 1980 by Donald Schon [10], in many ways the principles behind reflective practice draw on ancient wisdom, such as that of Socrates, and also common sense. In clinical practice, reflective practice is usually run in a group setting, providing healthcare practitioners with the time and space they need to manage the complex emotions that arise as a result of dealing with patient care. Reflective practice can be viewed as a luxury, however there is strong evidence to suggest that having access to high-quality support in order to reflect on practice is associated with increased staff wellbeing, job satisfaction and reduced burnout [11]. It is also becoming evident that high-quality reflective practice is directly associated with positive clinical outcomes, particularly when this is supported by the culture of the organisation [12].

As well as reflective practice, clinical supervision has long been used to support professionals manage their caseloads and identify stressors within the work place. This safe space enables people to talk through challenging cases with other professionals, offering support and guidance in various forms. Effective clinical supervision helps to reduce burnout in staff [11,12].

A key challenge within clinical practice with regards to reflective practice or clinical supervision is having access to high-quality support in order for this reflection to take place and also for this aspect of care to be given the time and acknowledgement it needs to be effective. Therefore, as a discipline we need to strive towards ensuring that we create a culture where reflective practices is seen as a need rather than a luxury. I am conscious that I am in the minority as I have access to clinical supervision and have found it instrumental in my recovery.

Virtual solution

HIV care professionals come from a variety of clinical and non-clinical settings, with a diverse range of work environments, and suggesting a one-size-fits-all model is not the most effective way of developing effective clinical supervision for a diverse working cohort. In a time when we have become used to accessing support via virtual platforms this may be a means of supporting each other to prevent the burn of burnout. I know that some areas have regional nursing networks that meet and these are found to be effective in supporting colleagues, but is this a national need?

Could we learn from ways in which we support people living with HIV? Peer support has rightly been championed as an incredibly powerful tool of support, but also one for reducing stigma within communities [13]. This could be a tool that we as professionals are effective at using in supporting our own emotional wellbeing and those of our colleagues. I have been a member of the National HIV Nurses Association (NHIVNA) since I started working in HIV, and have found that it is a supportive environment. This can be seen at conference on an annual basis where we are able to catch up with our peers between sessions, it has always been something I looked forward to. I believe that there is more work that can be done to increase the frequency and opportunities to 'catch up', either virtually or in person. In effect conference became my safe space to share experiences, something that could be developed moving forward.

Concluding thoughts

Writing this piece has been both cathartic and a challenge. It's actively made me reflect on my experiences, some of which are not easy to revisit. But the process has given me the opportunity to explore what happened and how I can move forward. Within the process I have also been able to share my experience and identify triggers for myself, as well as exploring self-doubts. For effective support to be accessed and utilised by professionals, it is imperative that people

feel that they are in a safe judgement-free space to explore their experiences. There are various models of support that may work for different people in various working environments. Ultimately we need to be mindful of our stressors and develop ways to deal with these. In providing quality care to people living with HIV, we as professionals need to acknowledge that part of being effective in our work is also about looking after ourselves and our colleagues. If people burn out and leave, we face losing significant experience within our teams, something we should be trying to avoid.

From a personal perspective this journey has made me realise that there are networks of support, formal and informal, that can be utilised. Sometimes it just takes someone to check in on a colleague for the opportunity to arise. I am incredibly thankful that this conversation happened for me. Thank you.

Acknowledgments

I would like to acknowledge the support from Michelle Croston in writing this piece. Being able to take ideas out of a jumbled mind and map them effectively is a gift. Thank you.

Conflicts of interests

The author declares no conflicts of interests.

Reference

1. Antiretroviral Therapy Cohort Collaboration. Life expectancy of individuals on combination antiretroviral therapy in high-income countries: a collaborative analysis of 14 cohort studies. *Lancet* 2008; 372 (9635): 293–299.
2. Thompson MA, Aberg JA, Hoy JF *et al.* Antiretroviral treatment of adult HIV infection: 2012 recommendations of the International Antiviral Society–USA panel. *JAMA* 2012; 308 (4): 387–402.
3. Samji, H., Cescon, A., Hogg, R. S. *et al.* Closing the gap: increases in life expectancy among treated HIV-positive individuals in the United States and Canada. *PLoS One* 2013; 8 (12): e81355.
4. McCann L and Pearlan LA. Vicarious traumatization as a framework for understanding the psychological effects of working with victims. *J Trauma Stress* 1990; 3: 131–149.
5. Raunick CB, Lindell Df, Morris DL, Blackman T. Vicarious trauma among sexual assault nurse examiners. *J Forensic Nurs* 2015; 11(3): 123–128.
6. Dalton A. *Cutting the Ribbon; the current health of UK based HIV/AIDS organisation and the effects of austerity.* University of Sunderland. Available at: sure.sunderland.ac.uk/id/eprint/7104/1/NEW%20PDF%20Cutting%20the%20Ribbon%20-%20the%20Current%20of%20UK%20based%20HIV%20Organisations%20GP-Update.pdf (accessed August 2020).
7. Grant LJ, Kinman G. *The importance of emotional resilience for staff and students in the helping professions: developing an emotional curriculum.* Higher Education Academy, 2013. Available at: www.heacademy.ac.uk/system/files/Emotional_resilience_Louise_Grant_March_2014_0.pdf (accessed August 2020).
8. World Health Organization. ICD-11 for mortality and morbidity statistics. WHO, 2019. Available at: icd.who.int/browse11/l-m/en#/http://id.who.int/icd/entity/129180281 (accessed August 2020).
9. Kurtz K. *How to run reflective practice groups.* London: Routledge, 2020.
10. Schon DA. *The reflective practitioner: how professionals think in action.* Michigan, US: Basic Books, 1983.
11. Hall LH, Johnson J, Watt I *et al.* Healthcare staff wellbeing, burnout and patient safety: a systematic review. *PLoS One* 2019; 11(7): 1–5.
12. White E, Winstanley J. A randomised trial of clinical supervision: selected findings from a novel Australian attempt to establish the evidence base for casual relationships with quality of care and patient outcomes, as an informed contribution to mental health nursing practice development. *J Res Nurs* 2010; 15 (2): 151–167.
13. British HIV Association. *Standards for HIV care for people living with HIV* 2018. London: BHIVA, 2018. Available at: www.bhiva.org/ClinicalStandards (accessed August 2020).

Correspondence: Matthew Wills
matthew.wills@nhs.net